PEDIATRIC PATIENT REGISTRATION – GALEN MEDICAL GROUP, PC

Your Child:
Child's Full Name: _____ Name Your Child Goes By: _____
Gender: ❑ Male ❑ Female DOB: _____ Age: _____ SS#: _____
Child's Home Address: _____
City: _____ State: _____ Zip: _____ Phone: _____
Primary Physician: _____

❑ **Mother** ❑ **Stepmother** ❑ **Guardian**
Name: _____ DOB: _____
SS #: _____ Home Phone: _____ Work Phone: _____
Employer: _____ Occupation: _____
Cell Phone(s): _____ E-Mail: _____

❑ **Father** ❑ **Stepfather** ❑ **Guardian**
Name: _____ DOB: _____
SS #: _____ Home Phone: _____ Work Phone: _____
Employer: _____ Occupation: _____
Cell Phone(s): _____ E-Mail: _____

MAY WE LEAVE MESSAGES BY:	EMAIL	TEXT CELL	HOME PHONE	WORK PHONE	CELL PHONE
FOR TEST RESULTS	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
FOR APPOINTMENT REMINDERS	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

PARENTAL MARITAL STATUS: ❑ SINGLE ❑ MARRIED ❑ SEPARATED ❑ DIVORCED ❑ WIDOWED

PREFERRED LANGUAGE: ***Must complete.*** ❑ English ❑ Spanish ❑ Other: _____

PATIENT ETHNICITY: ***Select one.*** ❑ Hispanic or Latino ❑ Non-Hispanic or Non-Latino

PATIENT RACE: ***Select one or more.*** ❑ African American ❑ American Indian or Alaska Native ❑ Asian ❑ Caucasian/White ❑ Native Hawaiian or Other Pacific Islander ❑ Other

INSURANCE INFORMATION:

We require copies of ALL Insurance Cards pertaining to child in order to file your insurance claims.

PRIMARY INSURANCE: _____ INS ID#:_____
RELATIONSHIP TO SUBSCRIBER: _____ SUBSCRIBER NAME: _____
SUBSCRIBER'S ADDRESS: _____
SS #: _____ DOB: _____ PHONE: _____
SECONDARY INSURANCE: _____ INS ID#:_____
RELATIONSHIP TO SUBSCRIBER: _____ SUBSCRIBER NAME: _____
SUBSCRIBER'S ADDRESS: _____
SS #: _____ DOB: _____ PHONE: _____

EMERGENCY CONTACT INFORMATION:

NAME: _____ HOME PHONE: _____ WORK PHONE: _____
RELATIONSHIP TO CHILD: _____

PLEASE COMPLETE THE ADDITIONAL INFORMATION ON THE BACK OF THIS SHEET

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:_____

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.

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

_____ _____

_____ _____

_____ _____

_____ _____

ADVANCED DIRECTIVES & AUTHORIZATION:

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***

THANK YOU!

Ver. 2017-01