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PATIENT INFORMATION FORM

(Please Print Clearly)

Patient's Last Name	First	M.I.	DOB	Social Security #
Address			City, State, Zip	Home Phone #
Mother's Name			DOB	Social Security#
Address (if different from pt)			City, State, Zip	Home Phone #
Mother's Employer			Work#	Cell#
Father's Name			DOB	Social Security#
Address (if different form pt)			City, State, Zip	Home Phone#
Father's Employer			Work#	Cell#
The children live with: (circle) Both Parents Mother Father Guardian other relative				
Emergency Contact	Relationship to Child		Address, City, State, Zip	Telephone#

INSURANCE INFORMATION

Primary Insurance Name		Subscriber's Name:	Subscriber's DOB and SS#	
Insurance ID#	Group#	Telephone#	Claim Address:	Copay Amt.
Secondary Insurance Name		Subscriber's Name:	Subscriber's DOB and SS#	
Insurance ID#	Group#	Telephone#	Claim Address:	Copay Amt.

How did you hear about us?

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize C.A.R. E. Pediatrics, LLC or insurance company to release any information required to process my claims.

 Parent/Guardian Signature

 Date