ROSWELL PEDIATRIC CENTER, P.C.
PATIENT INFORMATION FORM
(Patient over 18)

Date:_____

Patient Information

Name: _____ DOB ____/____/____ SS# _____ □Male □Female

Race: □Caucasian □African-American □Asian □American Indian/Alaska Native □Native Hawaiian/Pacific Islander □Other □Declined

Ethnicity: □Hispanic □Not Hispanic □Unknown □Declined

Street Address:_____ City_____ State_____ Zip _____

Phone Numbers: Home _____ Cell_____ Work_____ E-mail _____

Primary Practitioner in our office:_____

Preferred Method of Contact □ Home Phone □ Cell Phone □ Text

□ E-mail □ Secure E-mail (e-mails are for non-medical communication only)

How were you referred to us? □ Friend □ Physician □ Internet □ Other

Name of your regular pharmacy: _____Phone:_____

Pharmacy Address:_____

Insurance Information

Policy Holder's Name _____ DOB _____

Name of Insurance Company _____ Phone Number _____

ID Number _____ Group Number _____

Please sign below that you have been offered an opportunity to review a copy of our HIPAA Notice of Privacy Practices. You are entitled to a personal copy of the notice at any time to keep for your records. If you have any questions about our Privacy Policy, please feel free to contact our Privacy Official at 770-751-0800. Thank you for your cooperation.