

**Griffin Pediatrics, PA  
Patient Profile**

**PATIENT INFORMATION**

Name: \_\_\_\_\_ Sex: [ ] M [ ] F

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Allergies: \_\_\_\_\_

Names of Brothers, Sisters : \_\_\_\_\_

\_\_\_\_\_

**EMERGENCY CONTACT-OTHER THAN PARENTS**

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

**ALL INFORMATION IN THE BOX BELOW IS REQUIRED!**

<p><b><u>PARENT/GUARDIAN</u></b></p> <p>Relationship: <input type="checkbox"/>Dad <input type="checkbox"/> Mom <input type="checkbox"/> Other _____</p> <p>Name: _____</p> <p>Address: _____</p> <p>City, State, Zip: _____</p> <p>SSN: _____ DOB: _____</p> <p>Home#: _____ Cell #: _____</p> <p>Work #: _____ Employer: _____</p>	<p><b><u>OTHER PARENT/GUARDIAN</u></b></p> <p>Relationship: <input type="checkbox"/> Dad <input type="checkbox"/> Mom <input type="checkbox"/> Other _____</p> <p>Name: _____</p> <p>Address: _____</p> <p>City, State, Zip: _____</p> <p>SSN: _____ DOB: _____</p> <p>Home#: _____ Cell#: _____</p> <p>Work #: _____ Employer: _____</p>
<p><input type="checkbox"/> <b>PLEASE CHECK THIS BOX IF FOSTER CHILD AND LIST CASEWORKER, PHONE NUMBER, &amp; AGENCY.</b></p> <p>_____</p>	
<p><b><u>PRIMARY INSURANCE POLICY HOLDER -</u></b></p> <p>POLICY HOLDER: <input type="checkbox"/> Dad <input type="checkbox"/> Mom <input type="checkbox"/> Other _____</p> <p>Insurance Co. Phone: _____</p> <p>Company Employed: _____</p>	<p><b>INSURANCE:</b> _____</p> <p><b>POLICY GROUP NUMBER:</b> _____</p> <p><b>INSURANCE ID:</b> _____</p> <p><b>Medicaid/PeachCare #:</b> _____</p>

*ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE*

I authorize the release of any medical information, INCLUDING INFORMATION RELATED TO PSYCHIATRIC CARE, DRUG AND ALCOHOL ABUSE, AND HIV/AIDS CONFIDENTIAL INFORMATION, necessary to process insurance claims or any medical information that is needed for any utilization review or quality assurance activities. I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled to GRIFFIN PEDIATRICS, P.A. This assignment will remain effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original.

\_\_\_\_\_  
SIGNATURE OF PRIMARY CUSTODY HOLDER

\_\_\_\_\_  
DATE

\_\_\_\_\_  
FORM COMPLETED BY

\_\_\_\_\_  
RELATIONSHIP TO PATIENT

***CHARGES NOT COVERED BY INSURANCE COMPANY ARE THE RESPONSIBILITY OF THE PRIMARY CUSTODY HOLDER. PAYMENT OF COPAY IS DUE AT THE TIME OF SERVICE OR A SURCHARGE OF \$20.00 WILL BE APPLIED.***

**Griffin Pediatrics, PA  
1900 Zebulon Road  
Griffin, Georgia 30224**

**ACKNOWLEDGEMENT STATEMENT**

I understand that the services I receive from GRIFFIN PEDIATRICS may not be covered under my insurance program. I understand that my insuring agent determines the medical necessity of the services that I request and receive. I understand that I am responsible for payment of the services I request and receive for my child/children if these services are not covered under my insurance.

_____ Patients Name	_____ DOB
_____ Signature of Parent or Responsible Party	_____ Date
_____ Witness	_____ Date
_____ _____ Address	_____ _____ Phone #

# GRIFFIN PEDIATRICS, PA

1900 Zebulon Road, Griffin, GA 30224  
Phone (770) 227-5510 Fax (770) 228-8180

Patient Name: \_\_\_\_\_ Health Record Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## AUTHORIZATION FOR USE/RELEASE OF HEALTH INFORMATION

(This form applies only to the release and disclosure of information. It is not consent for treatment or intended for any other purposes.)

By signing this form, I authorize the following:

\_\_\_\_\_ Obtain Medical Records from \_\_\_\_\_

\_\_\_\_\_ Send Medical Records to \_\_\_\_\_

\_\_\_\_\_ Release Medical Records to Parent/Guardian  
Name of Parent/Guardian Information is Being Released \_\_\_\_\_

\_\_\_\_\_ Other \_\_\_\_\_

Please send this information on or about: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo/Day/Year

This authorization expires upon fulfillment of request unless special circumstances are noted below\*\* (Information will not be resent without another authorization)

Purpose of this disclosure (at request of patient, etc.): \_\_\_\_\_

### Authorized Description of Medical Record Information:

\_\_\_\_\_ Copies of all medical records for the period \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo/Day/Year Mo/Day/Year

\_\_\_\_\_ Copies of the information described below for period \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo/Day/Year Mo/Day/Year

\_\_\_\_\_ History & Physical Examination \_\_\_\_\_ Lab, X-ray Reports, etc.

\_\_\_\_\_ Reports from Other Physicians \_\_\_\_\_ Immunization Record

\_\_\_\_\_ Other (Please Specify) \_\_\_\_\_

I understand that this information may include any history of acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV) infection; behavioral health service/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions. I understand that there may be information in these records that I would not want released. The following information should *not* be released, even if occurring during dates above \_\_\_\_\_

\*\* Please describe any special requirements such as Faxing, certified mail, extended expiration date, etc. I have been provided a copy of Griffin Pediatrics, PC *Notice of Privacy Practices* and any charges that may be associated with this authorization. I have discussed any concerns I may have about the use, release, disclosure of my health information with Griffin Pediatrics, PC Privacy Officer or other appropriate office personnel. I understand that Griffin Pediatrics, PC assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release Griffin Pediatrics, PC from all legal liability that may arise from this authorization.

Signed: \_\_\_\_\_ (Parent/Legal Guardian)

My relationship to this patient is: \_\_\_\_\_ Date: \_\_\_\_\_