GFHS Pediatrics

Pediatric
Patient Registration Form

PATIENT INFORMATION	**ACCOUNT #:**		**Date: _____**
Patients Legal Name (Last, First, Middle)			**Preferred Name**
Social Security Number	**Date of Birth**	**Sex:** **Male Female**	**Home Phone Number**
The child lives with: ☐ **Mother** ☐ **Father** ☐ **Grandparent(s)** ☐ **Guardian(s): _____**			
Preferred Notification Method: ☐ **Postal Mail** ☐ **Phone** ☐ **Email** ☐ **Web Message**			

Mother / Guardian(s) Name:			**Father / Guardian(s) Name:**		
Date of Birth	**Sex**	**SSN**	**Date of Birth**	**Sex**	**SSN**
Address			**Address**		
City	**State**	**Zip**	**City**		**State / Zip**
Home Phone	**Cell Phone**		**Home Phone**	**Cell Phone**	
Work Phone	**E-Mail Address:**		**Work Phone**	**E-Mail Address:**	
Employer Name			**Employer Name**		

PRIMARY INSURANCE INFORMATION			SECONDARY / SUPPLEMENTAL		
Name of Plan			**Name of Plan**		
Claims Address (Street Address/P.O. Box)			**Claims Address (Street Address/P.O. Box)**		
City	**State**	**Zip**	**City**		**State / Zip**
Phone Number			**Phone Number**		
Patient Policy Number	**Group Number**		**Patient Policy Number**	**Group Number**	
Subscriber Name (if different from patient): (Last, First, MI			**Subscriber Name (if different from patient): (L, F, MI)**		
Subscriber Sex : ☐ **M** ☐ **F**	**Subscriber Policy #:**		**Subscriber Sex:** ☐ **M** ☐ **F**	**Subscriber Policy #:**	
Guarantor Employer Name			**Guarantor Employer Name**		
Effective Date	**Expiration Date**		**Effective Date**		**Expiration Date**
Copay Amount **$**	**Relationship to child**		**Copay Amount** **$**	**Relationship to child**	
Plan Type: ☐ **Medicaid** ☐ **PPO** ☐ **HMO** ☐ **POS** ☐ **Self Pay**			**Plan Type:** ☐ **Medicaid** ☐ **PPO** ☐ **HMO** ☐ **POS** ☐ **Self Pay**		
Person Responsible for Payment of Bill: ☐ **Mother** ☐ **Father** ☐ **Guardian or Other _____**					

EMERGENCY CONTACT: (Other than Mother or Father)		
Name (Last, First, Middle)		Relationship
Home Phone Number	Work Phone Number	Cell Phone Number

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF INSURANCE BENEFITS

I guarantee payment to GFHS and its affiliates for all charges for services provided to the patient. I understand I am personally responsible for all charges not covered by insurance. I authorize payment of medical, surgical and behavioral benefits, which would otherwise be payable to me, to GFHS Inc for services rendered. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment under Titles V, XVIII, and/or XIX of the Social Security Act is correct.

CONSENT FOR HEALTHCARE AND RELEASE OF MEDICAL INFORMATION

I voluntarily consent to healthcare treatment (i.e., physical and/or behavioral treatment) from the physicians, behavioral health providers, and staff of GFHS, inc. I consent to any necessary lab work, including HIV testing. I am aware that neither the practice of medicine nor the delivery of mental/behavioral health treatment are an exact science. No guarantees have been made to me regarding the results of treatments or examinations by my caregivers. I understand that GFHS employs a "team based" approach to the delivery of healthcare and that health information may be exchanged between GFHS providers and staff members involved in my care to ensure appropriate treatment planning and adequate care. I consent to the use and disclosure of protected health information about me for treatment, payment and healthcare operations. I certify that I have read and understand this form.

Signed: _____ Date: _____ / _____ / _____

Office Use Only:

_____ _____

Witness Signature **Date / Time**

General Comment Section

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter accepted _____ ☐ Interpreter Refused

Name /Number of Person/services chosen/used