PATIENT REGISTRAION FORM

Patient Information (Please use full legal name)

Last Name: ______________________ First Name: ______________________ MI: ________

Date of Birth: ____________________ SS# ______________________ □ Female □ Male

Street Address: ____ Unit# ______________

City: __________________________ State: ____________ Zip: ____________

Cell Phone# ______________ Alternate# ______________ Email: ____________________

How would you prefer to be contacted? □ Phone □ Email □ Text Msg

May we leave detailed voice messages? □ Yes □ No

Emergency Contact Must Be Different from Self

Emergency Contact: ________________ Relationship: ________________ Phone# ______________

Parent / Guardian Information (Please use full legal name)

Last Name: __________________ First Name: __________________ Relationship: ____________

DOB: ___________________ SS# ________________ Phone# __________________

Address if different from above: ____

Last Name: __________________ First Name: __________________ Relationship: ____________

DOB: ___________________ SS# ________________ Phone# __________________

Address if different from above: ____

Insurance Information

Primary Insurance

Insurance Name: ________________ Policy# ________________ Group# ________________

Insured DOB: ________________ Insured SS# ___________________

Secondary Insurance

Insurance Name: ________________ Policy# ________________ Group# ________________

Insured DOB: ________________ Insured SS# ___________________

I attest to the fact that my child has no other insurance coverage other than listed above. ________

I authorize Dr. Hall and Staff to treat my child. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to Dr. Hall for all medical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance, before my child is seen.

Medical care and/or immunizations can not be given unless my child is accompanied by myself or one of the following: (List Full Name and Relationship) ________________________________

____

Parent / Guardian Signature: ____________________ **Date:**

512 South Main Street, Suite A
Hinesville, GA 31313
Telephone: (912) 369-5437
Fax: (912) 369-5740

RE: Cancellation | No-Show Policy | Late Policy

Dear Parents,

Due to a significant number of no-shows, the office is implementing a new policy. This policy requires the patient's parent to notify the office at least 24 hours in advance for appointment cancellations. Failure to comply with this policy may result in a $25.00 no-show fee and repeated violations may result in the patient being dismissed from the practice. Please remember to call the office if you are not going to be able to make your scheduled appointment time and we will gladly reschedule you for a more convenient time.

Also, if you are more than 20 minutes late for your scheduled appointment time, you may be asked to reschedule. If you are running late for your appointment, please call our office to notify us.

Sincerely,

Eric L. Hall, M.D.

By signing you are acknowledging understanding of the late and no-show policy.

Patient's Name ______________________ Todays Date ______________

Parent / Guardian Name ______________________ Todays Date ______________

PRIVACY NOTICE
AND
RELEASE FOR PATIENT PHOTO

Please acknowledge and sign that you read and received a copy of the Privacy Notice then return this portion to the front desk.

____________________________ ____________________

Patient's Name Todays Date

____________________________ ____________________

Parent / Guardian Name Todays Date

I ______________________________, hereby authorize Eric L. Hall, M.D. or any of their assignees to take photographs of my child. I understand that the photographs will be used in my child's chart and updated once a year. The content may also be used for advertising (including website publication, Facebook post, etc.) I further understand that if the photographs are used in any publication, my child's identifying information (first name only) could be used unless stated differently below. I do not expect financial compensation or any other type of compensation for the use of these photographs. If I wish to revoke this consent, I acknowledge that I may do so in writing.

If declining this consent, leave blank.

Please initial one option:

_______ I do not mind if my child's photographs are used in any of the above stated circumstances.

_______ I only agree to have my child's photographs taken for sole use of medical record identification.