PATIENT REGISTRATION FORM

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

Home Address: _____ City/State/Zip Code:_____
Home Phone#_____ Preferred Pharmacy (Name/Location)_____
Mom's Full Name:_____ DOB_____
SSN:_____
Mom's Cell #_____ Mom's Employer_____ Mom's Wk #_____
Dad's Full Name:_____DOB_____SSN:_____

_____
Dad's Cell #_____Dad's Employer_____Dad's Wk #_____
Billing Address (if different from above):_____

LIST 2 EMERGENCY CONTACTS WHO CAN GIVE CONSENT IF PARENTS CANNOT BE REACHED
1)Name_____ Relationship_____ Phone #:_____
2)Name_____ Relationship_____Phone #:_____

PATIENT(S) INFORMATION: ***Please list ALL children who are seen in our office.***

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

PRIMARY INSURANCE:
Policy Holder's Name:_____ Insurance Name:_____ Policy ID/Contract #_____
Group #_____ Effective Date:_____

SECONDARY INSURANCE:
Policy Holder's Name:_____ Insurance Name:_____ Policy ID/Contract #:_____
Group #_____ Effective Date: _____

Initial _____**AGREEMENT TO PAY**: I, the undersigned, accepts the fee charges as a legal and lawful debt and agree to pay said fee including any/all collection agency fees (33.33%), attorney fees and/or court costs if such be necessary. I understand if my account is turned to collections, it will result in an automatic dismissal from the practice.

Initial _____ **EXPRESS PRIOR CONSENT TO CONTACT YOU BY CELL PHONE**: I, the undersigned, in order for us to service your account or to collect money you may owe, Montgomery, Prattville and Clanton Pediatrics

and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails using any email address you may provide. Methods of contact may include using pre-recorded/artificial voice message and/or use of automatic dialing device, as applicable.

Initial _____ **DISMISSAL**: I understand that I will be considered for dismissal for more than 3 “no-show”, cancelled or rescheduled appointments.

AUTHORIZATION: I authorize providers of Montgomery, Prattville, and Clanton Pediatrics to prescribe and use the necessary procedures for the physical and mental health and welfare of my child/children.

_____

_____

Parent or Legal Guardian Signature **Date**