

New/Existing Patient Intake Form

| Patient Registration Information | | |
|--|---|----------------------------------|
| Name: | | Date of Birth: |
| Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Decline to provide <input type="checkbox"/> Other | Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Decline to provide | |
| Preferred language (if not specified, English will be chosen as your preferred language): | | |
| Contact preference: <input type="checkbox"/> Mobile /texting <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Email (provide email address) To receive text message, opt in by texting "Sibley" to 622622 | | |
| Home Address: | Mailing Address (if different) | |
| Home Phone: | Mobile Phone: | Work Phone: |
| Reason for visit / diagnosis: | | |
| Primary Care Physician: | Referring Physician: | |
| Pharmacy: | | |
| Name: | Address: | |
| Guarantor / Responsible Party | | |
| Name: | | Date of Birth: |
| Relationship to patient: <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Family Member <input type="checkbox"/> Other _____ | | |
| Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other | | |
| Home Address: | Mailing Address (if different) | |
| Home Phone: | Mobile Phone: | Work Phone: |
| Emergency Contact(s) | | |
| Name: | | Phone: |
| Relationship to patient: <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Family Member <input type="checkbox"/> Other _____ | | |
| Home address: | City: | State: Zip: |
| Name: | | Phone: |
| Relationship to patient: <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Family Member <input type="checkbox"/> Other _____ | | |
| Home address: | City: | State: Zip: |
| Insurance | | |
| PRIMARY INSURANCE Name: | | SECONDARY INSURANCE Name: |
| Subscriber/Member ID #: | | Subscriber/Member ID #: |
| Group # | | Group # |
| Subscribe Name: | | Subscribe Name: |
| Address: | | Address |
| Employer: | | Employer: |
| Date of Birth: | | Date of Birth: |
| Relationship to patient: | | Relationship to patient: |

ALL CHARGES ARE DUE AT THE TIME OF SERVICE

- I hereby authorize Children's Healthcare of Atlanta Cardiology (Children's Cardiology) to obtain records from other sources as may be needed in the treatment of this patient.
- I hereby authorize the release of information concerning this patient's treatment to other physicians involved in the care and treatment of this patient.
- I hereby authorize payment of insurance benefits otherwise due to me to be made directly to Children's Cardiology or hospital. I understand that I am responsible for any amount not covered by the insurance company. A copy of this information shall be as valid as the original.

Signature of parent or responsible party

Date

MRN# _____