

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