BrightStarts Pediatrics, PC
102 Essex Ct., Ste A, Madison, AL 35758
Ph (256)461-8442 Fax (256)461-8447

Patient Information

Patient's Name:____ Name Child goes by:_____________________

Address:_____________________________________ City:_________________ State:______ Zip:_______________

Birthdate:_____________ Sex: M F Social Security #:____________________Preferred Language:_____________

Home Phone:_______________________ Cell Phone:______________________

Race: American Indian or Alaskan White Black Asian Hispanic Native Hawaiian Unknown

Ethnicity: Hispanic Origin Not of Hispanic Origin Refused by Patient

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Parent's Name:____________________________ Second Parent's Name:________________________________

SSN #:_________________DOB:_____________ SSN:____________________DOB:_____________________
Relationship to Patient:_______________________ Relationship to Patient:________________________________
Work #:_____________Cell #:________________ Work #:_______________Cell #_______________________
Email:_____________________________________ Email:____
DL#________________________State:_________ DL#:____________________________State:______________

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Emergency Contact:___________________________________Relationship to Patient:________________________
Home #:_______________________Cell #:______________________Work #:________________________________

Siblings that we see:____

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Insurance Information

Primary Insurance
Policy Holder Name:_________________________
Insurance Company:__________________________
Policy #:___________________________________
Group #:_______________DOB:_______________

Secondary Insurance
Policy Holder Name:_________________________________
Insurance Company:_________________________________
Policy #:____
Group #____________________DOB:__________________

Signature:____Date:___________________________________
Insurance Release: I hereby authorize BrightStarts Pediatrics to furnish the above named insurance company all the information they may Request concerning the patient's present illness or injury. I hereby assign to BrightStarts Pediatrics all benefit for service rendered.

BrightStarts Pediatrics PC

New Patient Registration Form 2 of 3

Pediatric or Minor Patient

I, ____, parent/legal guardian/legal custodian/caretaker of
(your name)

____, date of birth____/______/________ give permission for my minor child to
(Child's name)
receive health-related services such as physical examinations, immunizations, prescriptions, referrals, and other services as indicated. I understand that the child's medical records are strictly confidential. I hereby authorize use of these records by all persons within BrightStarts Pediatrics PC office (such as physicians, nurses, and other providers) participating in the provision of my health related services.

I release BrightStarts Pediatrics PC and their health officers, employees and agents from any liability resulting from their use of this form. I hereby authorize payment of insurance benefits to the above named clinic to release any information acquired in the course of the examination or treatment so that the insurance benefits may be promptly and correctly filed.

Furthermore, I authorize the following individuals who are listed below (1) to sign any necessary papers on subsequent visits, (2) to read and sign the information statements required before immunizations can be administered, and (3) to advise the nurse of any conditions following previous treatments or immunizations which would prevent my child's receiving further treatments or immunizations on a subsequent visit which may be made in my absence. Information given to the persons listed below and signature made by them will have the same effect as if I had personally received the information and signed by name on any documents on behalf of my child.

Person s authorized to bring my child to BrightStarts Pediatrics PC for services and sign papers on my behalf:

Name:____Relationship to Patient:__________________________Age:_____________

Name:____Relationship to Patient:__________________________Age:_____________

Name:____Relationship to Patient:__________________________Age:_____________

Name:____Relationship to Patient:__________________________Age:_____________

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RECEIPT OF NOTICE OF PRIVACY PRACTICIES WRITTEN ACKNOWLEDGEMENT FORM.

I, ____, have received a copy of BrightStarts Pediatrics PC's notice of privacy practices.

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I, ____, authorize BrightStarts Pediatrics PC to release any information acquired in the course of my child's examination or treatment. I also authorize any insurance payment directly to BrightStarts Pediatrics PC for medical benefits. I understand any monies received from the insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible for all charges and will be responsible for any collection fees, attorney fees, or court costs should my account become delinquent. I understand that all payments for services rendered are expected at the time of service.

____ _____________________

Signature of Parent/Guardian

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Patient Eligibility Screening Record

Alabama Vaccines for Children Program

Child's Name:____DOB:_________________________

Parent/Guardian/Individual of Record Name:____

This child qualifies for vaccination through the VFC program (please circle one if applicable) because he/she

A. Is enrolled in Medicaid

B. Does not have health insurance

C. Is American Indian or Native Alaskan

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MEDICAID PROGRAM RELEASE OF INFORMATION

I, ________________________________, ______________________, of________________________________

Name **Relationship** **Child's Name**

A qualified participant in the Alabama Medicaid Program, hereby agree to the release of my child's records to the Alabama Medicaid Agency and to any participating contractors or subcontractors with his/her medical care and follow-up. I also agree to the release of any program records pertaining to my child.

____ ____________________________________

Parent, Guardian or Custodian Signature **Date**

____ ____________________________________

Witness **Date**

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EPSDT CHILD HEALTH MEDICAL RECORD

I give permission for the child whose name is on this record to receive services at BrightStarts Pediatrics PC. I understand that he/she will receive tests, immunizations, and exams including physicals/screenings. I understand that I will be expected to follow plans that are mutually agreed upon between the health staff and me.

____ _____________________________ ____________________

Signature **Relationship** **Date**