

PRIMECARE PEDIATRICS

15A Baynard Park, Newnan, GA 30265
Phone: (770) 251-5253; Fax: (770) 251-5254

DEMOGRAPHICS UPDATE FORM

Please PRINT and complete ALL sections

PATIENT'S INFORMATION

PATIENT'S NAME:				What do you want us to call you? (Alias)	
_____		_____		_____	
LAST		First		Middle	
Patient's Date of Birth ____/____/____	Age _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F	NATIONALITY _____	Patient's Social Security Number (SSN) - - -	
Street Address (Not P.O. Box)		Apt #	City	State	Zip Code
				HOME TELEPHONE NO. () -	

FINANCIALLY RESPONSIBLE PARTY INFORMATION (PARENT OR GUARDIAN)			RELATIONSHIP: <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> OTHER _____		
NAME: (Parent/Guardian)		Parent or Guardian's Address (if different from above) <input type="checkbox"/> SAME		Email Address:	
				Consent for Email Communications: <input type="checkbox"/> Yes <input type="checkbox"/> No	
HOME TELEPHONE NO. () -	WORK TELEPHONE NO. () -	MOBILE/CELL PHONE NO. () -	Fin. Responsible Party SSN - - -	Fin. Responsible Party DOB / /	

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD AND DRIVER'S LICENSE TO THE RECEPTIONIST)					
PRIMARY Insurance Policy Holder's Name			Policy Holder's SSN - - -		Policy Holder's Birth Date ____/____/____
Name of Insurance Company		Insurance Company Address			Co-Payment Amount \$ _____
Insurance Policy #		Group #	Effective Date		Relationship to Patient
SECONDARY Insurance Policy Holder's Name			Policy Holder's SSN - - -		Policy Holder's Birth Date ____/____/____
Name of Insurance Company		Insurance Company Address			Co-Payment Amount \$ _____
Insurance Policy #		Group #	Effective Date		Relationship to Patient

PARENT INFORMATION					
Father's Name:			Mother's Name:		
Address			Address		
City		State/Zip Code:	City		State/Zip Code:
Tel:(Home)		Tel:(Cell)	Tel:(Home)		Tel:(Cell)
Employer:			Employer:		
Occupation:			Occupation:		
SSN:		DOB:	SSN:		DOB:

REFERRAL SOURCE	How did you hear about us?
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EMERGENCY CONTACT (Not living at the same address)					
Name:			Address:		
City:		Address:	Zip Code:		Relationship to Patient
Tel:(Home)		Tel:(Work)	Tel:(Cell)		INDICATE PREFERRED NUMBER TO CALL <input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> CELL

Assignment of Benefits • Financial Agreement

The above information is true to the best of my knowledge. I authorize PRIMECARE PEDIATRICS (PCP) to provide my child with medical care. I hereby give lifetime authorization to the insurance company or any third party payer to pay any benefits due directly to this office on any claim. I also authorize PCP or the insurance company to release any information required to process my claims. I agree to forward to PCP all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE ACCOUNT EVEN THOUGH INSURANCE MAY BE PENDING ON ALL OR A PORTION OF THE CHARGES. I have read and agree to the terms of the PCP Notice of Privacy Practices, Financial Responsibility and Billing Policy and No Show Policy. These authorizations remain in effect indefinitely unless revoked by me in writing. A photocopy or fax of this signed form is considered as valid as the original.

X _____
PARENT/GUARDIAN SIGNATURE

X _____
DATE