Atlanta Children's Clinical Center, P.C.

CONTACT INFORMATION

	Parent 1	Parent 2
Full Name		
Date of Birth		
Marital Status		
Home Address, Street		
City, State, Zip Code		
Cell Phone		
Home Phone		
Work Phone		
Preferred Contact # for Family		
***PERSONAL email address* (no work email addresses due to firewall issues)**		
Employer Name		

How did you hear about us? _____

CHILDREN (Please list ALL children in the family who are seen by our physicians.)

Full Name	Sex	Name Preferred	Date of Birth

INSURANCE

Subscriber Name	
Subscriber DOB	
*********Insurance cards are requested at every visit as required by law and will be scanned*********	
***If PCP selection is required make sure that has been completed. (BCBS Pathway plans, etc.)**	Please update to Dr. Megan Ference (also covers for current Dr. Maxey patients) or Dr. Reshma Chugani

In addition to verifying the accuracy of the contact information given, your signature below indicates that you have reviewed our Financial Policy and Privacy Policies and agree to the terms therein.

*Signature _____ Date:_____
Guarantor/Parent

*Print Name _____