SPECTRUM INTERNAL MEDICINE

401 South Main Street, Suite C7, Alpharetta, GA 30009. Tel.: 678-319-9901, Fax: 678-319-9902

YOUNG ADULT/CHILD REGISTRATION

Last Name_____ **First Name**_____ **MI**_____ **Gender**: M/F

Email: _____@_____ **DOB** _____ **SSN** _____ **Age**_____
Tel. #_(_____)_____

Parents Information: Whose insurance covers this patient? ___ Mother __ Father __ Both

Mother: Last Name_____ First Name _____ MI___ DOB _____
SSN:_____ Home Address _____
Home Tel. # _____ Cell # _____
Email Address: _____@_____ Employer:_____
Insurance Company_____ Policy Holder ID# _____
Group#_____

Father: Last Name _____ First_____ MI___ DOB_____
Home Address:_____ Email Address: _____@_____
Home Tel. #_____ Cell # _____ SSN: _____
Employer:_____ Occupation_____ Work Number_____
Insurance Company_____ Policy Holder ID #_____
Group#_____

Emergency Contact (both parents/Mother/Father), If different or additional contact person:
Name_____ Email Address_____@_____
Relationship to Patient_____ Home Phone_____ Cell_____

Financial Agreement and Authorization for Treatment

I authorize treatment of the person named above and agree to pay all fees and charges for treatment when presented with the bill. In the event legal action should be necessary to collect an unpaid balance due, I agree to pay reasonable attorney fees or other court costs, as decided by the court. **I agree that payments will not be delayed or withheld because of insurance coverage or pending claims.** I authorize my insurance company to send payments to my provider. A copy of my signature is as valid as the original one.

Signature_____ Name: _____

Relationship: _____ Date_____