



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# _____

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: _____

In Office Only Dr. Griner:

Accepted _____ Declined _____