



Johns Creek Pediatrics

PATIENT REGISTRATION

Patient Name:	M <input type="checkbox"/>	Social Security Number:
	F <input type="checkbox"/>	Birthdate:
Street Address:		
City / State:	Zip:	
Telephone:	E-mail Address:	

PARENT OR GUARDIAN

Last Name:	First Name:	Last Name:	First Name:
Street Address:		Street Address:	
City / State:		City / State:	
Zip:	Birthdate:	Zip:	Birthdate:
Home Phone:	Work Phone:	Home Phone:	Work Phone:
Cell Phone:	Pager:	Cell Phone:	Pager:

INSURANCE INFORMATION MUST BE FILLED OUT COMPLETELY IN ORDER FOR US TO FILE.

Primary Insurance Co.:	Address:	Secondary Insurance Co.:	Address:
	Phone:		Phone:
ID No.:	Group No.:	ID No.:	Group No.:
Effective Date:		Effective Date:	
Subscriber's Name:	Birthdate:	Subscriber's Name:	Birthdate:
SS #	Relationship:	SS #	Relationship:
Subscriber's Employer:		Subscriber's Employer:	

EMERGENCY CONTACT

Name:	Relationship:
Street Address:	Home Phone: Work Phone:
City / State:	Zip:

I authorize Johns Creek Pediatrics, P.C. to release any information regarding my child's examination or treatment for the purpose of obtaining insurance compensation, precertification, or medical records. I authorize payment of medical benefits to Johns Creek Pediatrics, P.C. when claim forms are filed upon my child's behalf when having office procedures. I understand that I am responsible for the bill should my insurance company not pay within 30 days.

A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE VALID AS THE ORIGINAL.

Signed _____ Date _____

I authorize the following people to bring my child to Johns Creek Pediatrics for medical treatment in my absence.

Name	Relationship	Phone No.
_____	_____	_____
_____	_____	_____

Signed _____ Date _____