PROFESSIONAL PEDIATRICS

4154 Carmichael Road • Montgomery, Alabama 36106

PATIENT REGISTRATION SLIP

(Fill in All Information)

Please Print

NAME OF PATIENT:_____
(First) (Middle) (Last) (Name child is called)

BIRTHDATE:_____ SEX:_____ RACE:_____

CHILD'S HOME ADDRESS:_____

_____ CHILD'S HOME PHONE:_____
(City & State) (Zip)

CHILD'S SS#_____

PERSON RESPONSIBLE FOR PAYING AND ADDRESS?_____

FATHER'S NAME:_____ Social Sec. #:_____

EMPLOYER:_____ Work Phone:_____

OCCUPATION:_____ Home Phone:_____

MOTHER'S NAME:_____ Social Sec. #:_____

EMPLOYER:_____ Work Phone:_____

OCCUPATION:_____ Home Phone:_____

Parent's Marital Status: Single, Married, Divorced. Separated, Widow, Other (Circle One)

If divorced, who has custody of child:_____ Religion:_____

Have we seen any other children in your immediate family? Yes_____ No_____

If yes, whom?_____

In Case of Emergency, if unable to locate parents, notify:_____(Relationship to child)

Home Phone#_____ Work Phone #_____

Who Referred You To Our Office:_____

INSURANCE INFORMATION:

Primary Insurance Company:_____

Primary Insurance Holder:_____ Contract/Member I.D.#:_____
(Person Carrying Ins.)

Birthdate_____ Group#:_____

Secondary Insurance Company:_____

Secondary Insurance Holder:_____ Contract/Member I.D.#:_____

Birthdate_____ Group#:_____

*PLEASE READ THE FOLLOWING AND SIGN BELOW:

We accept assignment of benefits from Blue Cross PMD, PMC, AHC, PCN & Blue Card PPO, United Health Care, ProAmerica/BCE Emergis Net., Prime Health, Aetna & Viva. I understand I am responsible for all co-pays, deductibles and non-covered charges by my insurance carriers. If your child does not have this type of coverage, you are expected to pay for your child's visit at the time of service in order to help keep the cost of health care down. Your insurance company will reimburse you directly. You will receive two copies of our itemized statement: one for insurance purposes and the other for your tax records. In the event of hospitalization, if we have record of your insurance carrier, we will automatically file the hospital charges incurred for our doctor treating your child. In case of default of payment and if this account is placed in the hands of a collector or an attorney for collection, all collection fees, attorney's fees, costs and all other expenses will be paid by the undersigned.

In signing below, you have read and understand our office policies and procedures in the Patient Information Booklet and our NOTICE OF PRIVACY PRACTICES which have been provided for you. You also declare that your child and any of your other children are not covered by Medicaid and that you do not plan to apply for Medicaid for this child or any of your other children while a patient of our practice.

I understand that the physicians of Professional Pediatrics, P.A. use blood and/or blood products when, in their judgement, is a medical necessity. I do hereby consent to the administration of blood and/or blood products when my attending physician deems they are necessary for the proper treatment of the patient.

I realize I am responsible for accompanying my child or children while on the premises.

_____

DATE SIGNATURE OF PARENT OR GUARDIAN

REV. 1/03