PREFERRED MEDICAL GROUP

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: ______________________________

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

____

Is your child up to date on immunizations?
☐ Yes ☐ No

Do you have a copy of the child's immunization record that you can bring to your first appointment?
☐ Yes ☐ No

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.)

____

____

____

Do you consent to communication via text?
☐ 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: (______) ______________

HIPAA 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?

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: 1) POLICIES ON HIPAA, 2) POLICIES AND PROCEDURES, and 3) HEALTH FORM POLICIES.*

______________________________ ______________________________
Parent/Guardian Signature Date

______________________________ ______________________________
Parent/Guardian Signature Date

Accepted By: ________ Date: ________