ROSWELL PEDIATRIC CENTER, P.C.

Family Information Form

Children's Information **Date:____________**

Name:____ DOB ____/____/_____ ☐Male ☐Female

Race

☐African-American ☐American Indian/Alaska Native ☐Asian ☐Caucasian
☐Native Hawaiian/Pacific Islander ☐Other ☐Declined ☐Unknown

Ethnicity

☐Hispanic ☐Not Hispanic
☐Unknown ☐Declined

Name:____ DOB ____/____/_____ ☐Male ☐Female

Race

☐African-American ☐American Indian/Alaska Native ☐Asian ☐Caucasian
☐Native Hawaiian/Pacific Islander ☐Other ☐Declined ☐Unknown

Ethnicity

☐Hispanic ☐Not Hispanic
☐Unknown ☐Declined

Name:____ DOB ____/____/_____ ☐Male ☐Female

Race

☐African-American ☐American Indian/Alaska Native ☐Asian ☐Caucasian
☐Native Hawaiian/Pacific Islander ☐Other ☐Declined ☐Unknown

Ethnicity

☐Hispanic ☐Not Hispanic
☐Unknown ☐Declined

Name:____ DOB ____/____/_____ ☐Male ☐Female

Race

☐African-American ☐American Indian/Alaska Native ☐Asian ☐Caucasian
☐Native Hawaiian/Pacific Islander ☐Other ☐Declined ☐Unknown

Ethnicity

☐Hispanic ☐Not Hispanic
☐Unknown ☐Declined

Mother's Information ☐ **Responsible for payment**

Mother's Name: ________________________________DOB___________SS#______________________

Street Address:______________________________________City_________________State________Zip_________

Phone Numbers: Home______________________ Cell ______________________ Work_____________________

Employer:__________________________________ E-mail Address: _____________________________________

Father's Information ☐ **Responsible for payment**

Father's Name :________________________________DOB__________ SS#_______________________

Street Address:______________________________________City_________________State________Zip_________

Phone Numbers: Home______________________ Cell ______________________ Work_____________________

Employer:__________________________________ E-mail Address :_____________________________________

Child lives with: ☐ Parents ☐ Mother ☐ Father ☐ Other____

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________________________________

Insurance Company Name: _____________________ ☐No Insurance Primary Practitioner in our office: ____________

Pharmacy: ________________________Phone:_________________Pharmacy Address: _____________________

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.

____

Signature of Patient or Parent/Guardian if Patient is under 18 **Date**

03/2014