POPLAR BLUFF PEDIATRIC ASSOC.

PATIENT REGISTRATION FORM

☐ NEW
☐ UPDATE

☐ Dr. Fernando ☐ Dr. Dye ☐ Dr. Robertson ☐ Dr. Preuschoff ☐ Tonya McClain ☐ Dr. Margreiter

PATIENT INFORMATION: (Please use full legal name, no nicknames please)

Last Name:_____ First Name:_____ Middle Name:_____

Address:_____ SS# _____

City:_____ State:_____ Zip:_____

Home Phone #: (____)_____ Cell Phone #: (____)_____

Date of Birth:_____ Sex: Female [ ] Male [ ]

IS THE PATIENT ALLERGIC TO ANY MEDICATIONS? ☐ Yes ☐ No ☐ Don't Know

If yes, write the name of the medicine(s) here _____

Does the patient have brothers and/or sisters living at the same address above? ☐ Yes ☐ No

If yes, list their names and birthdates: _____

_____

_____

Patient Lives with: ☐ *Both Parents* ☐ *Mother* ☐ *Father* ☐ *Other:* _____

MOTHER Full Name _____ Date of Birth _____
Last First Middle Maiden

Address _____ Social Security Number _____
If different from above

City, State, Zip _____
If different from above

Telephone (____) _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow
area code

Place of Employment _____ Occupation _____

Telephone (____) _____
area code

How related to patient (check one) ☐ Birth Mother ☐ Step Mother ☐ Foster Mother ☐ Other _____

FATHER Full Name _____ Date of Birth _____
Last First Middle

Address _____ Social Security Number _____
If different from above

City, State, Zip _____
If different from above

Telephone (____) _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widower
area code

Place of Employment _____ Occupation _____

Telephone (____) _____
area code

How related to patient: (check one) ☐ Birth Father ☐ Step Father ☐ Foster Father ☐ Other _____

AUTHORIZATION TO MAIL, CALL OR E-MAIL:

I certify that I understand the privacy risk of the mail, phone calls, and e-mail. I hereby authorize a representative or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not imited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Poplar Bluff Pediatrics to that effect in writing.

Email Address: _____

Name on email account: _____

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize direct payment of my insurance benefits to Poplar Bluff Pediatrics or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that is unable to collect from my insurance carier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:
I certify that the information given to me in applying for payment under theses programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct the payment of my or my dependent's authorized benefits be made directly to the physician on my behalf.

"I have been informed of Poplar Bluff Pediatric's Appointment Policy."

Signature: _____ Date: _____

"I have been offered a copy of Poplar Bluff Pediatric Assoiates' Notice of Privacy Practices."

Signature: _____ Date: _____

CONSENT TO TREATMENT:
I hereby consent to evaluation, testing, and treatment as directed by my physician or his or her designee.

Signature: _____ Date: _____

Every effort is made to protect our patients' privacy. However, in the case of an emergency in which a parent/legal guardian cannot be reached, we may need to call someone on your child's behalf. Please list below the name of someone we have your permission to contact if necessary.

Emergency Contact: _____
(Name of person NOT living with child) *(Relationship to child?)*

Emergency Contact's Phone Number: (____) _____

INSURANCE INFORMATION: (Please give your insurance(s) and photo ID to the receptionist):

Primary Insurance Company's Name: _____

Policy Holder's Name: _____

Member ID #: _____ Group #: _____ Date of Birth: _____

Secondary Insurance Company's Name: _____

Policy Holder's Name: _____

Member ID #: _____ Group #: _____ Date of Birth: _____

Insurance billing statement mailed to: ☐ Mother ☐ Father