Cedar Creek Pediactric & Adolescent Medicine, P.C.

Registration Form

(office use only)

verified by

date

PATIENT INFORMATION

Last Name:_____

First Name:_____Middle:_____

Sex:_____DOB:_____SS#:_____

Street Address:_____

City:_____St:_____Zip:_____

Home Phone:(_____)_____

MOTHER'S INFORMATION

Last Name:_____

First Name:_____Middle:_____

Street Address:_____

City:_____St:_____Zip:_____

Home Phone:(_____)_____

SS#:_____DOB:_____

Martial Status:_____

Occupation:_____

Employer:_____

Work Phone: :(_____)_____

Cell Phone: :(_____)_____

E-mail:_____

FATHER'S INFORMATION

Last Name:_____

First Name:_____Middle:_____

Street Address:_____

City:_____St:_____Zip:_____

Home Phone:(_____)_____

SS#:_____DOB:_____

Martial Status:_____

Occupation:_____

Employer:_____

Work Phone: :(_____)_____

Cell Phone: :(_____)_____

E-mail:_____

EMERGENY

Please list the name of a relative or friend that does not live with you and can be contacted in case of an emergency

Name:_____

Relationship to patient:_____

Home Phone:(_____)_____

TENNCARE

TennCare MCO: Please present card

TennCare MCO Name:_____

TennCare Number:_____

INSURANCE INFORMATION

First Policy: Please present insurance card

Name of Insured:_____

Insurance Provider:_____

Insurance Provider Address:_____

_____

Policy #:_____Group #:_____

Employer Name:_____

Employer Address:_____

Employer Phone:_____

Date of Birth of Insured:_____

Copay:_____

Second Policy: Please present insurance card

Name of Insured:_____

Insurance Provider:_____

Insurance Provider Address:_____

_____

Policy #:_____Group #:_____

Employer Name:_____

Employer Address:_____

Employer Phone:_____

Date of Birth of Insured:_____

Copay:_____

Pharmacy:_____

✖ _____

Signature of person completing information ***Date***

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION (Please Print):

Name:_____

DOB:_____ Social Security #:_____

Adress:_____

City:_____ State:_____ Zip:_____

Telephone #: _____

I hereby authorize and request you to release complete records from:

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Telephone #:_____Fax #_____

To:

Cedar Creek & Adolescent Medicine, P.C.

616 Smithview Drive

Maryville TN 37803

Tel: (865) 379-2277

Fax: (865) 379-2212

Please release a copy of all medical records, including but not limited to progress notes, operative notes, laboratory results, and diagnostic test.

BY MY SIGNATURE, I AUTHORIZE RELEASE OF MEDICAL RECORDS:

Parent/Legal Guardian Date

_____

Effective Date of Transfer

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION (Please Print):

Name:_____

DOB:_____ Social Security #:_____

Adress:_____

City:_____ State:_____ Zip:_____

Telephone #: _____

I hereby authorize and request you to release complete records to:

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Telephone #:_____Fax #_____

From:

Cedar Creek & Adolescent Medicine, P.C.
616 Smithview Drive
Maryville TN 37803
Tel: (865) 379-2277
Fax: (865) 379-2212

Please release a copy of all medical records, including but not limited to progress notes, operative notes, laboratory results, and diagnostic test.

BY MY SIGNATURE, I AUTHORIZE RELEASE OF MEDICAL RECORDS:

Parent/Legal Guardian Date

_____

*Effective Date of Transfer

*After this date, the above individual will no longer be a patient of Cedar Creek Pediatric & Adolescent Medicine, P.C. All future medical treatment must be provided by your new doctor.

Agreement and Consent for Medical Services

1. **Agreement and Consent.** I am the parent or legal guardian of the patient below and am authorized to act on his/her behalf. I hereby authorize medical services to be provided to the patient by the medical staff of Cedar Creek Pediatric and Adolescent Medicine, P.C.
2. **Release of Information.** I hereby authorize Cedar Creek Pediatric and Adolescent Medicine, P.C. to release to government agencies, third party payers and other agencies, any information reasonably requested by such parties, including any information necessary for the Practice to obtain payment for services.
3. **Assignment of Insurance Benefits.** I authorize and request that payment be made directly to Cedar Creek Pediatric and Adolescent Medicine, P.C., 616 Smithview Drive, Maryville, TN 37803 for any insurance benefits payable for services provided to the patient by Cedar Creek Pediatric and Adolescent Medicine, P.C. This authorization expressly includes any benefits that are to be provided by TennCare and any other public or private insurance plans. This order will be in effect until revoked by me in writing.
4. **Acknowledgment of Financial Responsibility.** While there may be insurance benefits available to pay the medical services provided to the Patient at Cedar Creek Pediatric and Adolescent Medicine, P.C., I understand that all services may not be covered by insurance, or that payment may be less than 100% of charges billed. I understand that it is my responsibility to be aware of what services are covered by insurance. I further agree to pay for any services rendered by Cedar Creek Pediatric and Adolescent Medicine, P.C. for the Patient that are not paid by insurance.
5. **Immunization Agreement:** Cedar Creek Pediatric & Adolescent Medicine, PC follows the American Academy of Pediatrics Immunization recommendations. I agree to comply with the required immunizations and with the standard immunization schedule. I am aware that if at anytime I refuse or change my mind on allowing my child to receive immunizations, I will not be able to continue receiving medical care and will immediately transfer to another office.
6. **HIPAA:** By signing below, I acknowledge that I have received/reviewed a copy of the office Health Insurance Portability and Accountability Act.
7. **Permission to Treat**: I give permission for the following people to bring my child to Cedar Creek Pediatric & Adolescent Medicine, PC for medical care as deemed appropriate by our Medical Staff, including but not limited to, Immunizations, lab work, testing.

1) _____

First Name *Last Name* *Relationship to Patient*

2) _____

First Name *Last Name* *Relationship to Patient*

Signature of Parent/Legal Guardian **DATE**