

Patient Demographics

Patient (last,first,middle): _____ **Nickname:** _____

Date Of Birth: _____ **Gender** (please circle one): Male Female **Adopted** (please circle one): Yes No

Ethnicity(please circle one):

Unknown

Hispanic or Latino

Not Hispanic or Latino

Other

Race (please circle one):

American Indian Or Alaskan Native

Asian

Black or African-American

White

Declined to specify

Hawaiian Native or Pacific Islander

Preferred Location (please circle one):

Marietta

Towne Lake

Roswell

Preferred PCP: _____

Patient Resides With (please circle one): Mom Dad Both Other _____

Patient's Primary Home Address:

Street: _____

City, State, Zip: _____

Primary Phone Number (confirmations/billing/clinical): _____

Primary Email: _____

Parent/Guardian (last,first): _____

Relation To Patient Biological Mother Biological Father Adoptive Mother Adoptive Father Step-Parent Other

Date Of Birth: _____ **Social Security Number:** _____

If address or phone number is different from patients primary address please fill out this section:

Phone Number: _____

Address: _____

Parent/Guardian (last,first): _____

Relation To Patient Biological Mother Biological Father Adoptive Mother Adoptive Father Step-Parent Other

Date Of Birth: _____ **Social Security Number:** _____

If address or phone number is different from patients primary address please fill out this section:

Phone Number: _____

Address: _____

Siblings:

Name: _____

Date of Birth: _____

Name: _____

Date of Birth: _____

Name: _____

Date of Birth: _____

Emergency Contact(other than parent):

Name: _____ **Phone:** _____

Relation to Patient: _____

Health Insurance Portability And Accountability Act (HIPAA)

Please sign below that you have been offered the opportunity to review a copy of our HIPPA notice. You are entitled to a personal copy of the notice at any time to keep for you records.

Signature of Parent/Guardian: _____ **Relationship to patient:** _____

PLEASE ONLY COMPLETE THIS SECTION IF YOUR CHILD WILL BE BROUGHT TO THE OFFICE BY SOMEONE OTHER THAN A LEGAL GUARDIAN (i.e. grandparent, aunt, uncle, nanny, friend)

Medical authorization for others to consent to treatment of a minor child

I authorize _____ to obtain medical care for the children named above, and I consent to hospitalization of, the performance of necessary diagnostic test upon, the use of surgery on, and/or administration of drugs to the child if an illness or an emergency occurs when I can not be immediately contacted.

Expiration (If applicable): _____ **Authorized Caregivers Phone:** _____

Signature Of Parent/Guardian

Date

FOR STAFF USE ONLY - Please initial and date below once registration has been entered in to the system.

Entered By: _____

Date: _____