Patient Registration

Bright Pediatrics

www.bright-pediatrics.com

Dalton: 706-529-4600, Ringgold: 706-841-0150

Today's Date:________________________

Child's Name:____

Address:____

Birthdate:_____________________________ Sex: Male Female

Parent #1:___________________________________ Birthdate:__________

Single or Married Spouse name:__________________________________

Address:____

Cell Phone #:______________________ Work #:________________________

Employer/Address:____

SS#:____________________Email address:____________________________

Parent #2:____________________________________Birthdate:___________

Single or Married Spouse name:___________________________________

Address: (if different than child)____

Cell Phone #:______________________Work #:_________________________

Employer/Address:____

SS#:____________________Email address:_____________________________

Patient Registration

Bright Pediatrics

www.bright-pediatrics.com

SIBLINGS

Full name:____________________________________Birthdate:____________

Full name:____________________________________Birthdate:____________

Full name:____________________________________Birthdate:____________

Full name:____________________________________Birthdate:____________

Full name:____________________________________Birthdate:____________

EMERGENCY

Full Name of Adult-not living with child in case of emergency:______________

____

Cell Phone # of adult (listed above)____

Address of adult (listed above)____

____

Relationship to Patient:____

PAYMENTS

Full Name of person legally responsible for Payments:__________________

____

Relationship to Patient:__________________Cell #:______________________

Bright Pediatrics____

WRITTEN ACKNOWLEDGEMENT OF RECIEPT OF BRIGHT PEDIATRICS NOTICE OF PRIVACY PRACTICES, CONSENT TO TREAT & ADVANCED DIRECTIVES

General Consent to Treat

I am the parent/guardian of____
I have the legal right to consent to medical and surgical treatment for this patient.

I understand by signing this form, I am giving permission to the doctors, nurse practitioners, nurses and other health care providers in this medical office to provide treatment to this child.

I have read this form or this form has been read to me in a language that I understand, and I have had an opportunity to ask questions about it.

Notice of Privacy Practices

By signing below, you acknowledge receiving the **Bright Pediatrics** Notice of Privacy Practices ("Notice"). The Notice explains how Bright Pediatrics may use and disclose your protected health information for treatment, payment, and health care operations purposes. "Protected health information" means your personal health information found in your medical and billing records.

Name of Patient:____
Signature of Patient or Patient's Representative:___________________________________
Relationship to patient:____
Date:__________________________________

Whom May bring Child for Appointment

(if name is not on this list, they WILL NOT be allowed to bring child)

Name of Authorized Person or Person's	Relationship to child
______________________________________	______________________________
______________________________________	______________________________
______________________________________	______________________________
______________________________________	______________________________

Signature_____________________________________Date_________________________