PEDIATRIC PATIENT REGISTRATION – GALEN MEDICAL GROUP, PC

Your Child:

Child's Full Name: _____ Name Your Child Goes By: _____

Sex: ❑ Male ❑ Female Birthdate: _____ Age: _____ SS #: _____

Child's Home Address: _____

City: _____ State: _____ Zip: _____ Phone: (_____) _____

Primary Physician: _____

❑ **Mother** ❑ **Stepmother** ❑ **Guardian**

Name: _____ SS#: _____

Birthdate: _____ Home Phone: (_____) _____ Work Phone: (_____) _____

Employer: _____ Occupation: _____

Cell Phone(s): _____ E-Mail: _____

❑ **Father** ❑ **Stepfather** ❑ **Guardian**

Name: _____ SS#: _____

Birthdate: _____ Home Phone: (_____) _____ Work Phone: (_____) _____

Employer: _____ Occupation: _____

Cell Phone(s): _____ E-Mail: _____

CONSENT FOR RELEASE OF MEDICAL INFORMATION: I, _____, parent/legal guardian of _____, grant permission for the person(s) listed below to have access to any and all of my child's medical information that pertains to his/her care from the physicians of this group. This includes, but is not limited to, appointment times, lab results, his/her physician's plans for health care, etc.

Signature: _____

Name: _____Relationship:_____

Name: _____Relationship:_____

Name: _____Relationship:_____

May we leave lab, testing results, appointment reminders & surgical procedure dates on your home answering machine? ❑ Yes ❑ No Cell Phone? ❑ Yes ❑ No Email? ❑ Yes ❑ No

Parent/Guardian Signature: _____

CONSENT FOR MEDICAL TREATMENT: I, _____, parent/legal guardian of _____, grant permission for the person(s) listed below to bring my child to Galen Medical Group, PC for medical treatment.

Signature: _____

Name: _____Relationship:_____

Name: _____Relationship:_____

Name: _____Relationship:_____

I AGREE TO NOTIFY GALEN MEDICAL GROUP, IN WRITING, IF THERE ARE ANY CHANGES IN THE PERSON(S) AUTHORIZED.

I authorize Galen Medical Group, PC to release to my insurance company, managed care organization, state agency(ies), federal agency(ies), Health Care Financing Administration, Third Party Administrators, and/or Workers' Compensation or its agents any information needed to process my claim and/or determine benefits payable for related services. I also authorize Galen Medical Group, PC to utilize a fax machine to transmit any or all of the above medical records pertaining to my medical care or insurance reimbursement. I acknowledge that faxing my medical records may increase the risk of accidental disclosure of my medical records.

I grant permission to Galen Medical Group, PC to release all or part of my medical record to any consulting entity that may be involved in my medical care. This includes, but is not limited to, testing facilities, consulting physicians, and outpatient facilities.

I understand that I am financially responsible for deductible amounts, co-payments, co-insurance amounts, non-covered charges and any and all balances not covered under a contractual write-off agreement between Galen Medical Group, PC and my third party payer. My carrier's failure to pay does not release me from this responsibility. I also agree that should this account be turned to collection, I will be responsible for all costs associated with debt collection, including attorney fees and court costs.

_____ _____

Signature of Responsible Party / Insured ***Date***

PLEASE COMPLETE THE ADDITIONAL INFORMATION ON THE BACK OF THIS SHEET **GMG 2015-P**

PLEASE FILL IN INSURANCE INFORMATION:

We Require Copies Of ALL Insurance Cards Pertaining To The Care Of Your Child To File Your Insurance Claims.

What **Primary Insurance** Is Child Covered By? _____Ins. ID#: _____

Who Carries This Insurance? _____Relationship to child: _____
(EXACT Name Listed On Card.)

Insurance Carrier's Address: _____

_____

Insurance Carrier's Birthdate: _____ Insurance Carrier's SS#_____

What **Additional Insurance** Is Child Covered By? _____Ins. ID#: _____

Who Carries This Insurance? _____Relationship to child: _____
(EXACT Name Listed On Card.)

Insurance Carrier's Address: _____

_____

Insurance Carrier's Birthdate: _____ Insurance Carrier's SS#_____

MISCELLANEOUS:

Preferred Language: Please list one. _____

Patient Ethnicity: Please select one. ❑ Hispanic or Latino ❑ Non-Hispanic or Non-Latino

Patient Race: Please select one or more. ❑ African American ❑ American Indian or Alaska Native ❑ Asian ❑ Caucasian/White ❑ Native Hawaiian or Other Pacific Islander ❑ Other

PARENT'S MARITAL STATUS:

❑ Single ❑ Divorced ❑ Married

❑ Widowed ❑ Separated

EMERGENCY CONTACT:

Name: _____

Address: _____

Telephone: (_____) _____ Cell: (_____) _____

Relationship: _____

Please list any siblings who are also patients of ours. Give both first and last names:

_____ _____

_____ _____

_____ _____

_____ _____

THANK YOU!

GMG 2015-P