

Pediatrics and Genetics, LLC

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www.pediatricsgenetics.com

PATIENT REGISTRATION

(Please Print)

Today's Date: _____ Contac Phone #:() _____ - _____ E-mail: _____

PATIENT'S INFORMATION:

First Name: _____ Last Name: _____

Middle Name: _____ Birth Date: _____ Sex: M F

Address: _____ City: _____ State: _____ Zip: _____

School's Name: _____ School's Phone #:() _____ - _____

MOTHER'S INFORMATION: (for pediatric patients only)

First Name: _____ Last Name: _____

Middle Name: _____ Birth Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ Cell#: () _____ - _____

FATHER'S INFORMATION: (for pediatric patients only)

First Name: _____ Last Name: _____

Middle Name: _____ Birth Date : _____

Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ Cell # : () _____ - _____

INSURANCE INFORMATION:

Primary Insurance Name: _____ Insurance Phone #:() _____ - _____

Subscriber's Name: _____ Subscriber's DOB: _____

Subscriber's SS#: _____ Insurance ID#: _____

Group #: _____ Claim Address: _____

SECONDARY INSURANCE NAME:

Insurance Name: _____ Insurance Phone #: () _____ - _____

Subscriber's Name: _____ Subscriber's DOB: _____

Subscriber's SS#: _____ Insurance ID#: _____

Group#: _____ Claim Address: _____

CERTIFICATION

To the best of my knowledge, the information provide on this form is complete and correct. I understand that is my responsibility to inform my doctor if my minor child ever has a change in health.

MINOR/CHILD CONCENT

I am the parent, guardian, or personal representative of _____
Please Print Name of Minor/Child

And there no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the pediatric staff to perform necessary pediatric services for the child name above, including but not limited to administration of immunizations, hemoglobin, and A 1 C glucose, which are deemed by the doctor, whether or not I am present when the treatment is rendered.

INSURANCE ASSIGNMENT AND RELEASE

I certify that my dependent(s) is covered by insurance with _____
Name of insurance Company(ies)

and assign directly to Dr. Vidya Krishnamurthy all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my minor/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment to minor/child. I accept full financial responsibility for all charges for services or items provided to me or the patient. I understand that filling a claim with my insurance company does not relive me from my responsibility for the payment of all charges.

ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I have read a copy of the Notice of Privacy Practice. The notice describes how my health information may be used or disclosed I understand that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling Pediatrics and Genetics, LLC

PRINT NAME

DATE

SIGNATURE

RELATION TO PATIENT