Sandy Springs Pediatrics
and Adolescent Medicine, PC
6100 Lake Forrest Dr. Ste 100
Sandy Springs, GA 30328

Patient Name _____**Preferred/Nickname**_____

Date of Birth_____ **Sex** ☐ Male ☐ Female **Race**: ☐America Indian/Alaska native

☐ Nat Hawaiian/Pacific Islander ☐ Asian ☐ Black/African American ☐ White ☐ Declined

Ethnicity - ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Declined

Home Address _____

City _____ **State** ____ **Zip** _____ **Home #**_____

Father's Name _____ **Date of Birth** _____ **Cell #** _____

Mother's Name _____ **Date of Birth** _____ **Cell #** _____

Preferred Email Address _____ **Preferred Cell#** _____

Preferred Communications - ☐ Home Phone ☐ Cell Phone ☐ Email ☐ Text ☐ Mail ☐Patient Portal

Child's Primary Physician: ☐ **Steven Shore, MD** ☐ **Estonna Wells-Jarrett, MD** ☐ **Vanna Jackson, MD**

☐**Sarah Aldridge, MD** ☐**Sarah Robertson, MD**

Emergency Contact _____ Phone _____

Address _____ Relationship_____

Preferred Pharmacy

Name _____ Street Address _____

City _____ Zip _____ Phone _____

Primary Insurance	**Secondary Insurance**
Name _____	Name _____
Address _____	Address _____
City,State,Zip _____	City,State,Zip _____
Insured Name _____	Insured Name _____
Relation to Patient _____	Relation to Patient _____
Policy Number _____	Policy Number _____
Group Number _____	Group Number _____

Other Children

Name _____ M / F	Name _____ M / F
Name _____ M / F	Name _____ M / F

Consent for Medical Care and Assignment of Benefits – I authorize Pediatrics Infectious Disease Associates to provide medical care for my child/children. I authorize payment of medical benefits directly to Pediatrics Infectious Disease Associates for service provided. I authorize physician to release any information required to process my claims.

Signature _____ Date _____