

2007 PATIENT REGISTRATION - GALEN PEDIATRICS

Your Child

Child's Full Name: _____ Name Your Child Goes By: _____ Sex: _____
(Abby, Billy, Katie, etc.)

Birthdate: _____ Age: _____ Social Security Number: _____

Primary Physician: _____

Child's Home Address: _____

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

Mother **Stepmother** **Guardian**

Name: _____ Social Security Number: _____

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

Employer: _____ Occupation: _____

Cell Phone(s): _____ E-mail Address(es) _____

Father **Stepfather** **Guardian**

Name: _____ Social Security Number: _____

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

Employer: _____ Occupation: _____

Cell Phone(s): _____ E-mail Address(es) _____

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 Pediatrics 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 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 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 to release all of 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 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 _____

Date _____

PLEASE REFER TO BACK OF FORM AND COMPLETE ALL APPLICABLE SECTIONS

**PLEASE FILL IN YOUR INSURANCE INFORMATION.
WE MUST HAVE A COPY OF ALL INSURANCE CARDS PERTAINING TO THE
CARE OF YOUR CHILD IN ORDER TO FILE YOUR INSURANCE.**

What **Primary Insurance** Is Your Child Covered By? _____

Who Carries This Insurance? _____ Relationship to your child: _____
(Exact Name as Listed on the Card)

Address of the person named above who carries this insurance: _____

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

Additional Insurance

Who Carries This Insurance? _____ Relationship to your child: _____
(Exact Name as Listed on the Card)

Address of the person named above who carries this insurance: _____

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

Parent's Marital Status

- Single Divorced Married
 Widowed Separated

Emergency Contact

Name: _____
Address: _____
Telephone: _____ Cell: _____
Relationship: _____

May we leave appointment reminders, lab or test results on your home answering machine? YES NO

Please list any siblings who are also patients of ours. Please give both first and last names. Thank You!!

_____	_____
_____	_____
_____	_____
_____	_____

Thank You