3525 SUGARLOAF PARKWAY
LAWRENCEVILLE, GA 30044
PH- 678-377-1113 FAX- 678-377-9390

Patient Information:

Last ______________________ First__________________MI____ DOB___________Sex___
Last ______________________ First__________________MI____ DOB___________Sex___
Last ______________________ First__________________MI____ DOB___________Sex___
Last ______________________ First__________________MI____ DOB___________Sex___

Street____ Phone#__________
City ______________________ State____________ Zip____________
E-Mail Address ____

Ethnic Group: Hispanic/Latino Not Hispanic/Latino

Race: American Indian African American Asian White Other

Preferred Language:____________________

Mother/Guardian Information:
Name______________________ Maiden Name____________ D.O.B______Phone#__________
Address____
City______________________ State____________ Zip____________

Father/Guardian Information:
Name________________________________ D.O.B__________ Phone#______________
Address____
City______________________ State____________ Zip____________

Responsible Party______________________________ Relation to Patient____________
With whom does the child live?_________________Who has legal custody? ______________

Preferred Pharmacy Name/Address/Phone#____

IN CASE OF EMERGENCY (Person NOT LIVING with Patient)

Name___________________________ Relation_______________Phone#______________

_______________________________ _______________

Signature of Parent/Guardian **Date**

Insurance Information:

Insurance Company Name____

I understand that payment of all medical care is due at the time of service. In case of divorced parents, responsibility and payment shall be that of the guardian bringing the child in for treatment. I understand that it is my responsibility to pay any deductible, co-insurance, or any other balance not paid by my insurance company. I understand that I am responsible for any cost incurred in the collection of patients account in case of default, including reasonable attorney fees and court cost. **I agree to pay any deductibles and any amount not covered by Insurance.**

I understand that it is my responsibility to call the office to cancel/reschedule any Well Visits/Yearly Physical, 24 hours before the scheduled appointment. Failure to do so will result in a "Missed Appointment" fee of $15 per appointment. Copies of Vaccination Forms (3231) and Hearing/Vision/Dental Forms (3300) after the Annual Physical will cost $5 per form.

I understand that insurance companies have agreements with certain laboratories for lab work and that it is my responsibility to know which laboratory my insurance authorizes and to inform the staff of Sugarloaf Pediatrics as to which laboratory my insurance covers.

I hereby grant permission to Sugarloaf Pediatrics to release any pertinent information to my insurance company upon request, and I also assign and authorize payment directly to Sugarloaf Pediatrics. A photo copy of this authorization shall be considered as effective and valid as the original.

____ ____________________
Signature of Parent/Guardian **Date**

Consent for Vaccinations

I am willing to give my child/children all the vaccinations that are required by the American Academy of Pediatrics and CDC.

____ ____________________
Signature of Parent/ Guardian **Date**

Notice of Privacy Practices-HIPAA

I have reviewed the attached copy of Sugarloaf Pediatrics notice of Privacy Practices.

____ ____________________
Signature of Parent/ Guardian **Date**

Text Message Authorization

I authorize Sugarloaf Pediatrics to send appointment reminder text messages to the cell phone number listed on the registration.

____- ____________________
Signature of Parent/Guardian **Date**