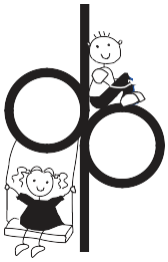

DUNWOODY PEDIATRICS

PATIENT INFORMATION FORM

How did you hear about us:

_____

_____

Patient Name: (Last, First, MI)		Today's Date (mm/dd/yyyy)	
Address		City, State, Zip Code	
Home Phone Number:		Email Address:	
Please circle one below:	Date of Birth	Social Security Number	
Male Female			
Legal Guardian (if other than parent):		Relationship:	
Emergency Contact and Phone #:			

PARENT'S INFORMATION:

Parent 1	Marital Status:	Parent 2	Marital Status:
	S M W D Sep		S M W D Sep
Address:		Address:	
Employer:		Employer:	
Work Phone:	Cell Phone:	Work Phone:	Cell Phone:
SS#	DOB:	SS#	DOB:

PRIMARY INSURANCE COMPANY INFORMATION

Name of Insurance Company:	Policy Holder DOB:
Policy Holders Name:	Policy/Member #:
Address:	City/State/Zip
Effective Date:	Group #:

SECONDARY INSURANCE COMPANY INFORMATION

Name of Insurance Company:	Policy Holder DOB:
Policy Holders Name:	Policy/Member #:
Address:	City/State/Zip
Effective Date:	Group #:

SIBLING'S NAMES AND DATES OF BIRTH

1.	DOB:	4.	DOB:
2.	DOB:	5.	DOB:
3.	DOB:	6.	DOB:

I, the undersigned, agree to permit Dunwoody Pediatrics, LLC to render medical services to my child. I also authorize the release of any medical or other information necessary to process my child's insurance claim. This release includes release of medical information to other doctors or to insurance companies. I authorize payment to be made directly to Dunwoody Pediatrics for services rendered and I understand that I am financially responsible for all charges whether paid by insurance or not.

Signature: **Date:**

THANK YOU!

Revised 02/2020
Dunwoody Pediatrics form #021

I verify that all information on the front side of this sheet is accurate. I agree to permit Dunwoody Pediatrics to process my child's insurance claims. This release includes release of medical information to other doctors for medical treatment or to insurance companies with payment to be made directly to Dunwoody Pediatrics for services rendered.

Signature:____Date:____________________

I verify that all information on the front side of this sheet is accurate. I agree to permit Dunwoody Pediatrics to process my child's insurance claims. This release includes release of medical information to other doctors for medical treatment or to insurance companies with payment to be made directly to Dunwoody Pediatrics for services rendered.

Signature:____Date:____________________

I verify that all information on the front side of this sheet is accurate. I agree to permit Dunwoody Pediatrics to process my child's insurance claims. This release includes release of medical information to other doctors for medical treatment or to insurance companies with payment to be made directly to Dunwoody Pediatrics for services rendered.

Signature:____Date:____________________

I verify that all information on the front side of this sheet is accurate. I agree to permit Dunwoody Pediatrics to process my child's insurance claims. This release includes release of medical information to other doctors for medical treatment or to insurance companies with payment to be made directly to Dunwoody Pediatrics for services rendered.

Signature:____Date:____________________

I verify that all information on the front side of this sheet is accurate. I agree to permit Dunwoody Pediatrics to process my child's insurance claims. This release includes release of medical information to other doctors for medical treatment or to insurance companies with payment to be made directly to Dunwoody Pediatrics for services rendered.

Signature:____Date:____________________