PATIENT REGISTRATION FORM

PARENT INFORMATION: *(Use full legal name, no nicknames please)*

Mom's First & Last Name: _____ DOB: _____ SSN: _____

Mom's Cell #: _____ Mom's Employer: _____ Mom's Work #: _____

Dad's First & Last Name: _____ DOB: _____ SSN: _____

Dad's Cell #: _____ Dad's Employer: _____ Dad's Work #: _____

Home Address: _____ City: _____ St.: _____ Zip: _____

Home Phone #: _____ Preferred Pharmacy (Name & Location): _____

Emergency Contact: _____ Phone #: _____ Relationship to Patient: _____

Person Responsible for Bill: ❒ Mother ❒ Father ❒ Other: _____

Billing Address (if different from above): _____

Other person(s) who can give consent if parents cannot be reached (MUST BE A RELATIVE), please provide NAME and RELATION:

_____

PATIENT(S) INFORMATION: *(Please list ALL children that are seen in our office, use full legal names please)*

Patient's Name: _____ DOB: _____ Preferred Name: _____ Sex: M F

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INSURANCE INFORMATION: *(Please allow receptionist to photocopy your insurance ID cards)*

PRIMARY INSURANCE:

Policy Holder's Name: _____ Insurance Name: _____

Policy Holder's SSN: _____ Policy Holder's DOB: _____

Policy / ID#: _____ Group #: _____ Effective Date: _____

SEONDARY INSURANCE:

Policy Holder's Name: _____ Insurance Name: _____

Policy Holder's SSN: _____ Policy Holder's DOB: _____

Policy / ID#: _____ Group #: _____ Effective Date: _____

Initial _____ **AGREEMENT TO PAY:** The undersigned accepts the fee charged as a lawful debt and promises to pay said fee including the cost of collection, attorney fees, and court costs if such be necessary waiving now and forever the right to claim exemption under the constitution and laws of the state of Alabama or any other state.

Initial _____ **EXPRESS PRIOR CONSENT TO CONTACT YOU BY CELL PHONE:** I, the undersigned, give Montgomery Pediatric Associates, Prattville Pediatric Associates, its employees and/or agents "express prior consent to contact me at any/all phone numbers, including cell phone number (by phone call or text message), for the purpose of treatment, insurance, and/or payment.

AUTHORIZATION: I authorize Dr. Sumners, Dr. Rabon, Dr. Anagnos, Joia Henson, CRNP, Katie Jones, CRNP or either of them to prescribe and use the necessary procedures for the physical and mental health and welfare of my children. I have no objections to the use of blood transfusions should it become necessary:

_____ _____

SIGNATURE OF PARENT OR LEGAL GUARDIAN TODAY'S DATE

ALL CHARGES ARE DUE THE SAME DAY