Pediatric Development Center of Atlanta, LLC

CLIENT REGISTRATION FORM

Child's Last Name: First Name: M.I:

Sex: M ☐ F ☐ Age: Birth Date: Nickname:

Home Address: _____

City/State/Zip: _____Home Telephone: _____

Mother's Name: _____

Address: ☐ Same as Child's _____

City/State/Zip: _____ Home Telephone: _____

Pager/Mobile: _____ Email _____

Employer:_____ Work Telephone: _____

Father's Name: _____

Address: ☐ Same as Child's _____

City/State/Zip: _____ Home Telephone: _____

Pager/Mobile: _____ Email _____

Employer:_____ Work Telephone: _____

Child's Primary Care Physician _____ Telephone: _____

Referred to Clinic by: Dr. ☐ Family ☐ Friend ☐ Website ☐ Other _____

INSURANCE

Does the Child Have Insurance Coverage: Y ☐ N ☐ Insured's Name: _____

Primary Insurance Co. _____ Effective Date _____ Co-pay _____

Policy # _____ Group # _____ Telephone: _____

Secondary Insurance Co. _____ Insured's Name: _____

Policy # _____ Group # _____ Telephone: _____

I authorize our insurance benefits be paid directly to Pediatric Development Center of Atlanta. I also authorize Pediatric Development Center of Atlanta or our insurance company to release any information required to process our claims. I agree to pay for all charges denied by my insurance carrier, including, but not limited to: non-covered services, deductibles, co-pays, services exceeding maximum benefit limits, and for services for which a referral authorization was not properly obtained. I shall promptly notify Pediatric Development Center of Atlanta of any changes in Insurance coverage.

Signed: _____ Date: _____