Children's Healthcare of Atlanta
Cardiology

New/Existing Patient Intake Form

Patient Registration Information		
Name:		Date of Birth:
Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Decline to provide ☐ Other		Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to provide
Preferred language (if not specified, English will be chosen as your preferred language):		
Contact preference: ☐ Mobile /texting ☐ Home Phone ☐ Work Phone ☐ Email (provide email address) To receive text message, opt in by texting "Sibley" to 622622		
Home Address:		Mailing Address (if different)
Home Phone:	Mobile Phone:	Work Phone:
Reason for visit / diagnosis:		
Primary Care Physician:		**Referring Physician:**
Pharmacy: Name:	Address:	
Guarantor / Responsible Party		
Name:		Date of Birth:
Relationship to patient: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Family Member ☐ Other _____		
Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other		
Home Address:		Mailing Address (if different)
Home Phone:	Mobile Phone:	Work Phone:
Emergency Contact(s)		
Name:		Phone:
Relationship to patient: ☐ Parent ☐ Legal Guardian ☐ Family Member ☐ Other _____		
Home address:	City:	State: Zip:
Name:		Phone:
Relationship to patient: ☐ Parent ☐ Legal Guardian ☐ Family Member ☐ Other _____		
Home address:	City:	State: Zip:
Insurance		
PRIMARY INSURANCE Name:		**SECONDARY INSURANCE** Name:
Subscriber/Member ID #:		Subscriber/Member ID #:
Group #		Group #
Subscribe Name:		Subscribe Name:
Address:		Address
Employer:		Employer:
Date of Birth:		Date of Birth:
Relationship to patient:		Relationship to patient:

ALL CHARGES ARE DUE AT THE TIME OF SERVICE

- I hereby authorize Children's Healthcare of Atlanta Cardiology (Children's Cardiology) to obtain records from other sources as may be needed in the treatment of this patient.
- I hereby authorize the release of information concerning this patient's treatment to other physicians involved in the care and treatment of this patient.
- I hereby authorize payment of insurance benefits otherwise due to me to be made directly to Children's Cardiology or hospital. I understand that I am responsible for any amount not covered by the insurance company. A copy of this information shall be as valid as the original.

_____ _____

Signature of parent or responsible party **Date**

MRN# _____