We will need a copy of Drives License at each visit

Patient Information (18 and Older)

Name: *First/Last*	*Race (circle one)*	*Ethnicity (circle one)*	*F/M*	*Birth Date*
	Black White Hispanic Asian Native American	Hispanic/ Latino Non Hispanic/Latino		

Address_____
(Street or PO Box) *(City)* *(State & Zip)*

E-mail address_____

Home phone_____

Cell phone_____

Preferred Language: English, Spanish, Arabic, ASL (Sign), Chinese, French, Other:_____

Appointment Reminders phone_____ *(circle one)* TEXT *or* LIVE PHONE CALL

Mother *(circle one)*: **Birth / Stepmother / Legal Guardian or Adoptive Mother / Grandmother / Foster Mother**

Full Name (First Last)	*Social Security #*	*Date of Birth*	
Home address (if different from patient)	*City*	*State*	*Zip Code*
Home phone / Cell phone	*Is it ok to talk to this person about any medical decisions for you?*		
Occupation/ Employer	*Business Telephone Number*		

Father *(circle one)*: **Birth / Stepfather / Legal Guardian or Adoptive Father / Grandfather / Foster Father**

Full Name (First Last)	*Social Security #*	*Date of Birth*	
Home address (if different from patient)	*City*	*State*	*Zip Code*
Home phone / Cell phone	*Is it ok to talk to this person about any medical decisions for you?*		
Occupation/ Employer	*Business Telephone Number*		

Emergency Contact *(other than in the home)* **Name**_____ **Phone**_____

Preferred Pharmacy_____ **City**_____ **Phone**_____

Insurance Information

Primary Insurance Co Name		*Employer*	
ID #		*Group #*	
Policy Holder's Name	*Date of Birth (Policy Holder)*	*Social Security #*	*Relationship to Child*

Does patient have Secondary Insurance? ☐ **Yes** *or* ☐ **No** *(if yes, please give card to receptionist)*

- I voluntarily give consent for my medical treatment or my child's medical treatment to the Providers at Dawson Pediatrics, P.C. I fully understand that payment is required at the time of service and should my claims be filed to my insurance company, any unpaid balance is my responsibility. When necessary, I further authorize the release of medical records to my insurance company. In the event that the physician files to my insurance, I authorize benefits to be paid directly to the physician.
- I have been offered a written copy of the **Notice of Privacy Practices** of DAWSON PEDIATRICS, P.C. prior to signing this consent. DAWSON PEDIATRICS, P.C. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices will be posted in the office and on our website at www.dawsonpediatrics.com. It may also be obtained by forwarding a written request to the Privacy Officer, Dawson Pediatrics 300 Dawson Commons Circle, Ste 320 Dawsonville GA 30534.

Patient Signature_____ **Date**_____

***Who can we thank for referring you to our practice?

____Insurance ____Website Friend_____ Physician_____ Other_____