1497 Fair Rd, Ste 200
Statesboro, GA 30458
Phone: 912-871-(HUGS) 4847
Fax: 912-871-5562
www.bullochpediatrics.com

PLEASE FILL OUT FORM COMPLETELY AND PRINT CLEARLY DATE:____________________

PATIENT INFORMATION:

Last Name: First: Middle:	Child lives with:
Preferred Name or Nickname:	Sex (circle one): Male or Female
Date of Birth: Age:	Parents are (circle one): Married, Divorced, Other
Address:	City: State: Zip:
Race: ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ White ☐ American Indian/Alaska Native ☐ Black/African American ☐ Other	Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Preferred Pharmacy:	Preferred Language:

GUARANTOR/PARENT INFORMATION (MOTHER):

Name:	DOB: SSN:
Employer:	Drivers Lic #:
Home Phone: Cell Phone: Work Phone:	Email:

GUARANTOR/PARENT INFORMATION (FATHER):

Name:	DOB: SSN:
Employer:	Drivers Lic #:
Home Phone: Cell Phone: Work Phone:	Email:

EMERGENCY CONTACT (OTHER THAN PARENT):

Name: ____________________
Phone #: ____________________
Relationship to patient: ____________________

At which number(s) may we leave a confidential message? (check all that apply)

Mom home______ Dad home______
Mom cell ______ Dad cell_____ Emergency Contact:______
Mom work______ Dad work_____

CHILD'S PRIMARY INSURANCE:

Insurance Company:____________________
Policy/Member ID:____________________
Group #: ____________
Policy Holders Name:________________ DOB:________

CHILD'S SECONDARY INSURANCE:

Is this patient covered by additional insurance? ☐Yes ☐ No
Circle one: Medicaid Amerigroup Wellcare Peach State
Member ID #:____________________

Currently we ONLY file with Medicaid, Amerigroup, Wellcare and Peach State as secondary insurance.

THE INFORMATION ON THIS SHEET IS TRUE & CORRECT

I authorize the physicians of this practice and/or their assistants to provide medical care for my child. I authorize payment of medical benefits directly to the providers of Bulloch Pediatrics Group for services provided. I authorize the practice to release any information required to process my claims. I understand that it's my responsibility to pay all amounts due at the time of service & that I am financially responsible for all charges whether or not paid by said insurance.

⇨ SIGNATURE:____________________ PRINTED NAME:____________________ DATE:__________

Last Updated 10/2013