Pediatric Associates of North Atlanta, P.C.
5185 Peachtree Parkway, Suite 330, Peachtree Corners, GA 30092
Tel. 770-476-9885 Fax. 770-476-8482

PLEASE FILL OUT THE FOLLOWING INFORMATION IN ITS ENTIRETY				
Your Child's Full Name	M/F	Date of Birth	Primary Doctor	Preferred Name

Patient's Home Address:	
Billing Address if different:	

Mother's Name:		Mother's DOB:	
Mother's **Primary** Phone number:	Cell Home Work (circle)		
Mother's Maiden Name (for vaccine registry):			

Father's Name:		Father's DOB:	
Father's **Primary** Phone number:	Cell Home Work (circle)		

Insurance Company:	
Who is the primary insurance carrier? (circle)	Mother Father Child
What is the primary insurance carrier's DOB?	

Parents' Marital Status: (circle)	Single Married Divorced
If divorced, who do the children live with? (circle)	Mom Dad

Which **email** can we use to send *confidential PHI* for your family? (School forms, letters, etc.):
@
May we send you **text** message reminders? (circle) Yes No
May we leave detailed **phone** messages for you? (circle) Yes No
Which is the **primary phone** number for the family?

☐ I have reviewed PANA's **Financial** and **Privacy Policies**. Availble on website or by request.

Signed:		Date:	
IF **OVER AGE 18** I authorize release of my information to:			
I was referred to the practice by:			

ASSIGNMENT, RELEASE AND PAYMENT: I hereby authorize Pediatric Associates of North Atlanta, PC to file claims with my insurance company. I hereby authorize my insurance benefits be paid directly to Pediatric Associates of North Atlanta, P.C. I accept financial responsibility for co-pays, co-insurance, cancellation fees and non-covered services at the time of service. I hereby authorize Pediatric Associates of North Atlanta, P.C. to release medical records to referring and family physicians, my insurance company and/or other medical or educational institutions as per my instructions. If I am referred to a specialist, I authorize the release of my medical record. I hereby understand that past due accounts may be sent to collections.
AUTHORIZATION FOR TREATMENT: I consent to examination, treatment, and any procedures including emergency treatment deemed necessary and ordered by our physician for my child, and I am personally responsible for any charges not covered by our insurance company.
AUTHORIZATION TO CONTACT ME: I authorize Pediatric Associates of North Atlanta, PC to contact me by any means provided for clinical reasons, appointment reminders, upcoming office events and services, or to gather demographic information as needed.