Patient Registration & Consent

Fort Payne Pediatrics

Is this your first visit to this office? ☐Yes ☐No
How did you hear about us? ☐Facebook ☐Instagram ☐Google ☐Family/Friend: _____

Patient's Legal Name: _____
Last First Middle

Address: _____
Street Apt #

_____
City State Zip

Date of Birth: _____ SS #: _____

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

Email: _____

PARENT/GUARDIAN INFORMATION

Parent/Legal Guardian: _____

Date of Birth: _____ SS#: _____

Address (if different): _____

_____

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

Parent/Legal Guardian: _____

Date of Birth: _____ SS#: _____

Address (if different): _____

_____

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

Siblings & DOBs: _____ _____ _____

We are required to collect the following information for each patient.

Please complete this section before returning the form.

Preferred Doctor/CRNP:

_____

Your preferred language:

_____

Sex (Circle): M☐ F☐

Your child's Race/Ethnicity:
(select one primary)

- ☐ American Indian
- ☐ Asian
- ☐ Black/African American
- ☐ Caucasian
- ☐ Hispanic
- ☐ Multiracial
- ☐ Unknown
- ☐ Other
- ☐ Decline to answer

PRIMARY INSURANCE INFORMATION

Plan Name: _____ Policy ID #: _____ Group #: _____

Policy Holder: _____ DOB: _____ SS #: _____

Patient's Relationship to Policy Holder: _____ Copay: ☐Y ☐N Amount: _____

SECONDARY INSURANCE INFORMATION

Plan Name: _____ Policy ID #: _____ Group #: _____

Policy Holder: _____ DOB: _____ SS #: _____

Patient's Relationship to Policy Holder: _____ Copay: ☐Y ☐N Amount: _____

I agree that the above information is true and correct to the best of my knowledge. **If over the age of 14, the patient MUST sign this form.**

_____ _____ _____
Print Name (Patient or Guardian if under 14) Signature (Patient or Guardian if under 14) Date

_____
Relationship to Above Patient

Delegation of Consent for Minor Children & Acknowledgment of Receipt of Privacy Practices

I, _____, authorize Fort Payne Pediatrics, LLC and its personnel to deliver
Print Name (Patient or Guardian if under 14)
any and all medical care and attention which is deemed necessary and appropriate by a healthcare provider licensed in the state of Alabama to me and/or child(ren) listed below. This consent includes, but is not limited to, medical treatment, surgical intervention, elective procedures, and emergency care. This authorization shall be valid until I withdraw my delegation of consent.

(Please Print)

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

The following section must be completed if the patient is under the age of 14:

I, _____, authorize the following people to bring my child(ren) in for
Print Name of Biological Parent or Legal Guardian
treatment and to consent to any and all medical care and attention which is deemed necessary and appropriate by a healthcare provider licensed in the state of Alabama. This consent includes, but is not limited to, medical treatment, surgical intervention, elective procedures, and emergency care. This delegation shall be valid until I withdraw my delegation of consent.

Name: _____ Phone: _____ Relationship to Child: _____

Name: _____ Phone: _____ Relationship to Child: _____

Name: _____ Phone: _____ Relationship to Child: _____

Name: _____ Phone: _____ Relationship to Child: _____

Name: _____ Phone: _____ Relationship to Child: _____

Name: _____ Phone: _____ Relationship to Child: _____

Please note: If the patient is under the age of 14, the individuals listed above are the **ONLY** people (other than biological parents or legal guardians) authorized to bring your child(ren) to the doctor.

I have reviewed this office's Notice of Privacy Practices which explains how my or my child(ren)'s medical information will be used and disclosed, and/or I understand that I am entitled to receive a copy of this document upon my request. Furthermore, I agree to receive calls, detailed messages, or correspondence about my or my child(ren)'s appointments, lab and x-ray results, or other health care information at the address and phone numbers listed on Page 1 of this Patient Registration form. **If over the age of 14, the patient MUST sign this form.**

_____ _____
Print Name (Patient or Guardian if under 14) Relationship to Patient

_____ _____
Signature (Patient or Guardian if under 14) Date

_____ _____
Witness Translator/Reader (If Applicable)