



CONYERS PEDIATRICS

NEW PATIENT INFORMATION

CHILD'S NAME: _____ **SEX:** Male
Last First Middle Female

DATE OF BIRTH: _____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

EMAIL ADDRESS: _____

HOME PHONE #(_____) _____ May we leave messages at this number? _____

MOTHER'S CELL PH #(_____) _____ FATHER'S CELL PH#(_____) _____
May we leave a detailed message at this number? _____ May we leave a detailed message at this number? _____

MOTHER'S NAME _____ Birthdate _____ SS# _____ - _____ - _____
EMPLOYER _____ PHONE #(_____) _____
FATHER'S NAME _____ Birthdate _____ SS# _____ - _____ - _____
EMPLOYER _____ PHONE #(_____) _____

DO YOU HAVE MEDICAL INSURANCE? YES NO IF YES, PLEASE PROVIDE COPIES OF ALL CARDS

NAME OF PRIMARY INSURER _____

Subscriber Name/DOB _____

NAME OF SECONDARY INSURER _____

Subscriber Name/DOB _____

Please note - we do not accept Kaiser Permanente

****PLEASE PRESENT CARDS AT TIME OF SERVICE****

How did you hear about our office? _____

THANK YOU FOR CHOOSING US AS YOUR CHILD'S HEALTH CARE PROVIDER. WE ARE COMMITTED TO YOUR CHILD'S HEALTH. PLEASE UNDERSTAND THAT PAYMENT OF YOUR BILL IS NECESSARY TO MAINTAIN THE HIGH QUALITY MEDICAL CARE WE ARE COMMITTED TO. TO FACILITATE CLAIM APPROVAL, ALL PATIENTS MUST COMPLETE OUR INFORMATION AND INSURANCE FORM AT THE FIRST VISIT IN OUR OFFICE OR WHENEVER THIS INFORMATION CHANGES. **FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD/DISCOVER. ALL CO-PAYS AND DEDUCTIBLES ARE DUE PRIOR TO LEAVING THE OFFICE.** IF THE INSURANCE COMPANY IN WHICH WE ARE A PROVIDER FAILS TO PAY YOUR ACCOUNT IN FULL WITHIN 60 DAYS, THE BALANCE IS YOUR RESPONSIBILITY. SHOULD YOU HAVE ANY QUESTIONS REGARDING THIS MATTER, PLEASE ASK ANY OF THE OFFICE STAFF. THE ADULT ACCOMPANYING MINOR PATIENTS OR PARENT(S)/GUARDIAN(S) OF THE MINOR ARE RESPONSIBLE FOR FULL PAYMENT.

I HAVE READ THE ABOVE INFORMATION AND HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE NAMED PHYSICIANS. I HEREBY AUTHORIZE MY CONSENT FOR TREATMENT FOR THE ABOVE NAMED CHILD. I ALSO AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS.

SIGNED _____ TODAY'S DATE _____