3301 N. Oak St. Ext.
Valdosta, Ga 31605
Phone:229-242-6061 * Fax:229-242.6151

Pediatric New Patient Approval Form

Date: ________ ____Date of Birth:______________ ______SS# ________________________

First Name: ______________________________ Middle Name:______________________ Last Name: ________________________

Address____

(City, St, zip)____ County_________________________ SEX: M/F

Home Number: ________________ Cell Number: _______________ E-mail:______________________________

Mother Name _______________________________ DOB ______________________________ SS#_________________________

Father Name ________________________________ DOB ______________________________ SS# ________________________

Reason for coming:____

Insurance Information:

Primary:_______________________________ID #___________________________ Group#______________________

Secondary: ____________________________ID #___________________________ Group#______________________

Tricare Sponsor: ____ID#_________________________________

Previous Physicians:

1. ____2. ____

Have you seen Dr. Griner previously as your Primary Care Physician? □ yes □ no

If so, when ______________________________

Please list any family members who are current or previous patients of Dr. Griner.

1. __ 2. ____________________________________

Current / Previous Diagnosis:

1. __ 2. ____________________________________

Current/ Previous Medications:

1. __ 2. ____________________________________

Do you vaccinate or plan to vaccinate? Yes or No * NOTE: WE DO NOT ACCEPT PATIENTS WHO DO NOT VACCINATE*

Signature of Authorizing Party:____ _Date:_______________

Print Name:____

Relationship to Patient:____

Witness Signature: ____ _Date: ________________

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In Office Only Dr. Griner:

Accepted __________Declined______________