Preferred Medical Group's Pediatric Registration Form

Please select your preferred location:

____ Phenix City Children's ____ Fort Mitchell Clinic ____ Opelika Pediatric and Family Clinic

Child's Information

Last Name: _____ First: _____ Middle: _____

Address Line 1: _____ Home Phone: (____) _____

Address Line 2: _____ Date of Birth: _____ Gender: M or F

Zip Code: _____ Social Security #: _____

City: _____ State: _____ Language: _____

Race: _____ Ethnicity: _____

Pharmacy Preferred: _____ Previous Doctor: _____Practice_____

Who carries the insurance for this child? _____ Relationship: _____

How many children under 18 live in your home? _____

What are the names of the children that live in your home? (Please list all siblings.)

_____

When was the last time the child was seen by the previous physician? _____

Reason for leaving previous practice? _____

Is your child up to date on immunizations, to the best of your knowledge? _____ Yes _____ No

Do you have a copy of the child's immunization record that you can bring to your first appointment with Preferred Medical Group? _____ Yes ____ No

Mother/Guardian Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Last Name: _____ First Name: _____

Address Line 1: _____ Driver's License #:_____

Address Line 2: _____ Home Phone: (____) _____

City/State: _____ Work Phone: (____) _____

Zip Code: _____ Cell Phone: (_____) _____

Social Security #: _____ Employer/Military Unit(If applicable): _____

Date of Birth: _____ Email: _____

Father/Guardian Marital Status: □ Married □ Single □ Divorced □ Widowed

Last Name: _____ First Name: _____

Address Line 1: _____ Home Phone: (____) _____

Address Line 2: _____ Work Phone: (____) _____

City/State:_____ Cell Phone: (____) _____

Zip Code: _____ Employer/Military Unit(If applicable): _____

Social Security #: _____ Date of Birth: _____

Emergency Contact Information (A local person other than Parents or Guarantor)

Last Name: _____ First Name: _____

Relationship: _____ Home Phone: (____) _____

Work Phone: (____) _____ Cell Phone: (____) _____

Insurance Information (Please provide all the insurances for the child, Not providing all the insurance information will result patient being discharged from the practice)

Parent/Guardian Signature for Person Responsible for Bill: _____

Insurance Carrier Name Primary: _____ Subscriber ID Number: _____

Group Number on Insurance Card _____

Phone Number on the Back of the Insurance Card _____

Insurance Carrier Name Secondary: _____ Subscriber ID Number: _____

Group Number on Insurance Card _____

Phone Number on the Back of the Insurance Card _____

Insurance Carrier Name Secondary: _____ Subscriber ID Number: _____

Email of person responsible for paying bill: _____

Who is authorized to bring the children for a visit and make medical decisions on their behalf?

Name and Relationship to Child:

1._____

2._____

3. _____

How did you hear about us? Please Circle One

Friend	Tv	Advertisement	Google/Internet	Yellow Pages
Newspaper	PR Manager	Facebook	OB	Other: please explain

CONSENT FOR EXAMINATION, MEDICAL TREATMENT AND CONDITIONS OF EXAMINATION

Consent is hereby given to perform any and all examinations, tests, procedures, and treatments necessary and/or advisable; and in an emergency, without the presence of parents or responsible adults. I hereby authorize examination and treatment of the above named child by the physician, any assistants or designees deemed necessary by the physician. I realize that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examination in this pediatric practice. Parent or Guardian should be present for the administration of all immunizations.

INFORMATION CONCERNING FILING A CLAIM WITH YOUR INSURANCE COMPANY

If we participate with your primary insurance, Preferred Medical Group will gladly file a claim for you. We will allow your insurance company up to 45 days from the date of service to pay the claim. If your company fails to fully compensate Phenix City Children's or Fort Mitchell Clinic within this time frame, any unpaid balance becomes your sole responsibility.

AUTHORIZATION TO FILE INSURANCE CLAIMS, TO RELEASE MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

- I authorize Preferred Medical Group to file insurance claims for services and supplies rendered to and for my/our child(ren).
- I authorize Preferred Medical Group to release information, including my/our child(ren)'s medical and billing information, to referring or consulting doctors and to my insurance company. The transmission of all information may be done electronically, including the Internet.
- I authorize that payment of all third party benefits otherwise payable to me be made directly to Preferred Medical Group.
- I assign to Preferred Medical Group all payments for medical services and supplies provided to my/our dependent child(ren).

I understand that I am financially responsible to Preferred Medical Group for the above named patient(s). If my insurance company fails to fully compensate Preferred Medical Group, any unpaid balance becomes my sole responsibility. I agree to pay all amounts not covered or paid by a third party payer within 30 days after notification from Preferred Medical Group and/or a billing company acting on its behalf.

AGREEMENT AS TO CO-PAYMENTS, NON-COVERED OR NON-PAID SERVICES AND GUARANTEE OF PAYMENT

I understand that Preferred Medical Group cannot bill for co-payments. Any co-payments or payments for non-covered services are due at the time medical services are provided. I acknowledge that the above information is correct and that I am responsible for the balance on my account for any services not covered or not paid by my insurance plan.

****** Please Initial*** _____ *I/WE ACKNOWLEDGE THAT I/WE HAVE RECEIVED OR REVIEWED A COPY OF THE FOLLOWING, ALL OF WHICH ARE FOUND AT wwww.preferredmedgroup.com: 1) POLICIES ON HIPAA, 2) POLICIES AND PROCEDURES, and 3) HEALTH FORM POLICIES.*

_____ _____

Parent/Guardian Signature Date

_____ _____

Parent/Guardian Signature Date