# 18 Yr Patient Update

CONYERS PEDIATRICS

Today's Date: _____

## PATIENT INFORMATION

Name: _____

Date of Birth: _____ Sex: ☐ M ☐ F

Home Address: _____

City: _____ State: _____ Zip: _____

Employer: _____

PRIMARY EMAIL: _____

PRIMARY PHONE: (____) _____ (*OFFICE USE: LABEL AS "MAIN"*)
*May we leave a message at this number?___*

Sibling Names & Dates of Birth _____

_____

_____

## PARENT/EMERGENCY CONTACT INFORMATION

Name: _____ Date of Birth: _____

Mobile Phone: (____) _____ Work Phone: (____) _____

*May we leave a message at this number?___* *May we leave a message at this number?___*

Home Address (*if different from patient*): _____

City: _____ State: _____ Zip: _____

Employer: _____

Relationship to patient: _____

**We are required to collect the following information for each patient. Please complete this section before returning the form.**

**Thank you.**

Pharmacy Name/Phone Number:

_____

Your Preferred Language:

_____

Your Race/Ethnicity
*(select one primary)*

_____

- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black/African American
- ☐ Caucasian/White
- ☐ Hispanic
- ☐ Multiracial
- ☐ Unknown
- ☐ Other _____
- ☐ Decline to answer

**Please present all insurance cards & a photo ID at the time of service**

**Thank you for choosing us as your healthcare providers.**
**We are committed to your health!**

Please understand that payment of your account is necessary to maintain the high quality medical care we strive to provide. To facilitate claim approval, all patients must complete our information and insurance forms as requested. Copayments and co-insurances are due at the time of service. We accept cash, check, Visa, MasterCard, Discover and American Express. If your insurance company fails to pay your claim within 45 days, the balance is then your responsibility. Should you have any questions regarding this matter, please speak with our Insurance and Billing staff.

**All adult patients are responsible for any payment due at the time of service.**

I have read the above information and hereby authorize payment directly to Conyers Pediatrics. I hereby give my consent for treatment and authorize the release of any medical information necessary to process claims for payment.

_____ _____ _____

**Name** *(print)* **Signature** **Date**