BEHAVIORAL PEDIATRICS of Rural Georgia

PLEASE COMPLETE ALL FORMS

Patient's Full Name:	Child lives with:
Preferred Name:	Sex (check one): ☐ Male ☐ Female
Date of Birth: Age:	Parents are (check one): ☐ Married ☐ Divorced ☐ Other
Address:	City: State: Zip:
Preferred Pharmacy/City: **Primary Care Provider/City:**	Preferred Language: Translator services needed: ☐ Yes ☐ No

PARENT/GUARDIAN INFORMATION #1 ☐ Check if this person is responsible for patient bill

Name:	DOB: / / SSN: - -
Employer:	Work Phone: ( ) -
Home Phone: ( ) - Cell Phone: ( ) -	Email:

PARENT/GUARDIAN INFORMATION #2 ☐ Check if this person is responsible for patient bill

Name:	DOB: / / SSN:
Employer:	Work Phone: ( ) -
Home Phone: ( ) - Cell Phone: ( ) -	Email:

EMERGENCY CONTACT (OTHER THAN PARENT/GUARDIAN LISTED ABOVE)

Name: _____ Phone #: _____ Relationship to patient:	**May we leave a confidential message? (check all that apply)** **Guardian #1** ☐ Home ☐ Cell ☐ Work **Guardian #2** ☐ Home ☐ Cell ☐ Work ☐ Emergency Contact

CHILD'S PRIMARY INSURANCE

Insurance Company: _____

Policy/Member ID: _____

Group #: _____

Policy Holder(s): _____

Name: _____ DOB: _____

CHILD'S SECONDARY INSURANCE

Is this patient covered by additional insurance?

☐ Yes ☐ No

Check one: ☐ Medicaid ☐ Amerigroup ☐ WellCare ☐ CareSource ☐ Other: _____

Member ID#: _____