

# Cobb Pediatric Associates, PC

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Dear Parents:

Congratulations on the birth of your new baby! You are now beginning a very rewarding chapter of your life – Parenthood. Cobb Pediatric Associates has been a part of the Cobb County Health Community for over 30 years, with a dedication to provide quality medical care for your infants, children, and adolescents. Children are our future and it is our goal to maintain a friendly, professional and responsive relationship with you to better serve your family's medical needs.

We ask parents of newborns to assist us in the registration process with their insurance information *prior* to the baby's first visit. The baby's hospital re-check visit can be overwhelming with the many things new parents must remember (not to mention while being sleep deprived). We are your child's health care provider first, and his/her health remains our number one concern. However; we are in business, with employees and overhead that must be met. Your help in the registration-eligibility process will insure fewer mistakes with the original claim and a quicker response from your insurance carrier, which helps to establish a good base in our relationship for the future.

If you would like Cobb Pediatric Associates to bill your insurance company or Medicaid, please fill out the information on the attached page and return it to the Nurse. You may also go to our website at [www.cobbpedassoc.com](http://www.cobbpedassoc.com) and download the attached Newborn Information Packet from the "Forms" section, to complete and return to our office. You may also want to review our policy regarding childhood vaccines while visiting the site. *Please remember, if we are unable to file your claim, you will be billed directly for the balance.* Your help in this matter is very much appreciated.

Sincerely,

Cobb Pediatric Associates, P.C.



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web: [www.cobbpedassoc.com](http://www.cobbpedassoc.com)

## **NEWBORN INFORMATION:**

### **PLEASE PRINT**

First Name \_\_\_\_\_

Middle Name \_\_\_\_\_

Last Name \_\_\_\_\_

Current Address \_\_\_\_\_

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

Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_

### **ADDITIONAL INFORMATION:**

Mom's Name \_\_\_\_\_ Mom's DOB \_\_\_\_\_  
Will Newborn reside with Mom? Y\_\_\_ N\_\_\_

Home Phone # \_\_\_\_\_ Mom's Work # \_\_\_\_\_ Mom's Cell # \_\_\_\_\_

Dad's Name \_\_\_\_\_ Dad's Work # \_\_\_\_\_

Dad's Cell # \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Insurance ID # \_\_\_\_\_ Group # \_\_\_\_\_

Mother's Medicaid # \_\_\_\_\_

Please check one: Amerigroup \_\_\_\_\_ Peach State \_\_\_\_\_ Wellcare \_\_\_\_\_

Please use the back of this sheet to write any additional information you feel will expedite the filing of your insurance/Medicaid. Thank you.

