patient registration

Children's Medical Group, S.C.

Please complete both sides of this form

patient 1 information *(please print)*

PATIENT NAME *(last, first, middle)*	SOCIAL SECURITY #	SEX ☐M ☐F ☐T	DATE OF BIRTH
ADDRESS	CITY / STATE / ZIP		

patient 2 information

PATIENT NAME *(last, first, middle)*	SOCIAL SECURITY #	SEX ☐M ☐F ☐T	DATE OF BIRTH
ADDRESS	CITY / STATE / ZIP		

parent 1 information ☐ BIOLOGICAL PARENT LEGAL GUARDIAN ☐ YES ☐ NO		**parent 2 information** ☐ BIOLOGICAL PARENT LEGAL GUARDIAN ☐ YES ☐ NO	
PARENT NAME ☐ M ☐ F ☐ T		PARENT NAME ☐ M ☐ F ☐ T	
ADDRESS *(if different from patient)*		ADDRESS *(if different from patient)*	
CITY / STATE / ZIP		CITY / STATE / ZIP	
DATE OF BIRTH	HOME PHONE #	DATE OF BIRTH	HOME PHONE #
SOCIAL SECURITY NUMBER	WORK PHONE #	SOCIAL SECURITY NUMBER	WORK PHONE #
OCCUPATION	CELL PHONE #	OCCUPATION	CELL PHONE #
EMAIL		EMAIL	
EMPLOYER		EMPLOYER	
EMPLOYER ADDRESS		EMPLOYER ADDRESS	
EMPLOYER CITY / STATE / ZIP		EMPLOYER CITY / STATE / ZIP	

emergency contact *(other than those listed above)*

NAME			LEGAL GUARDIAN ☐ YES ☐ NO
HOME PHONE #	WORK PHONE #	RELATIONSHIP TO PATIENT ☐ GRANDPARENT ☐ STEP PARENT ☐ FRIEND ☐ AUNT / UNCLE ☐ BROTHER / SISTER ☐ OTHER	

primary pharmacy

PHARMACY NAME	LOCATION (INTERSECTION / CITY)	PHONE #

insurance *(attach copy of the front & back of insurance cards)*

INSURANCE COMPANY NAME	SUBSCRIBER NAME	SUBSCRIBER DATE OF BIRTH	GROUP #
GROUP NAME	MEMBER ID / POLICY #	RELATIONSHIP ☐ SPOUSE ☐ PARENT ☐ STEP PARENT ☐ OTHER	EFFECTIVE DATE

EMPLOYER NAME	EMPLOYER ADDRESS	EMPLOYER CITY / STATE / ZIP	COPAY

assignment of benefits

I authorize the assignment of benefits payable to CHILDREN'S MEDICAL GROUP and/or its designee for physician services and supplies by government and/or any other private third party payer. I understand that I will be held responsible for payment of all co-payments, co-insurance, deductibles and non-covered services.

X

SIGNATURE DATE

(continued on opposite side)

patient registration

Children's Medical Group, S.C.

Please complete the information below in order for us to register all of your children in your family.

patient 3 information			
PATIENT NAME *(last, first, middle)*	SOCIAL SECURITY #	SEX ☐M ☐F ☐ T	DATE OF BIRTH
ADDRESS	CITY / STATE / ZIP		
patient 4 information			
PATIENT NAME *(last, first, middle)*	SOCIAL SECURITY #	SEX ☐M ☐F ☐ T	DATE OF BIRTH
ADDRESS	CITY / STATE / ZIP		
patient 5 information			
PATIENT NAME *(last, first, middle)*	SOCIAL SECURITY #	SEX ☐M ☐F ☐ T	DATE OF BIRTH
ADDRESS	CITY / STATE / ZIP		
patient 6 information			
PATIENT NAME *(last, first, middle)*	SOCIAL SECURITY #	SEX ☐M ☐F ☐ T	DATE OF BIRTH
ADDRESS	CITY / STATE / ZIP		

authorization for release of information

I authorize CHILDREN'S MEDICAL GROUP to release to my insurance carrier or its designated agents any information concerning medical care (physical and/ or psychological), advice, treatment or supplies provided to me for purposes of administration, review, investigation or evaluation of claim coverage and utilization of services. I authorize that a copy of this information to be as valid as the original. I will notify CHILDREN'S MEDICAL GROUP in writing of any information I do not want released.

authorization for additional fees

In the event any lawsuit or action is brought to collect this account or any portion thereof, the custodial parent/guardian will be responsible for any and all costs, not limited to attorney's fees, court costs, collection fees, interest and any additional costs that this action may incur.

authorization for treatment

I agree to any examination, treatment and procedures that may be performed during my child's office visits, including emergency treatment considered necessary by the physician and/or his/her providers.

after hours care and missed appointment/cancellation policies

After regular office hours, CHILDREN'S MEDICAL GROUP asks that calls be only for emergencies or urgent problems that cannot wait until morning. I understand that I may be charged for after hours consultations with a provider as outlined by the American Academy of Pediatrics Policy Statement *Payment for Telephone Care* which is available on the website *www.childrensmedicalhome.com* .

I also am aware that there is a fee for missed appointments or appointments cancelled without 24 hours notice.

X

SIGNATURE DATE