Cottonwood Medical Center, Ltd
Child Registration Form

Date:________________ **Account No.: ____________**

Child's Name: __________________________Sex: ____ Birth Date:______________ Student: Yes No
(Last) (First) (M.I.)

Child's Social Security No.: ____

MOTHER'S INFORMATION:

Name: _______________________________ Soc. Sec. No.: __________________ Birth Date: ___________
(Last) (First) (M.I.)

Address: ___________________________ City: ____________State: ____ Zip: ______ Phone: __________

Employer: _________________________ Address: __________________ Phone: ___________ Ext.: _____

FATHER'S INFORMATION:

Name: _______________________________Soc. Sec. No.: ___________________ Birth Date: ___________
(Last) (First) (M. I.)

Address: __________________________ City:____________ State:____ Zip: ________ Phone: _________

Employer: _________________________ Address: _________________ Phone: ___________ Ext.: ______

Primary Insurance Company: ____

Policy Holder: ____________________ _____________________Group No.: _____________ I.D. No.: ________________

Secondary Insurance Company ____

Policy Holder:____Group No.:______________I.D. No.:________________

MOTHER'S AND FATHER'S FAMILY HISTORY:

Names & ages of children at home: ______________________ ________________________ ________________________

HAS ANY MEMBER OF THE IMMEDIATE FAMILY HAD ANY OF THE FOLLOWING

Yes	No	Relation		During Pregnancy Did The Mother:	Yes	No
			Heart Trouble	Have Medical Problems?		
			Kidney or Urinary Trouble	Smoke Or Drink?		
			Seizures	Use Any Medications?		
			Mental/Emotional Problems	Use Alcohol or Other Drugs?		
			Sickle Cell	Have Problems With Labor/Delivery?		
			Allergies/Asthma	Birth weight: ______________ Length: _____________		
			Cancer or Malignancy	Place of Birth: _________________________________		
			Tuberculosis			
			High Blood Pressure	How long did baby stay in the hospital after birth? ____		
			Diabetes	Have any of the child's brothers or sisters died?_______		

Child's History-Allergies: To Medicine: ____

Foods: ____ Other: ____

Medication: Please List all medications that the child is now taking: ____

Please list any operations, serious illnesses or accidents with dates: ____

Are the child's immunizations up to date? Yes ____ No ____ Please provide immunization record.

HAS CHILD HAD ANY OF THE FOLLOWING? **DO YOU HAVE ANY QUESTIONS ABOUT THE FOLLOWING?**

Yes	No	PROBLEMS WITH EYES/VISION	Yes	No	DEVELOPMENT	EXPLAIN
		PROBLEMS WITH FEET			BEHAVIOR	
		PROBLEMS WITH DIGESTION/NUTRITION			EATING HABITS	
		PROBLEMS WITH EARS/HEARING			SLEEPING HABITS	
		PROBLEMS WITH URINE/KIDNEYS			SCHOOL EXPERIENCE	
		PROBLEMS WITH JOINTS			TOILET HABITS	
		PROBLEMS WITH SKIN			DISCIPLINE	
		PROBLEMS WITH LUNGS/BREATHING			OTHER	
		HEART TROUBLE				
		SEIZURES				
		REPEATED INFECTION				

COTTONWOOD MEDICAL CENTER Ltd.

FINANCIAL AGREEMENT

I have read and agree to abide by Cottonwood Medical Center's financial policy. If the account is sent to an attorney for collection, I agree to pay reasonable attorney's fees and collection expenses. The amount of the attorney's fee shall be established by the court and not by a jury in any court action. A delinquent account may be charged interest at the legal rate.

If any signer is entitled to medical benefits under any policy insuring the patient or any party liable to the patient, the benefits are hereby assigned to Cottonwood Medical Center, Ltd. for application towards the patient's bill. However, IT IS UNDERSTOOD THAT THE PATIENT AND UNDERSIGNED ARE PRIMARILY RESPONSIBLE FOR PAYMENT OF THE PATIENT'S BILL.

______________________	______________________	________
Patient	**Other Party Agreeing to Pay**	**Date**

______________________	______________________	________
Witness	**Relationship to Patient**	**Date**

In Case of Emergency, Contact: ______________________ Phone: ______________

CONSENT FOR MEDICAL CARE

The following person (s) listed have permission to authorize medical care for my child in my absence.

______________________	______________________
Child's Name	DOB

Authorized Person (s) Name (s)	Relationship to Patient	Telephone Number (s)

______________________	________	______________________	________
Witness	Date	Parent Signature	Date