



## Pediatric Registration Form

Please print and use black ink.

Preferred location: \_\_\_ Phenix City \_\_\_ Opelika Hwy 280 \_\_\_ Fort Mitchell \_\_\_ Opelika Executive Park

### Child's Information

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

First: \_\_\_\_\_ Middle: \_\_\_\_\_

Address Line 1: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) - \_\_\_\_\_

Address Line 2: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: M or F

City: \_\_\_\_\_

Social Security #: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Language: \_\_\_\_\_

Race: \_\_\_\_\_

Ethnicity: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_

Email Address: \_\_\_\_\_

Previous Doctor: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

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? \_\_\_\_\_

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 State \_\_\_ # \_\_\_\_\_

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: \_\_\_\_\_ Driver's License State \_\_\_\_\_ # \_\_\_\_\_

Address Line 2: \_\_\_\_\_ Home Phone: (\_\_\_\_\_) \_\_\_\_\_

City/State: \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_

Zip Code: \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

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

Date of Birth: \_\_\_\_\_ Email: \_\_\_\_\_

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

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Home Phone: (\_\_\_\_\_) \_\_\_\_\_

Work Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

**HIPPA Disclosure** (People other than parents/guardians)

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

**Insurance Information** Please provide all the insurances for the child. Not providing all the insurance information will result in the patient being discharged from the practice

Name of Person Carrying Insurance for Child: \_\_\_\_\_ Relationship: \_\_\_\_\_

DOB of Responsible Party: \_\_\_\_\_ SSN of Responsible Party: \_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_ Subscriber ID Number: \_\_\_\_\_

Group Number on Insurance Card: \_\_\_\_\_ Phone # on Back of Card: \_\_\_\_\_

Responsible Party Signature (by signing you are agreeing to pay any copays, deductibles and balances):

Secondary Insurance Company: \_\_\_\_\_ Subscriber ID Number: \_\_\_\_\_

Group Number on Insurance Card \_\_\_\_\_ Phone # on Back of Card: \_\_\_\_\_

**Who is authorized to bring the child(ren) 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 Ad	PR Manager	Facebook	OBGYN	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 physicians and physician extenders employed by Preferred Medical Group. 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 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 insurance company fails to fully compensate Pinnacle Enterprises PC within this time frame, any unpaid balance becomes your sole responsibility.

**CONSENT TO OFFICE POLICIES AND PROCEDURES**

- I understand that Preferred Medical Group has a smoke free office for the health and wellbeing of all patients, parents and staff, and agree to come to the office without the smell of cigarette smoke on my clothing or personal possessions.
- I understand that Preferred Medical Group does not allow eating or drinking in its offices in order to maintain sanitary facilities for all patients and staff.
- I understand that Preferred Medical Group requires 24-hours advance notice for an appointment to be rescheduled. A cancellation with less than 24-hours' notice results in a "No Show." I acknowledge that Preferred Medical Group reserves the right to discharge a pediatrics patient after the accumulation of two or more no shows in an 18-month time period. I also understand that for each "No Show" I may accumulate a \$25 No Show Fee, which I must pay to be seen again. Failure to pay this fee may result in discharge.

**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. I agree to pay all costs of collection, including attorney's fees and agrees to pay the legal rate of interest on the account until paid in full.

**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 [www.preferredmedgroup.com](http://www.preferredmedgroup.com): 1) POLICIES ON HIPAA, 2) POLICIES AND PROCEDURES, and 3) HEALTH FORM POLICIES.**

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

Accepted By: \_\_\_\_\_ Date: \_\_\_\_\_