Kids Choice Pediatrics
2775 Cruse Road Suite 1801
Lawrenceville, GA 30044

Patient Registration Information

Please PRINT AND complete ALL sections below!

Patient's Personal Information

First Name: _____ **Last Name**: _____ Initial: _____
Date of Birth (MM/DD/YYYY): ____/____/_____ **Sex** (Circle): Male / Female SS#: _____
Street Address: _____ _____ (Apt # _____)
City: _____ State: _____ Zip: _____
Home Phone: (____) _____ **Cell Phone**: (____) _____
Father's Name: _____ **Work Phone**: (____) _____
Mother's Name: _____ **Work Phone**: (____) _____
Child's School: _____

Patients/Responsible Party Information

Name of Responsible Party: _____ **Date of Birth**: _____
Relationship to Patient: _____ **SS#**: _____
Address: _____ (Apt # ____)
City: _____ State: ____ Zip: _____
Employer's Name: _____ Phone #: (____) _____
Address: _____ City: _____ State: _____ Zip: _____
Your Occupation: _____
Spouse's Employer's Name: _____Spouse's Work Phone#: (____) _____
Address: _____ City: _____ State: _____ Zip: _____

Patient's Insurance Information

Please present insurance cards to receptionist.

PRIMARY insurance company's name: _____
Insurance Address: _____ City: _____ State: _____ Zip: _____
Name of Insured: _____ Date of Birth: _____Relationship to Insured: _____
Insurance ID number: _____ Group Name: _____

Secondary Insurance company's name: _____
Insurance Address: _____ City: _____ State: _____ Zip: _____
Name of Insured: _____ Date of Birth: _____Relationship to Insured: _____
Insurance ID number: _____ Group Name: _____

Emergency Contact

Name of person **not** living with you: _____Relationship:_____
Address: _____City: _____ State: _____ Zip: _____
Home Phone: (____) _____ Work Phone: (____) _____

Assignment of Benefits ● Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Kids Choice Pediatrics LLC, and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay to costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.

I further agree that a photocopy of this agreement shall be valid as the original.

Date: _____ **Your Signature**: _____
PRINT NAME: _____