Children's of Alabama

Greenvale Pediatrics General Information

Father's Name_____ **Date of Birth**_____

Please check- Race: ☐ American Indian/Alaska Native ☐ Blk/African American ☐ Nat Hawaiian/Pacific Islander ☐ Unknown ☐ Asian ☐ Declined ☐ Other ☐ White

Please check- Ethnicity: ☐ Declined ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown

Best way for messages from the office: ☐ Email ☐ Text Message ☐ Phone

Primary Language_____ Email Address_____

Mailing Address_____ City_____ State_____ Zip Code_____

Home Phone #_____ Cell Phone #_____ Work Phone #_____

Employer_____ Address_____

PRIMARY INSURANCE_____ OWNER OF POLICY_____

POLICY #_____ GROUP #_____

EFFECTIVE DATE_____ CO-PAY_____

Mother's Name_____ **Date of Birth**_____

Please check- Race: ☐ American Indian/Alaska Native ☐ Blk/African American ☐ Nat Hawaiian/Pacific Islander ☐ Unknown ☐ Asian ☐ Declined ☐ Other ☐ White

Please check- Ethnicity: ☐ Declined ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown

Best way for messages from the office: ☐ Email ☐ Text Message ☐ Phone

Primary Language_____ Email Address_____

Mailing Address_____ City_____ State_____ Zip Code_____

Home Phone #_____ Cell Phone #_____ Work Phone #_____

Employer_____ Address_____

Emergency Contact/Relationship_____ Phone #_____

List patients(in this family) to be seen by us:

Name_____ M F Birth Date_____ Physician_____

Name_____ M F Birth Date_____ Physician_____

Name_____ M F Birth Date_____ Physician_____

Name_____ M F Birth Date_____ Physician_____

PLEASE READ THE FOLLOWING VERY CAREFULLY

CONSENT FOR TREATMENT: I, the undersigned, consent to the care and treatment by the attending physician, his/her associates, or assistants.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND INSURANCE INFORMATION: I hereby authorize the release of any or all medical records including psychiatric, drug, alcohol, substance abuse and any and all financial and accounting records, including insurance information to referring physicians or agencies from whom the patient seeks medical care.

ASSIGNMENT OF BENEFITS AND GUARANTEE OF ACCOUNT: I acknowledge full financial responsibility for any services rendered and I understand that the payment of charges incurred in this office is due at the time of service. I also understand that the charges not covered by insurance remain my responsibility and assign insurance benefits to this office. In the event my account is turned over to a collection agency, I agree to pay all costs of collection including attorneys' fees and all court cost if any.

DIVORCED PARENTS: In keeping with our policy that payment is due at the time service is rendered, it is the person who brings the patient to us who is responsible for payment and who should sign as responsible party.

DATE_____ **Responsible Party's Signature**_____