

# Bulloch Pediatrics Group, LLC

1497 Fair Road, Ste 200, Statesboro, Georgia 30458

Office #: (912) 871-HUGS (4847)

Fax #: (912) 871-5562

Cheryl E. Perkins, MD

Austin Whitlock, MD

Michelle Zeanah, MD

## REGISTRATION SHEET (PLEASE PRINT CLEARLY)

Date: \_\_\_\_\_

### PATIENT INFORMATION

Name: \_\_\_\_\_  
LAST FIRST NAME MIDDLE INITIAL  
Address: \_\_\_\_\_ SSN#: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Home #: \_\_\_\_\_  
Sex:  Male  Female Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Patient School: \_\_\_\_\_  
Parent/Guardian Name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer Address: \_\_\_\_\_ Employer Phone # \_\_\_\_\_  
In case of emergency who should be notified? \_\_\_\_\_ Phone #: \_\_\_\_\_  
Alternate Contact Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

### PRIMARY INSURANCE

Policy Holders Name: \_\_\_\_\_  
Relation to Patient: \_\_\_\_\_ Birthdate: \_\_\_\_\_ SocSec#: \_\_\_\_\_  
Address:(if different from patients) \_\_\_\_\_ Phone#: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Person Employed By: \_\_\_\_\_ Business Phone: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_  
Policy #/Member ID: \_\_\_\_\_ Group#: \_\_\_\_\_

### ADDITIONAL INSURANCE

Is this patient covered by additional insurance  YES  NO

**\*\*Currently we only file Medicaid, Wellcare and Amerigroup as Secondary insurance\*\***

**Circle one:**

Medicaid

Member ID: \_\_\_\_\_

Amerigroup

Member ID: \_\_\_\_\_

Wellcare

Member ID: \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I certify that I, and /or my dependent(s) have insurance coverage with \_\_\_\_\_ and assign directly to Cheryl Perkins, MD, Austin Whitlock, MD, or Michelle Zeanah, MD all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctors may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed for one year from the date signed below.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian, or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian, or Personal Representative

\_\_\_\_\_  
Date