

Morgan Family Practice, LLC
141 Golfview Drive, Arab, AL 35016
Phone: 256-459-7771 Fax: 256-673-2212

Pediatric Patient Information

Date: _____

Child's Information

Name: _____ Primary Phone: _____

SS#: _____ Date of birth: _____ Sex: M or F Race: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Parent/Guardian Information

Father's Name: _____ Date of birth: _____

SS#: _____ Cell: _____ Work: _____

Employer: _____

Mother's Name: _____ Date of birth: _____

SS#: _____ Cell: _____ Work: _____

Employer: _____

Insurance Information

Primary Policy: _____ Contract Number: _____

Subscriber Name: _____ Date of birth: _____

Secondary Policy: _____ Contract Number: _____

Subscriber Name: _____ Date of birth: _____

Person to contact in case of EMERGENCY (Outside your home): _____

Relationship: _____ Phone: _____

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Child's Name:_____ **Date of Birth:**_____

I consent to necessary treatment, including drugs, medicine, procedures and conduction of x-ray and other studies that may be used by Morgan Family Practice, LLC, or staff.

I authorize Morgan Family Practice, LLC, to furnish my medical information requested by insurance companies with whom I have coverage, any public agency which may be assisting in payment of my care or my employer who is providing payment of my medical bills due to an on-the-job injury.

I hereby authorize payment directly to Morgan Family Practice, LLC, of benefit otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed the charges of these services. I understand that I am financially responsible for charges not covered by this assignment. I authorize the refund of overpaid insurance benefits where my coverage is subject to coordination of benefits. For services furnished by Morgan Family Practice, LLC, I hereby guarantee the payment of all accounts for services rendered. For payment of said accounts I hereby waive all claims of exemption under the State of Alabama and agree to pay if necessary all cost of collection, including attorney fees.

I have received a Notice of Privacy Practice. I release Morgan Family Practice, LLC, to release any medical information regarding myself to the people listed below.

Parent or Guardian Signature

Date

Release Medical Inforamtion to the Following People:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

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Previous Physician: _____ **Telephone:** _____

Pharmacy: _____ **Telephone:** _____

Medications

Please include prescriptions, over-the counter medications, vitamins, and supplements. *If you need additional space please use the back of this form.

Medication	Dose	Route	Frequency

Allergies: Please list all medication or food allergies and the reaction that you have to them.

Medication/Food	Reaction

Medical History: Please circle all that apply.

ADHD or ADD	Blood Transfusion	Reflu Heart Burn (GERD)	Nerve/Muscle Disease
Allergies	Cancer	Heart Murmur	Seizures
Anemia	Heart Disorders	HIV/AIDS	Sickle Cell Anemia
Anxiety	Clotting Disorder	Kidney Disease	Thyroid Disease
Asthma	Diabetes	Meningitis	Tuberculosis

Other Medical History:

Surgical History: Please list all surgeries and past hospitalizations. * If you need additional space please use the back of this form.

Date	Procedure —please specify left or right if surgery was performed on a joint or extremity	Surgeon/Location

Family History: Please list your blood relatives' health problems.

Relative	Age	Deceased? Y/N	Heath Issues
Mother			
Father			
Sister			
Brother			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

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