Sandy Plains Pediatrics

Patient & Family Registration Form

Last Name: ______________________________ (if child's last name is different, list below)

Child: ______________________________ Date of Birth: ________________ Gender_____

Child: ______________________________ Date of Birth: ________________ Gender_____

Child: ______________________________ Date of Birth: ________________ Gender_____

Child: ______________________________ Date of Birth: ________________ Gender_____

Parent/Guardian Name(s): ____

Address: ____

City: ____________________________________ Zip Code: __________________________

Parent/Guardian Email: ____

Parent/Guardian: Cell #1: _______________________ Cell #2: _______________________

Home Phone: ___________________________ Work Phone: _________________________

Emergency Contact: ______________________________ Relationship: _______________

Emergency Contact Phone Number: ____

Primary Insurance: ____

Cardholders name: _____________________________ Date of Birth: __________________

The above information is true to the best of my knowledge. I authorize treatment for the above individual(s) and I understand that I am ultimately responsible for charges associated with the medical services and agree to pay all bills within 30 days from receipt of statement, unless other arrangements are made. I authorize the physician and Sandy Plains Pediatrics to release any information required to process my insurance claims. I also authorize my insurance to directly pay, Sandy Plains Pediatrics.

Parent/Guardian Signature: ______________________________ Date: ___________________

Please Fill out and sign all pages. Thank you

Email: sandypeds@yahoo.com

3225 Shallowford Road, Bldg. 1300, Marietta, GA 30062
Phone: (678) 560-7160 • Fax: (678) 560-7185