



## PATIENT INFORMATION FORM

**DIRECTIONS:**

1. PLEASE FILL IN ALL APPROPRIATE FIELDS AS IT APPLIES TO YOU.
2. SIGN THE HIGHLIGHTED SECTION.
3. **PLEASE PROVIDE ASTS WITH A COPY OF YOUR INSURANCE CARD(S) AND DRIVER'S LICENSE!**  
THANK YOU!

PATIENT INFORMATION		
CHILD'S FULL NAME _____		MALE / FEMALE
DATE OF BIRTH: _____	AGE: _____	
ADDRESS: _____		
CITY: _____	STATE: _____	ZIP CODE: _____
APT. COMPLEX (if applicable): _____		APT # / BLDG # _____
HOME PHONE #: _____		
DOCTOR INFORMATION		
REFERRING DR.'S OFFICE/PRACTICE: _____		
DOCTOR NAME: _____		
ADDRESS _____		
DR'S PHONE #. _____	FAX # _____	
DIAGNOSIS (IF KNOWN): _____		
PARENT / GUARDIAN INFORMATION		
MOTHER'S NAME: _____	DATE OF BIRTH: _____	
EMPLOYER/ADDRESS: _____		
WORK #: _____	CELL: _____	
EMAIL: _____	SOCIAL SECURITY #: _____	
FATHER'S NAME: _____	DATE OF BIRTH: _____	
EMPLOYER/ADDRESS: _____		
WORK #: _____	CELL: _____	
EMAIL: _____	SOCIAL SECURITY #: _____	
PRIVATE INSURANCE INFORMATION <small>(IF APPLICABLE)</small>		
INSURANCE ELIGIBILITY EFFECTIVE DATE: _____		ENDING DATE: _____
INSURANCE POLICY HOLDER: (I.E. MOTHER/FATHER) _____		
INSURANCE NAME: _____		
INSURANCE ADDRESS: _____		
INSURANCE PHONE #: _____		
INSURANCE ID #: _____		
GROUP #: _____		
GEORGIA MEDICAID INFORMATION <small>(IF APPLICABLE)</small>		
MEMBER IDENTIFICATION #: _____		
MANAGED CARE CO. PLEASE CIRCLE ONE (CHOOSE FROM - AMERIGROUP, WELLCARE, PEACH STATE)		
THE ABOVE STATED INSURANCE WILL BE BILLED IN THE ORDER LISTED, AS APPROPRIATE, HOWEVER, THE ABOVE LISTED MOTHER, FATHER, GUARDIAN AND/OR INSURED PARTY ARE FULLY RESPONSIBLE FOR ANY BALANCE DUE AND/OR UNPAID SERVICES.		
--> **THERE WILL ALSO BE A MINIMUM OF \$30 FEE FOR ANY RETURNED CHECKS/BANK FEES.** <--		
PRINT NAME _____	SIGNATURE _____	DATE _____

**\*\*ASTS USE ONLY \*\*** DATE SUBMITTED FOR VERIFICATION: \_\_\_\_\_  
 START OF CARE DATE: \_\_\_\_\_