Southside Medical Center

PATIENT REGISTRATION FORM 10TH GRADE VACCINE

Date: _____MR# _____

IF YOU PREFER TO COMPLETE ONLINE, SCAN THIS QR CODE. IF COMPLETE ONLINE NO NEED TO RETURN FORM.

PATIENT (CHILD'S INFORMATION)

Name: _____Date of Birth: ____/____/_____ Sex: ___M ____F
Soc. Sec. #: _____/_____/_____ Race or Ethnicity: _____ Religion: _____
Street Address: _____ Apt #: _____ City/State: _____ Zip: _____
ALLERGIES:_____

PARENT/GUARDIAN INFORMATION

Primary Language: ___English ___Spanish ___Other: _____

Name: _____ Phone: (____) _____ E-Mail: _____
Street Address: _____ Apt #: _____ City/State: _____ Zip: _____
Parent's Birthdate:_____ Employed by: _____ Phone: (____) _____ Ext. _____
Address: _____ City/State: _____Zip: _____
Emergency Contact Person: _____ Phone: (____) _____

Do your CHILD have Medical Insurance? __NO __Yes If yes, complete:

A. Medicaid: (Include all letters in the number)
   #_____
B. Insurance Company: _____
   Address: _____
   City/State/Zip: _____
   Group #: _____

Policy Holder's Name: _____
Soc. Sec. # _____
Date of Birth: _____
Policy #: _____

AUTHORIZATION TO PAY INSURANCE BENEFITS AND RELEASE OF INFORMATION

I hereby authorize and direct any insurance company to pay directly to Southside Medical Center any insurance benefits otherwise payable to me. I further authorize and direct Southside Medical Center or any physician to release all information with respect to myself or any of my dependents, which may have bearing on the benefits payable under the above stated insurance plan, or any other plan providing benefits or services.

Date: _____ Person Responsible for Bill (If not patient): _____ Date of Birth: _____

CONSENT TO TREATMENT AND AUTHORIZATION TO RELEASE AND ASSIGNMENT and APPROVAL FOR MEDICAL TREATMENT

I further authorize Southside Medical Center to release any appropriate medical information to the hospital upon my admission to a medical consultant or third-party payors (Medicaid, Medicare, or private insurance companies when needed for reimbursement purposes). I agree to be responsible for any charges to my account, which is not covered by Medicare, Medicaid or my insurance. Southside Medical Center utilizes Physician Assistants (P.A.) and Nurse Practitioners (NP) in the health center for those levels of practice that have been approved by the Georgia State Board of Medical Examiners. Your signature on this approval form conveys that you are in agreement with being treated by the Physician Assistant who acts under direct supervision of a Southside Medical Center physician for medical treatment.

Signature of Person Authorized to Consent: _____ _____Parent _____Guardian

CONSENT TO RECEIVE STATE REQUIRED 11TH GRADE VACCINE and CONSENT FOR RELEASE OF INFORMATION

I consent for my child, _____, to receive the STATE REQUIRED vaccine of MCV4 (Menactra), based on current school immunization and/or GRITS records, on the campus of Jackson High School by the State-licensed health professionals with the Southside Medical Center. I also authorize release of medical and educational information pertinent to my child's health care and wellbeing between Butts County Schools and Southside Medical Center (SMC) whenever necessary related to the administration of these vaccines, including allergies and immunization history.

Signature of Parent/Guardian: _____ Date: _____