1044 Bermuda Run
Statesboro, GA 30458
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BULLOCH PEDIATRICS GROUP NEW PATIENT INTAKE FORM

CHILD #1

Name:_____ DOB:_____ Gender: _____

Insurance Plan:_____ Member ID#_____ P or W

CHILD #2

Name:_____ DOB:_____ Gender: _____

Insurance Plan:_____ Member ID#_____ P or W

CHILD #3

Name:_____ DOB:_____ Gender: _____

Insurance Plan:_____ Member ID#_____ P or W

SAME INFO FOR ALL CHILD(REN) IN FAMILY

MAILING ADDRESS:_____

PHYSICAL ADDRESS:_____

Cell Phone #_____ Primary Phone #_____

Race: African American Caucasian Asian Hispanic American Indian Other

Ethnicity: Hispanic/Latino or Not Hispanic/Latino

Email Address:_____

Preferred Pharmacy:_____

Mom: Name_____DOB_____SSN_____

Address if different:_____

Dad: Name_____DOB_____SSN_____

Address if different:_____

If the child has private insurance who is the policy holder? Mom or Dad

We will need to scan copies of your insurance cards and driver's license, please have them out and ready

Bulloch Pediatrics follows the American Academy of Pediatrics guidelines and recommendations for childhood vaccinations. We do not accept new patients that choose not to vaccinate. ***Please provide a copy of your child's immunization record to our office with this application.*** A decision on admitting your child to our practice will not be made without the immunization records. If admitted to the practice, no appointments will be made until medical records are received from prior physician.

BULLOCH PEDIATRICS NEW PATIENT INTAKE FORM (PAGE 2)

Medical History: Do any of your children see any medical specialists or have any medical diagnoses? If so, please provide details:

_____
_____
_____
_____
_____
_____
_____
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