Patient Demographics

Patient (last,first,middle): ________________________ **Nickname:** ____________________

Date Of Birth: ______________ **Gender** **(please circle one):** Male Female **Adopted** **(please circle one):** Yes No

Ethnicity(please circle one):

Unknown Hispanic or Latino Not Hispanic or Latino Other

Race **(please circle one):**

American Indian Or Alaskan Native Asian Black or African-American

White Declined to specify Hawaiian Native or Pacific Islander

Preferred Location **(please circle one):** Marietta Towne Lake Roswell

Preferred PCP: ____

Patient Resides With **(please circle one):** Mom Dad Both Other ______________________

Patient's Primary Home Address:

Street: ____

City, State, Zip: ____

Primary Phone Number (confirmations/billing/clinical)**:** ______________________________

Primary Email: ____

Parent/Guardian (last,first)**:** ______________________________________
Relation To Patient Biological Mother Biological Father Adoptive Mother Adoptive Father Step-Parent Other

Date Of Birth: ____________________ **Social Security Number:** ____________________

If address or phone number is different from patients primary address please fill out this section:

Phone Number: ____________________
Address: ____

Parent/Guardian (last,first)**:** ______________________________________
Relation To Patient Biological Mother Biological Father Adoptive Mother Adoptive Father Step-Parent Other

Date Of Birth: ____________________ **Social Security Number:** ____________________

If address or phone number is different from patients primary address please fill out this section:

Phone Number: ____________________
Address: ____

Siblings:

Name: ______________________________ **Date of Birth:** ____________________

Name: ______________________________ **Date of Birth:** ____________________

Name: ______________________________ **Date of Birth:** ____________________

Emergency Contact(other than parent)**:**

Name: ______________________________**Phone:** ____________________________

Relation to Patient: ____

Health Insurance Portability And Accountability Act (HIPAA)

Please sign below that you have been offered the opportunity to review a copy of our HIPPA notice. You are entitled to a personal copy of the notice at any time to keep for you records.

Signature of Parent/Guardian: ________________________ **Relationship to patient:** ________________

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PLEASE ONLY COMPLETE THIS SECTION IF YOUR CHILD WILL BE BROUGHT TO THE OFFICE BY SOMEONE OTHER THAN A LEGAL GUARDIAN (i.e. grandparent, aunt, uncle, nanny, friend)

Medical authorization for others to consent to treatment of a minor child

I authorize ____ to obtain medical care for the children named above, and I consent to hospitalization of, the performance of necessary diagnostic test upon, the use of surgery on, and/or administration of drugs to the child if an illness or an emergency occurs when I can not be immediately contacted.

Expiration (If applicable)**:** ______________ **Authorized Caregivers Phone:** ________________________________

____ ___________________________________

Signature Of Parent/Guardian **Date**

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FOR STAFF USE ONLY - Please initial and date below once registration has been entered in to the system.

Entered By: ________________________ **Date:** ___________________

LB 12-10-21