Athens Kids Specialists, PC
1500 Oglethorpe Ave, Suite 100
Athens GA 30606
Tel 706-543-9899/Fax 706-613-3995

Patient Registration

PATIENT INFORMATION (Please list all children who will be patients)

1. ________________________ DOB: ____/____/____ SSN: ____-____-____ M / F
2. ________________________ DOB: ____/____/____ SSN: ____-____-____ M / F
3. ________________________ DOB: ____/____/____ SSN: ____-____-____ M / F
4. ________________________ DOB: ____/____/____ SSN: ____-____-____ M / F

Address: ________________________ City: ____________ Zip ____________
Home Tel: (____) ____-____ CellPhone: (____)____-____ Email: ____________
Race and Ethnicity? ________________________
Preferred Pharmacy: ____________ Location: ____________ Tel: (____) ____-____
Previous Doctor: ____________ Location: ____________ Tel: (____) ____-____

PARENT OR GUARDIAN INFORMATION

Name1: ____________ Relationship: ____________ DOB: ____/____/____ SSN: ____-____-____
Address (If different): ________________________ City: ____________ Zip: ____________
Home Tel: (____)____-____ Employer: ____________ Work Tel: (____)____-____
Employer Address: ____________ City: ____________ Zip: ____________

Name2: ____________ Relationship: ____________ DOB: ____/____/____ SSN: ____-____-____
Address (If different): ________________________ City: ____________ Zip: ____________
Home Tel: (____)____-____ Employer: ____________ Work Tel: (____)____-____
Employer Address: ____________ City: ____________ Zip: ____________

NOTIFY IN CASE OF EMERGENCY

Name: ____________ Relationship: ____________ DOB: ____/____/____ Tel: ____________
Address (If different): ________________________ City: ____________ Zip: ____________

INSURANCE INFORMATION

Insurance Name: ____________ Member ID: ____________ Group Number: ____________

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How did you hear about us? ________________________

(Important—Please read carefully before signing)

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I understand that payment of all medical care is due at the time of service. I understand that it is my responsibility to pay any deductible, co-insurance, or any other balance NOT PAID by my insurance company. I understand that I am responsible for any costs incurred in the collection of patient accounts in case of default, including reasonable attorney fees and court costs.

I hereby grant permission to Athens Kids Specialists, PC to release any pertinent information to my insurance company upon request, and I also assign and authorize payment directly to Athens Kids Specialist, PC. I permit a copy of this authorization to be used in place of the original.

Signature: ________________ Date: ____/____/____ Witness: ____________

ACKNOWLEDGMENT OF PRIVACY PRACTICES

I certify that I have read and understood Athens Kids Specialists, PC's privacy practices.

Signature: ________________ Date: ____/____/____ Witness: ____________