Patient Demographic Information

Patient Information

Patient's Last Name: _____First Name: _____ DOB:_____

Name of Patients School: _____ In What Grade?: _____

Current Age: _____ Gender: **Male** or **Female** Primary Language: _____

Name of Person Filling Out this form (YOU): _____

If the patient is over the age of 18, Patient's E-Mail address _____

Please Circle one of the options below.

I am the patient's (Parent) (Foster Parent) (Legal Guardian) (Temporary Custodian)

Legal documentation of temporary custody or guardianship must be provided

Patient's Mother or Legal Guardian Information:

Last Name: _____ First Name: _____ DOB:_____

Driver's License #: _____ State Issued : _____ SS #: _____

Street Address : _____ Apt # _____ State _____ Zip Code_____

Primary Phone #: _____ Secondary Phone #: _____

Employer: _____ Employer Address _____ Phone#: _____

E-Mail Address : _____Social Security #:_____

Patient's Father or Legal Guardian Information:

Last Name: _____ First Name: _____ DOB:_____

Driver's License #: _____ State Issued : _____ SS #: _____

Street Address : _____ Apt # _____ State _____ Zip Code_____

Primary Phone #: _____ Secondary Phone #: _____

Employer: _____ Employer Address _____ Phone#: _____

E-Mail Address : _____Social Security #:_____

Who Does the Patient Live with? (Please circle one of the following)

Mother Only --- Father Only --- Mother and Father ---- Grandmother ----- Grandfather

Grandmother and Grandfather ---- Foster Parent ----- Temporary Custodian/Guardian ----- Other

Insurance Information

Patient's Last Name: _____First Name: _____ DOB:_____

Is this patient covered by a commercial Insurance? (please circle one) **YES** or **NO**
(Such as: Blue Cross/ Blue Shield – Cigna – Aetna – United Healthcare – Humana or others)

IF YES then please fill out S**ection A**. **IF NO** please skip to S**ection B** for Medicaid or Peach Care Insurance

Section A

Name of **Primary** Insured Member (The parent or guardian who provides the insurance)

Last: _____ First: _____ DOB: _____ SS#: _____

Name of the Insurance Company: _____ Amount of Copayment $_____

Patient's Member ID #: _____ Group #: _____

Employer of Primary Insured _____ Relationship to Patient _____

I**s the patient covered by another commercial policy (secondary insurance) YES or NO**

Name of **Secondary** Insured Member (The parent or guardian who provides the insurance)

Last: _____ First: _____ DOB: _____ SS#: _____

Name of the Insurance Company: _____ Amount of Copayment $_____

Patient's Member ID #: _____ Group #: _____

Employer of Secondary Insured _____ Relationship to Patient _____

Section B

If the Patient has Insurance Coverage through Medicaid or Peach Care for Kids Please complete below

Which Type of Insurance is the patient covered by? **(Please Circle one)**

1. Peach State 2. Amerigroup 3. WellCare 4. CareSource or 4. Straight Ga Medicaid

Member ID Number : _____
(This Number is 12 digits long and usually starts with 222 or 111)

CMO Member ID Number : _____
This is a shorter number for people with Amerigroup, WellCare or CareSource.

Remember that you must have us listed as your PCP (primary care provider) with your Insurance Company.
Ask us if you do not know how to make this change.

Authorization and Consent Section

Patient's Last Name: _____First Name: _____ DOB:_____

Please read and **initial** the following statements:

_____ I give The Pediatric Center of Stone Mountain, LLC permission to evaluate and treat my child. I understand that there will be written, oral and electronic communication between care providers, insurance companies and employees. I understand that all practices of confidentiality will be followed when using information gathered.

_____ I give The Pediatric center of Stone Mountain, LLC permission to submit bills directly to the insurance carrier.

_____ I have checked with my child's Healthcare Plan before this appointment to confirm my financial responsibilities.

_____ I have read and agree to follow The Pediatric Center of Stone Mountain, LLC Office, Appointment, Missed appointment and Financial policies.

Patent/ Guardian signature: _____ Date: _____

Emergency Medical Release

In the event your child needs emergency medical attention while on our property and in our care, we will need your permission to provide such emergency medical attention. Please read and sign the statement below.

As the legal guardian of (child's Name) _____ I give my permission for The Pediatric Center of Stone Mountain, LLC to contact emergency personnel in the event of a medical emergency.

Patent/ Guardian signature: _____ Date: _____

Who has permission to seek medical care for this patient ? Please list full legal name below

1.)_____ Relationship:_____

2.) _____ Relationship: _____

3.) _____ Relationship: _____

Emergency contact Information:

1.)_____ Phone# _____ Relationship:_____

1.)_____ Phone# _____ Relationship:_____

1.)_____ Phone# _____ Relationship:_____

Federal Race/Ethnicity Information and Disclosure of Travel

Patient's Last Name: _____First Name: _____ DOB:_____

In compliance with Federal regulations, The Pediatric Center of Stone Mountain, LLC collects information on race/ethnicity, country or origin and primary language of **all patients** we serve.

Please circle the patient's Race:

Black or African American White/Caucasian Asian

Native HI/Pacific IS American Indian/AK Native Prefers Not to Answer

Other (please list the appropriate race) _____

Please circle the patient's Ethnicity:

Hispanic or Latino Not Hispanic or Latino Prefers Not to Answer

OR Other (please list the appropriate ethnicity): _____

What is the country of origin: _____

Has the patient or any family/household member traveled internationally? **YES** or **NO**

If the answer is YES : Who traveled? _____

Where did they travel? _____When? _____

Acknowledge of receipt of Notice of Privacy Practices (HIPPA)

I acknowledged that I have received a copy of the Privacy Practices that states the rights of the patient and or the patient's parent/guardian.

Patent/ Guardian signature: _____ Date: _____