770-962-3141

SHAH PEDIATRICS, INC.

310 Philip Boulevard
Lawrenceville, GA 30046

PLEASE PRINT CLEARLY:

Child's Name:_____ Date: _____

Sex: Male Female Age: _____ Birth Date:_____

Address: _____ City: _____ Zip Code: _____

Phone Number: _____ Cell Number:_____

Father's Name: _____ S.S. No.: _____

Employed By: _____ Occupation:_____

Business Address: _____ Phone:_____

Mother's Name: _____ Maiden Name:_____ S.S. No.: _____

Employed By: _____ Occupation:_____

Business Address: _____ Phone:_____

In case of emergency, notify (other than parents):

Name: _____ Relationship:_____

Address: _____ City: _____ Zip Code: _____

Phone Number: _____

Insurance: Yes No Company: _____

Name of Insured:_____

Policy No. _____ Group No. _____

Medicaid: Yes No Number: _____

Referred By:_____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION - I hereby authorize this practice to furnish any medical information requested by insurance companies with whom I have coverage or any public agency which may be assisting in payment of my care.

ASSIGNMENT OF BENEFITS - I hereby authorize payment directly to this practice of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed the charges for these services. I understand that I am financially responsible for charges not covered by this assignment.

GURANTEE OF ACCOUNT - I understand that I am financially responsible for all charges for services rendered to my child/children, including the balance remaining after payment of possible insurance benefits.

_____ _____

Signature *Date*