New Patient Information

CONYERS PEDIATRICS

PATIENT INFORMATION

Name: _____

Date of Birth: _____ Sex: ☐ M ☐ F ☐ Other

Home Address: _____

City: _____ State: _____ Zip: _____

Sibling Names/Dates of Birth _____

_____

PARENT/GUARDIAN INFORMATION

Primary Family Email: _____

Primary Family Phone: (___) _____ (*OFFICE USE: LABEL AS "MAIN"*)
May we leave a message at this number?___

Parent 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*): _____

City: _____ State: _____ Zip: _____

Employer: _____

Parent 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*): _____

City: _____ State: _____ Zip: _____

Employer: _____

Emergency Contact (relative or friend): _____

Emergency Contact Phone: (___) _____ *May we leave a message at this number?___*

Address: _____ 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: _____

_____

Your Preferred Language:

_____

Your Child's Race/Ethnicity
(select one primary)

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

Patient's Insurance: _____

_____

Plan Name/Policy#/Address/Insured's name & DOB

Please present all insurance cards & a photo ID of parent/guardian/caregiver @ each visit.

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

Please understand that payment of your child's 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 child's insurance company fails to pay his or her 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 minor patients must be accompanied by an adult, who is 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 for the above named child and authorize the release of any medical information necessary to process claims for payment.

_____ _____ _____ _____

Name *(print)* **Signature** **Relationship to Patient** **Today's Date**