MOREHOUSE COMMUNITY MEDICAL CENTERS, INC.

PEDIATRIC REGISTRATION FORM

Today's Date ____/____/____

PATIENT INFORMATION (Please give your driver's license to the receptionist)

Patient's Last Name	First	Middle	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Marital Status Circle One Single / Mar / Div / Sep / Wid

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Former Name	Birth Date / /	Age	Sex ☐ M ☐ F

Work Status: ☐ Migrant Worker ☐ Seasonal Worker ☐ N/A | Veteran Status: ☐ I am a Veteran ☐ I am not a Veteran

Housing Status: ☐ Homeless ☐ Doubling Up ☐ Street ☐ Transitional ☐ N/A | Number of people living in your household:

Ethnicity (Check One): ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Race (Check One):
☐ Asian ☐ Native Hawaiian ☐ Pacific Islander
☐ More than one race ☐ White ☐ Black/African American
☐ American Indian/Alaska Native ☐ Do not wish to disclose

Annual Household Income (if willing to report):
☐ Less than $10,000 ☐ $10,001-$20,000 ☐ $20,0001-$40,000
☐ $40,001 - $60,000 ☐ $60,0001-$100,000 ☐ $100,000+

PO Box	City	State	Zip Code	Social Security #	Home Phone No. ( )

Street Address	City	State	Zip Code

Occupation	Employer	Employer Address	Employer Phone No. ( )

Email address: | Preferred contact method: ☐ Phone ☐ email ☐ mail

PARENT/GUARDIAN INFORMATION (To be completed if the patient is a minor)

Mother's/Guardian's Name	Mother's/Guardian's Birth Date / /	Mother's/Guardian's Social Security #	Home Phone No. ( )
Father's Name	Father's Birth Date / /	Father's Social Security #	Cell Phone No. ( )

Address (if different from above)

Person Responsible for Bill	Relationship to the Patient	Occupation

Employer	Employer Address	Employer Phone No. ( )

INSURANCE INFORMATION (Please give your insurance card to the receptionist)

Is this patient covered by insurance? ☐ Yes ☐ No
If Yes, please check one: ☐ Private Insurance ☐ Medicare ☐ Medicaid ☐ Other:

Name of Primary Insurance	Policyholder's Name	Policy #	Co-Payment $

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other | Policyholder's DOB:

Name of Secondary Insurance	Policyholder's Name	Policy #	Co-Payment $

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other | Policyholder's DOB:

IN CASE OF EMERGENCY

Name of Local Friend or Relative	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )	Cell Phone No. ( )

EMERGENCY CONTACT – If person above lives with you we also need:

Name of Local Friend or Relative (not living at same address as you)	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )	Cell Phone No. ( )

Name of person completing this form, if other than patient: _____

(Updated 2/17/12)

GENERAL QUESTIONS

Answering the following questions will help us determine what other services the clinic offers that you may qualify for:

Yes	No	
___	___	Do you have reliable transportation?
___	___	Do you have prescription drug coverage?
___	___	Do you currently qualify for any government programs such as Medicaid, WIC, welfare, food stamps, Social Security disability or unemployment? If yes, please list_____
___	___	If you do not currently have Medicaid, have you ever applied for Medicaid? What was the outcome? _____

NOTICE OF PRIVACY PRACTICES

I have been provided with and understand the contents of the NOTICE OF PRIVACY PRACTICES for Morehouse Community Medical Centers, Inc. and its' entities. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations and that Morehouse Community Medical Centers, Inc. and its' entities are not required to agree to the restrictions requested.

ASSIGNMENT AND RELEASE OF BENEFITS

PRIVATE INSURANCE: The undersigned assigns and hereby authorizes whether he/she signs as agent or as patient, direct payment to the clinic of all insurance and plan benefits otherwise payable to or on behalf of the patient for medical services. It is agreed that payment to the clinic pursuant to this authorization by an insurance company or health plan shall discharge said insurance company or health plan of any and all obligations under the policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment.

MEDIARE/MEDICAID: I certify that the information given by me in applying for payment under Title 18 of the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that the payment of authorized benefits be made in my behalf. I assign payment for any unpaid charges for the clinic is authorized to bill in connection with its services. I understand that I am responsible for any remaining balance not covered by other insurance.

GENERAL OFFICE POLICIES

1. All co-pays and deductible amounts must be paid at the time of service unless other signed arrangements have been made.
2. All returned checks are subject to a $25.00 or 5% of check amount (whichever is higher) service charge. Signage information will be posted.
3. All delinquent accounts are automatically turned over to collection after 90 days if no response of payment is received.
4. All patients will be seen on a first come first serve basis or by scheduled appointments, although Morehouse Community Medical Centers, Inc., has the right to take patients with medical emergencies first.
5. This is a "SMOKE FREE" building. All smoking is prohibited.
6. No alcohol or drug use is allowed on the premises. Anyone abusing this policy will be asked to vacate the premises. If this request is not followed, Law Enforcement will be called.
7. No firearms/weapons are allowed on the premises. Law Enforcement will be called and said persons will be banned from any Morehouse Community Medical Centers, Inc., property.

I understand and agree to abide by the general office policies.

CONSENT FOR TREATMENT

I authorize Morehouse Community Medical Centers, Inc. and such assistants as they may designate, to carry out diagnostic procedures if needed to better diagnose my condition and to administer such treatments and medications, as they determine necessary. I understand that my condition may call for a consultation with another Healthcare Provider. If this situation occurs, I authorize Morehouse Community Medical Centers, Inc. to release any medical information that may be needed to better provide for my medical treatment.

Patient's Signature (or Parent/Guardian's Signature): _____ Date: _____

Witness Signature _____

HEALTH HISTORY

Name of Patient		Allergies
Date of Birth		Pregnancy Weeks at Birth
Prenatal Care (circle) Yes No		Infections During Pregnancy
Type of Delivery		Pregnancy Complications
Hospital of Delivery		Newborn Nursery Stay Days
Newborn ICU stay (circle) Yes No		Oxygen required at birth (circle) Yes No
Newborn Genetic Screen		Newborn Hearing Screen
Birth Weight	Height	Head Circumference
Mom's Blood Type	GBS	Baby's Blood Type

PATIENT HISTORY (Circle any that apply)

Heart Disease	Sickle Cell Anemia	Arthritis	Stroke
Kidney Disease	Hypertension	Anemia	TB
Cancer	Diabetes	Seizures	Smoking Alcohol/Drug Use
Asthma	Thyroid Problems	Immune Problems	Psychiatric Problems
Nasal Allergies	Liver Problems	Lupus	Bleeding Disorder
Fractures or injuries:		Other:	

FAMILY HISTORY (Circle all that apply and indicate family member)

Disease	**Relationship**	**Disease**	**Relationship**
Heart Disease		Arthritis	
Kidney Disease		Anemia	
Cancer		Seizures	
Asthma		Immune Problems	
Nasal Allergies		Lupus	
Sickle Cell Anemia		Stroke	
Hypertension		TB	
Diabetes		Smoking	
Thyroid Problems		Alcohol/Drug Use	
Liver Problems		Psychiatric Problems	
Other:		Bleeding Disorder	

SOCIAL HISTORY

Number of Brothers & Sisters	Travel	Pets

OTHER MEDICAL HISTORY

Routine Medicine	**Past Medical**	**Past Hospitalization**	**Surgeries**

I certify that the above information is correct to the best of my knowledge. I will not hold Morehouse Community Medical Centers, Inc. or any of its employees responsible for any errors or omissions that I may have made in the completion of this form.

Patient/Guardian Signature _____ Date_____