



Patient Information Form

Thank you for choosing Intown Pediatrics as your child's healthcare provider. Please fill out the front and back of this form completely.

PLEASE PRINT

CHILD'S LAST NAME		FIRST		MI	NICKNAME	
BIRTHDATE	AGE	SEX	SOCIAL SECURITY #		PATIENT PORTAL USERNAME	PASSWORD
ADDRESS			CITY	STATE	ZIP	PHONE

CHILD'S INSURANCE INFORMATION

COPY OF INSURANCE CARD REQUIRED

POLICYHOLDER'S NAME		BIRTHDATE	SOCIAL SECURITY #		RELATIONSHIP TO PATIENT	
INSURANCE COMPANY		SUBSCRIBER / POLICY #			GROUP #	COPAY
INS. ADDRESS		CITY	STATE	ZIP	PHONE	

PARENT/ GUARDIAN INFORMATION

PARENT/GUARDIAN NAME		ADDRESS IF DIFFERENT		CITY	STATE	ZIP
EMPLOYER		WORK #		CELL #	EMAIL ADDRESS	
PARENT/GUARDIAN NAME		ADDRESS IF DIFFERENT		CITY	STATE	ZIP
EMPLOYER		WORK #		CELL #	EMAIL ADDRESS	

EMERGENCY CONTACT

NAME	ADDRESS	PHONE	RELATIONSHIP TO PT
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LIST ANY ADDITIONAL CHILDREN

CHILD'S LAST NAME	FIRST	MI	DOB	M/F	SS#/SUBSCRIBER #

I request that payment of authorized benefits be made to Intown Pediatric & Adolescent Medicine, PC.

I further authorize the release of any medical information necessary to process insurance claims or any medical information that is required for any health care related utilization review or quality assurance activities or any healthcare professional requiring this information.

I understand and acknowledge that this assignment of benefits does not relieve me of my financial obligation for all medical fees and charges incurred by me or my child/ren and I hereby accept such responsibility, including, but not limited to, payment of those fees and charges not directly reimbursed to Intown Pediatric & Adolescent Medicine, PC by any insurance policy, self-insurance program or other benefit plan.

This authorization will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

Parent/Guardian _____ Date _____

Relationship to patient _____

ALTERNATIVE CONTACT AUTHORIZATION

I do I do not authorize you to contact or leave messages at my place of work.

I do I do not authorize you to contact me at my e-mail address.

I do I do not authorize you to leave messages on my home answering machine regarding appointments and to inform me that laboratory results are available. **Laboratory results are NEVER left on the answering machine. You must call the office to receive them.**

Parent/Guardian _____ Date _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES

This is to acknowledge that I have received or seen a copy of the office's Notice of Privacy Practices.

Parent/Guardian _____ Date _____

REFERRAL SOURCE

How did you hear about us? (please circle one)

Porch Press Walk-in/Drove by Yellow Pages

Our website Obstetrician Kudzu.com

Atlanta Baby/Atlanta Parent Magazine Friend

Other (please specify) _____