



Faul S. Trover, M.D., PC  
pediatric and Adolescent Medicine

**NEW PATIENT INFORMATION**

Today's Date \_\_\_\_\_

**Patient**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Ph \_\_\_\_\_ Cell Ph \_\_\_\_\_ Work Ph \_\_\_\_\_

Birth Date \_\_\_\_\_ Sex M F (circle one) SSN \_\_\_\_\_

Emergency Contact-(not Parent/Guardian) \_\_\_\_\_ Ph \_\_\_\_\_

**\*\*\*Does Dr. Trover's office have your permission to discuss your child's care with the above listed Emergency Contact? YES or NO**

.....  
**Person Presenting Child for Care/ Guarantor (May not be same as insurance carrier )**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_

Address \_\_\_\_\_ City, State \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Phone number if different from above \_\_\_\_\_

Employer \_\_\_\_\_ PH \_\_\_\_\_

.....  
**Insurance –Please be sure to list ALL insurances under which your child is covered.**

1. Primary Insurance \_\_\_\_\_ Ph# of Ins Co. \_\_\_\_\_

Policy/Member # \_\_\_\_\_ Group # \_\_\_\_\_

Name of Policyholder? \_\_\_\_\_

(This will not be the child's name unless insurance is GA Medicaid or Peach Care)

Policyholder's Date of Birth \_\_\_\_\_ Policyholder's SSN \_\_\_\_\_



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**Insurance (Continued)**

2. Secondary Insurance \_\_\_\_\_ Ph # of Ins Co. \_\_\_\_\_

Policy/Member # \_\_\_\_\_ Group # \_\_\_\_\_

Name of Policyholder \_\_\_\_\_

(This will not be the child's name unless insurance is GA Medicaid or Peach Care)

Policyholder's date of Birth \_\_\_\_\_ Policyholder's SSN \_\_\_\_\_

.....  
**Insurance Authorization and Assignment**

1. I authorize Faull S Trover, M.D., P.C. to release to any insurance carrier(s) any information requested concerning this patient's examination or treatment, and I understand that I am responsible to promptly notify the practice of any changes in this child's insurance coverage or status. I understand that I am responsible for any charges not covered by my child's insurance or as a result of lapses in my child's insurance coverage.
2. I authorize payment from my child's insurer directly to Faull S Trover, M.D., P.C. for benefits payable for the services performed there or by the physician in a hospital setting. (Example: newborn exams, treatment or examination while inpatient in hospital.)
3. I authorize the administration of analgesics that the doctor advises.
4. I understand that payment of co-payment and any uninsured charge is expected at time of service and that a reasonable fee may be added monthly to accounts over 90 days old. I also understand that delinquent accounts remaining unresolved after 90 days will be assigned to an agency for collection and credit reporting. Agency assigned accounts will not be extended further credit privileges, and will be treated as self pay patients for all subsequent encounters, regardless of insurance status.
5. I authorize Faull S Trover, M.D., P.C. to contact me and or leave messages at my listed numbers:  
Home Yes or No      Cell Yes or No      Work Yes or No.

Signature of Parent or Guardian \_\_\_\_\_

Printed name of Parent or Guardian \_\_\_\_\_

Date \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_