Patient Registration Form

PEDIATRICS OF DALTON

Patient Information

Last Name_____ First Name_____ Middle_____

SSN_____ DOB_____ SEX M F

Address_____

City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____

Is this a foster child? Yes No

ADDITIONAL CONTACT (other than parent): Name_____ _____

Home Phone_____ Cell Phone_____

Relationship_____ Work Phone_____

MOTHER/GUARDIAN DOB_____

Name_____

Address_____

City_____ State_____ Zip_____

H-Ph_____ Cell_____

Email_____

SSN_____ Wk-Ph_____

Employer Name_____

FATHER/GUARDIAN DOB:_____

Name_____

Address_____

City_____ State_____ Zip_____

H-Ph_____ Cell_____

Email_____

SSN_____ Wk-Ph_____

Employer Name_____

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Name_____ Relationship to Patient_____

Address_____

City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell_____

SSN_____ DOB_____ Email_____

Guarantor's Employer_____

Address_____

City_____ State_____ Zip_____

OTHER FAMILY MEMBERS	Birthday	Sex	SSN

(Continued on Back)

PRIMARY INSURANCE

(Please present card for copying)

Insurance Name_____

Subscriber_____

Relationship_____

Subscriber ID_____

Group Number_____

Patient/Member ID_____

Address_____

City/State/Zip_____

Home PH_____

Work PH_____

Cell PH_____

Subscriber SSN_____

Subscriber DOB_____

SECONDARY INSURANCE

(Please present card for copying)

Insurance Name_____

Subscriber_____

Relationship_____

Subscriber ID_____

Group Number_____

Patient/Member ID_____

Address_____

City/State/Zip_____

Home PH_____

Work PH_____

Cell PH_____

Subscriber SSN_____

Subscriber DOB_____

I verify that the information is accurate

_____ _____

Signature Date

Relationship to patient (Please circle one) - mother father grandparent stepparent legal guardian other_____

AUTHORIZATION:

I authorize Pediatrics of Dalton, its physicians and staff to render appropriate medical care to my dependent child/children listed above. I authorize Pediatrics of Dalton to release to my insurance company or its agents any information needed to process insurance claims and/or determine benefits payable for related services. I request payment of insurance benefits be made on behalf of my dependent to Pediatrics of Dalton for any services furnished my dependent by that provider. I understand that I am financially responsible for deductible amounts, non-covered charges, and any balances not covered under contractual write off agreement between Pediatrics of Dalton and my insurance carrier. My insurance carrier's failure to pay does not relieve me from this responsibility. All non-covered charges and copays are due at time of service. I am aware that if this account is turned to an outside agency for collection, I am responsible for collection fees plus 15% of the balance and attorney fees. I further authorize the release of private health information to other providers involved in my child's care.

_____ _____

Signature of Responsible Party **Date**

DATE: _____

INDIVIDUAL DOCUMENT ACKNOWLEDGEMENT REGISTRATION FORM

I acknowledge that I received a copy of the Pediatrics of Dalton Notice of Privacy Practice for my minor child: (Please print full name of child) _____

Patient's DOB: _____ **Parent Signature:** _____

Patient Signature if over 18 years of age: _____

I hereby authorize the following for my child or self if over 18 years if age: (Initial all that apply)

_____ Release of medical information to other medical providers, by phone, in person, or by mail, as necessary, for continued care processes.

_____ Release of medical information to other medical providers, as necessary, via fax, as requested by them.

_____ Release of medical information, as necessary, via fax, interoffice courier, phone, in person or by mail for claims/billing/referral processes.

_____ Voicemail messages on my personal phone/answering machine regarding appointments callbacks, etc.

____ **** I authorize the following person(s) to bring my child in for treatment and to be given Private Health Information regarding my child while in the office for treatment or to receive PHI, i.e. test results, call backs, appointments, etc. regarding my child via telephone in my absence:**

_____ **Relationship to patient:** _____ **Phone #:** _____

_____ **Relationship to patient:** _____ **Phone #:** _____

_____ **Relationship to patient:** _____ **Phone #:** _____

____ **I acknowledge that I have received for review the Patient's Privacy of Healthcare information in accordance with HIPAA federal regulations.**

Parent or Patient (if over 18 yrs of age) or Personal representative of the child did not sign the acknowledgement for the following reasons:

(Check one of the reasons below)

__ Parent/Individual refused
__ Parent/Individual refused, stating that he/she has already signed acknowledgement for child.
__ Parent/Individual unable to sign because of medical condition
__ There was not a personal representative of the individual available to sign (Patient is underage)
__ Other: (explain) _____