PEDIATRIC GASTROENTEROLOGY ASSOCIATES
CARING FOR KIDS AND ADOLESCENTS
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Phone: (678) 474-1115 Fax: (678) 474-1116

PEDIATRIC PATIENT DATA SHEET
THIS FORM MUST BE COMPLETED IN FULL

☐ **Male** ☐ **Female**

Patient Name _____**Date of Birth**_____ **S.S.#**_____

Home Address _____**City** _____**State** _____**ZIP**_____

Home Phone ( )_____ **Cell Phone ( )** _____

Pediatrician's Name _____ **Telephone# ( )** _____

IF PATIENT IS A MINOR:

Mother's Name _____ **DOB** _____**SS#**_____

Employer Name/Address _____ **City**_____ **State** _____ **ZIP** _____

Employers Telephone ( ) _____

Father's Name _____ **DOB** _____**SS#**_____

Employer's Name/Address _____ **City**_____ **State** _____ **ZIP** _____

Employers Telephone ( ) _____

EMERGENCY CONTACT (other than parents):

Name _____ **Telephone ( )** _____

Relationship to patient _____

PLEASE INDICATE PRIMARY, AND SECONDARY INSURANCE:

Primary Ins. Co. _____ **Ins. Address** _____

Policy #_____ **Grp#** _____ **Policy Holder** _____

Secondary Ins. Co. _____ **Ins. Address** _____

Policy #_____ **Grp#** _____ **Policy Holder**_____

PLEASE READ THE FOLLOWING CAREFULLY: In order to control our cost of billings, we request that you pay your deductible, co-insurance, and previous balance at the conclusion of EACH visit. Also please by advised, (HMO/POS clients), it is your responsibility to make sure you have a updated referral for each visit. By signing, you understand that you are responsible for co-payments, deductibles and non-covered services, at the time of each visit.

PARENT/GUARDIAN SIGNATURE_____**DATE**_____