Centennial Pediatrics, PA
Patient Registration Form

Today's Date__________________

Patient Information:

Pt's Full Name: ________________________ DOB: ________________________ Male ☐ Female ☐

Physician:
(Please Circle) Dr Guetersloh Dr. Nail Dr. Newton Dr. Crow Dr. McClendon Dr. Bridgewater Dr. Lestz Dr. Smith Dr. Tran

List of Siblings: ***Please only list Siblings that attend Centennial Pediatrics***

Name: ____ Male ☐ Female ☐ Date of Birth ______________

Name: ____ Male ☐ Female ☐ Date of Birth ______________

Name: ____ Male ☐ Female ☐ Date of Birth ______________

Parent/Guardian:		***Parent/Guardian:***	
Name:		Name:	
Date of Birth:		Date of Birth:	
Address:		Address:	
City, State, Zip:		City, State, Zip:	
Employer Name:		Employer Name:	
Cell #:		Cell #:	
Work #:		Work #:	
Relationship to Pt:		Relationship to Pt:	
Marital Status:	☐ Married ☐ Single ☐ Widowed ☐ Divorced	**Marital Status**:	☐ Married ☐ Single ☐ Widowed ☐ Divorced

In cases of separated or divorced parents, who does the child live with?

INSURANCE NAME: ______________________ **POLICY HOLDER:** ______________________

Please list the Phone number you would like to be contacted at regarding Medical Issues/Concerns:

PHONE: ***(List Phone number below)***

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How would you prefer to be contacted regarding Medical Appointment Reminders:

EMAIL/PHONE/TEXT: ***(Choose one and list below) -*** **Can we leave a message at the number listed below:** ***YES or NO***

____

Please list an email below to be linked to the Patient Portal: ***(only one email per Family allowed)***

____

Emergency Contact - OTHER THAN PARENT/OTHER PERSON(S) Allowed to bring patient to the Office or receive medical information/advice

Name of Contact: ______________________ Male ☐ Female ☐ Best Phone # ______________
Relationship to Child: ☐ Grandparent ☐ Aunt / Uncle ☐ Step Parent ☐ Friend ☐ Other

Name of Contact: ______________________ Male ☐ Female ☐ Best Phone # ______________
Relationship to Child: ☐ Grandparent ☐ Aunt / Uncle ☐ Step Parent ☐ Friend ☐ Other

Parent/Guardian Signature ______________________________ **Date**______________________

Authorization to Release Patient Information

I authorize Centennial Pediatrics (Chad D. Guetersloh, M.D., Christopher L. Newton, M.D., Richard C. Nail, M.D., Susan W. Crow, M.D., Dr. McClendon) or their covering physicians (collectively referred to as "Physician") or their designee to release and furnish all medical and financial data for purposes for utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMO's and PPO's, managed care organizations contracting with any of the above to perform such functions.

Authorization for Treatment

I authorize and give my consent to the Physician at Centennial Pediatrics to treat my child, as he/she deems medically necessary in the event of my absence.

Authorization for Payment

If I am a member of a health care plan, of which Physician is an authorized provider, I understand that I must present my Health Plan identification at each visit or I agree to pay the charges billed by my physician at the time of the visit. If I am a member of an HMO, EPO, or POS health care plan that requires me to choose a primary care physician, I must choose a physician from this practice before my child's visit and the insurance card that I present must include this physician's name that is rendering services. I understand that I am responsible for all copayments and deductibles under the plan and must pay them at the time of the visit.

In the event I request that my Physician provide medical services, lab procedures or immunizations which are not authorized or covered by my health care plan, I hereby agree in advance, to pay the Physician the customary billed charges for such services. In the event that my Physician does not perform certain in-office lab services under my health care plan and I request that the Physician perform such lab services in his office for my convenience, I agree to pay the Physician his billed charges since this service is considered to be "out of network".

I authorize payment of medical benefits to CENTENNIAL PEDIATRICS. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled to CENTENNIAL PEDIATRICS. This assignment will remain in effect until revoked by me in writing. A photocopy of this document is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Acknowledgement of Receipt and Review of Financial Policies

I have received and reviewed this office's Financial Polcy, which explains how my financial responsibilities to Centennial Pediatrics. The document can be obtained at the office of Centennial Pediatrics, PA or on their website http://centennialpediatrics.net/office-visit-policies

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document. The document can be obtained at the office of Centennial Pediatrics, PA or on their website **http://www.centennialpediatrics.net/patient-forms.html**

My signature below indicates that I have read, understand, and agree to the above terms.

Child's Name: ______________________ **Parent/Guardian Signature:** ______________________

Child's Name: ______________________

Child's Name: ______________________ **Date:** ______________

Child's Name: ______________________

Child's Name: ______________________