ALL FIELDS MUST BE COMPLETED FOR REGISTRATION

Pediatric Endocrine Specialists

REGISTRATION FORM (v06.2013)

DEMOGRAPHICS

PATIENT INFORMATION

Last Name:	First:	Middle:	☐ Married ☐ Single	☐ Male ☐ Female	Date of Birth: / /	Age:
Street Address:			Home Phone #: ( )		Cell Phone #: ( )	
City:	State:	ZIP Code:	Work Phone #: ( )		Preferred Method of Contact: ☐ Phone ☐ eMail	
Ethnicity: ☐ Non-Hispanic/Latino ☐ Hispanic/Latino ☐ Unreported/Refused to report			eMail:			
Language(s): ☐ English ☐ Spanish ☐ Other: _____						
Race (check all): ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ Pacific Islander ☐ White ☐ Unreported/Refused						

PARENT / GUARDIAN #1 INFORMATION ☐ MOTHER ☐ FATHER ☐ STEP MOTHER ☐ STEP FATHER ☐ OTHER: _____

Is this person legally responsible for health care decisions for the above patient? ☐ YES ☐ NO

Last Name:	First:	Middle:	☐ Married ☐ Single	☐ Male ☐ Female	Date of Birth: / /
Street Address:			Home Phone #: ( )		Cell Phone #: ( )
City:	State:	ZIP Code:	Work Phone #: ( )		Preferred Method of Contact: ☐ Phone ☐ eMail
Employer and Occupation:			eMail:		

PARENT / GUARDIAN #2 INFORMATION ☐ MOTHER ☐ FATHER ☐ STEP MOTHER ☐ STEP FATHER ☐ OTHER: _____

Is this person legally responsible for health care decisions for the above patient? ☐ YES ☐ NO

Last Name:	First:	Middle:	☐ Married ☐ Single	☐ Male ☐ Female	Date of Birth: / /
Street Address:			Home Phone #: ( )		Cell Phone #: ( )
City:	State:	ZIP Code:	Work Phone #: ( )		Preferred Method of Contact: ☐ Phone ☐ eMail
Employer and Occupation:			eMail:		

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BILLING AND INSURANCE INFORMATION

PERSON RESPONSIBLE FOR BILL ☐ MOTHER ☐ FATHER ☐ STEP MOTHER ☐ STEP FATHER ☐ OTHER: _____

Method of Payment Today: ☐ Self Pay ☐ Insurance

Last Name:	First:	Middle:	☐ Male ☐ Female	Date of Birth: / /	Social Security Number: - -
Street Address:			Home / Work Phone #: ( )		Cell Phone #: ( )
City:	State:	ZIP Code:	Work Phone #: ( )		eMail:

PRIMARY INSURANCE (Please give your insurance card to the receptionist)

Please Indicate Primary Insurance: ☐ Blue Cross/Blue Shield (BCBS) ☐ United Healthcare (UHC)
☐ Cigna ☐ Aetna ☐ Coventry ☐ Humana
☐ Other: _____

ID / Policy #:

Group #:

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Group Name:

Last Name:	First:	Middle:	☐ Male ☐ Female	Date of Birth: / /	Social Security Number: - -
Street Address:			Home / Work Phone #: ( )		Cell Phone #: ( )
City:	State:	ZIP Code:	Work Phone #: ( )		eMail:

SECONDARY INSURANCE (Please give your insurance card to the receptionist)

Please Indicate Primary Insurance: ☐ Blue Cross/Blue Shield (BCBS) ☐ United Healthcare (UHC)
☐ Cigna ☐ Aetna ☐ Coventry ☐ Humana
☐ Other: _____

ID / Policy #:

Group #:

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Group Name:

Last Name:	First:	Middle:	☐ Male ☐ Female	Date of Birth: / /	Social Security Number: - -
Street Address:			Home / Work Phone #: ( )		Cell Phone #: ( )
City:	State:	ZIP Code:	Work Phone #: ( )		eMail:

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REFERRAL SOURCE

Referral Source (please check one box): ☐ Referral Physician ☐ Primary Physician ☐ Website ☐ Insurance Plan ☐ Family/Friend ☐ Advertisement

Primary Care Physician:	Name of Medical Practice and Location:	Phone #: ( )
Referring Physician (if different):	Name of Medical Practice and **SPECIALTY**:	Phone #: ( )

PHARMACY

Pharmacy Name:	Street Address / City / Zip:	Phone #: ( )

IN CASE OF EMERGENCY

Emergency Contact Name (Other Than Parent / Guardian):	Relationship to Patient:	Home Phone #: ( )	Work/Cell Phone #: ( )

SIGNATURE

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Pediatric Endocrine Specialists of Georgia to release any information required to process my claims.

Patient/Guardian Signature:_____ Date:_____