

PEDIATRICS AT WHITLOCK, P.C.  
707 Whitlock Ave. Suite D-30  
Marietta, GA 30064  
770-499-8909 (Office); 770-499-8911 (Fax)

**Patient Information**

**Patient Name:** \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Gender: M F School: \_\_\_\_\_

**Mother/Legal Guradian Name:** \_\_\_\_\_ SSN: \_\_\_\_\_  
DOB: \_\_\_\_\_ Marital Status: Single Married Widowed Divorced  
Driver's License #: \_\_\_\_\_ Email: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Work Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Home address (if different from patient): \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Father/Legal Guradian Name:** \_\_\_\_\_ SSN: \_\_\_\_\_  
DOB: \_\_\_\_\_ Marital Status: Single Married Widowed Divorced  
Driver's License #: \_\_\_\_\_ Email: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Work Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Home address (if different from patient): \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Siblings Names/DOB/Gender: \_\_\_\_\_  
\_\_\_\_\_

Emergency Contact Name (not living with you): \_\_\_\_\_  
Relation to patient: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Insurance Information**

**Primary Insurance Company:** \_\_\_\_\_  
Primary Insured's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Subscriber ID#: \_\_\_\_\_ Group Number: \_\_\_\_\_ Effective Date: \_\_\_\_\_

**Secondary Insurance Company:** \_\_\_\_\_  
Primary Insured's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Subscriber ID#: \_\_\_\_\_ Group Number: \_\_\_\_\_ Effective Date: \_\_\_\_\_

**Medicaid/CMO:** \_\_\_\_\_ Member ID: \_\_\_\_\_ Medicaid ID: \_\_\_\_\_

The undersigned agrees that all services are rendered on a paid basis only. Our policy is to collect for services at the time they are rendered. If the collection becomes necessary, the undersigned shall pay all reasonable costs. We will bill insurance for those companies that we have a contractual obligation to do so. The undersigned agrees to authorize insurance benefits to be paid directly to the physician. The undersigned is responsible for all non-covered services. The undersigned authorizes the physician to provide any information to process claims for benefits. Parents agree to have chart notes copied and forwarded when requested by a specialist or school.

\_\_\_\_\_  
Signature of Insured or Authorized Representative

\_\_\_\_\_  
Print Name of Insured or Authorized Representative

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date