GRINER MEDICAL GROUP
Quality Healthcare For All Ages

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 FOLLOW THE BOARD OF EDUCATION VACCINE SCHEDULE*

Signature of Authorizing Party:_____Date:_____

Print Name:_____

Relationship to Patient:_____

Witness Signature: _____Date: _____

In Office Only Dr. Griner:

Accepted _____Declined_____