PEDIATRIC
ASSOCIATES OF SAVANNAH

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4600 Waters Ave., Suite 100, Savannah, GA 31404 • 110 Medical Park Drive, Pooler, GA 31322
1001 Memorial Lane, Savannah, GA 31410

Patient: DOB: / / Date: / /

PATIENT RECORD

Street _____ Street _____
Phone _____ Phone _____
Name of Father _____ Name of Mother _____
Social Security# _____ DOB: ___/___/___ Social Security# _____ DOB: ___/___/___
Father's Employment _____ Mother's Employment _____
Address _____ Address _____
Phone _____ Phone _____
Position Held _____ Position Held _____

Parent's Marital Status Single _____ Married _____ Separated _____ Divorced _____

INSURANCE INFORMATION

PRIMARY

Name of Insurance Company _____
Address _____ City _____ State _____ Zip _____
Insured _____ Group _____

SECONDARY

Name of Insurance Company _____
Address _____ City _____ State _____ Zip _____
Insured _____ Group _____

In case of emergency, contact:

1. _____ Phone: _____
2. _____ Phone: _____

Child's Maternal Grandparents: Name _____
Address _____
Child's Paternal Grandparents: Name _____
Address _____

Other children already under our care: _____

I do hereby agree to be responsible for any and all services rendered by Pediatric Associates of Savannah, PC as follows:

_____

_____

Date: ____/___/_____ Signature of Responsible Party _____
Relationship to Child _____