Lawrenceville Pediatrics
3815 Harrison Road
Loganville, Georgia 30052

PATIENT INFORMATION PROFILE (FOR PATIENT/PATIENTS BEING SEEN TODAY)

Date: _____

Patient's Name: _____ Age: _____ Gender: _____ DOB: _____

Patient's Name: _____ Age: _____ Gender: _____ DOB: _____

Patient's Name: _____ Age: _____ Gender: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip code: _____

Parent's Name: _____ DOB: _____ SSN#: _____

Address (or same as above): _____ City: _____ State: _____ Zip code: _____

Cell #: _____ Home #: _____ Work #: _____

Email address: _____ Employed by: _____

Parent's Name: _____ DOB: _____ SSN#: _____

Address (or same as above): _____ City: _____ State: _____ Zip code: _____

Cell #: _____ Home #: _____ Work #: _____

Email address: _____ Employed by: _____

Parent who is financially responsible for patient's account balance: _____

Emergency contact (not living with you): _____ Relation: _____

Address: _____ City: _____ State: _____ Zip code: _____

Cell #: _____ Home #: _____ Work #: _____

Do you have insurance? ☐ Yes ☐ No *If yes, please provide a copy of your card*

Do you have Medicaid? ☐ Yes ☐ No *If yes, please provide a copy of your card*

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION – I hereby authorize this practice to furnish any medical information requested by insurance companies with whom I have coverage, or any public agency which may be assisting in payment of my care.

ASSIGNMENT OF BENEFITS – I hereby authorize payment directly to this practice of benefits otherwise payable to me, including major medical insurance and payment of surgical or medical benefits, but not to exceed the charges for these services. I understand that I am financially responsible for charges not covered by this assignment.

GUARANTEE OF ACCOUNT – I understand that I am finically responsible for all charges for services rendered to my child/children, including the balance remaining after payment of possible Insurance benefits

SIGNATURE: _____ **DATE:** _____