COOPER PEDIATRICS 3645-A HOWELL FERRY ROAD DULUTH, GA 30096

Patient Information:

CHILD'S Name (First, Middle, Last): _____

Address _____ City _____ State _____ Zip _____

Home Phone ( ) _____ SS# _____ Birthdate _____ Sex: M / F

Brothers & Sisters (first & last names if other than patient) : _____

Emergency contact person (other than parents):_____ Phone ( ) _____

Parent's/Guardian's Information:

MOM'S Name (First, Middle, Last): _____ DOB: _____

Address _____ City _____ State _____ Zip _____

SS# _____ Place of Employment: _____

Phone Numbers: Home ( ) _____ Work ( ) _____

Pager ( ) _____ Cell ( ) _____

E-mail address: _____

DAD Name (First, Middle, Last): _____ DOB: _____

Address _____ City _____ State _____ Zip _____

SS# _____ Place of Employment: _____

Phone Numbers: Home ( ) _____ Work ( ) _____

Pager ( ) _____ Cell ( ) _____

E-mail address: _____

Person Responsible (IF other than parents): _____ Relationship to Child _____

Home ( ) _____ Work ( ) _____

Insurance Information:

Primary Insurance: _____ Name on card: _____

Secondary Insurance: _____ Name on card: _____

By my signature, I give permission for Cooper Pediatrics to treat my child(ren) or ward. All professional services rendered are charged to the patient or his guarantor. We will file claims for the patient if the patient is covered under an insurance plan with which our office is contracted. We must have a *valid* copy of the insurance card to file claims. If the patient is not covered by insurance with which our office has a contract, it is the responsibility of the guardian to pay for services *when rendered*, regardless of insurance coverage.

I authorize any holder of medical or other information about me to release to my insurance company or to the social security administration and health care financing administration or its intermediaries or carrier any information needed for this or a related insurance claim. I permit a copy of this administration to be used in place of the original, and request of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signature: _____ Date: _____

A record must be kept in the healthcare provider's office that reflects the status of all children 18years of age or younger, who receive immunization through the VFC program. The record may be completed by the parent, guardian, individual record or the healthcare provider. This same record may be used for all subsequent visits as long as the child's eligibility status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine(s). The cost of this program is $14.81 per vaccine.

This child qualifies for vaccination through VFC program because he/she (circle only one):

(a) Does NOT have health insurance
(b) Enrolled in Medicaid
(c) Has health insurance that DOES NOT pay for vaccines
(d) Is an American Indian or Alaskan native

Signature: _____ Date: _____