PATIENT REGISTRATION FORM

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

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

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

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 #: _____

List 2 Emergency Contacts (Other than parents) who can give consent if parents cannot be reached.

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

1) Name: _____ Relation: _____ Phone No.: _____

2) Name: _____ Relation: _____ Phone No.: _____

Responsible for Bill: ❒ Mother ❒ Father ❒ Other _____

Billing Address (if different from above): _____

PATIENT(S) INFORMATION: *Please list ALL children who are seen in our office. Use full legal names please.*

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

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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#: _____ Group #: _____ Effective Date: _____

SECONDARY INSURANCE:

Policy Holder's Name: _____ Insurance Name: _____

Policy / ID#: _____ 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 monies you may owe, Montgomery Pediatrics, Prattville Pediatrics, 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 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 I will be considered for dismissal for more than 3 "no-shows", 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 children.

_____ _____

SIGNATURE OF PARENT OR LEGAL GUARDIAN **TODAY'S DATE**