

Patient Registration *(Pediatric)*

Patient Information

Date _____ Chart No.

Patient _____ Sex: M F DoB ___ / ___ / ___ SS# _____

Mother / Guardian _____ DoB ___ / ___ / ___ SS# _____

Address _____ Home Phone _____

City / State / Zip _____ Cell Phone _____

Email _____ Occupation _____ Employer _____ Work Phone _____

Father / Guardian _____ DoB ___ / ___ / ___ SS# _____

Address _____ Home Phone _____

City / State / Zip _____ Cell Phone _____

Email _____ Occupation _____ Employer _____ Work Phone _____

Sibling _____ Sex: M F DoB ___ / ___ / ___ SS# _____

Sibling _____ Sex: M F DoB ___ / ___ / ___ SS# _____

Sibling _____ Sex: M F DoB ___ / ___ / ___ SS# _____

Children Live with: Mother Father Guardian _____

Emergency Contact Person _____ Relation _____ Phone _____

Party Responsible for Payment of Medical Services: Father Mother Guardian Both _____

Who Referred you to our office? _____

Insurance Information

Primary _____ Claims Address _____

Policy # _____ Group # _____ Co-payment \$ _____

Secondary _____ Claims Address _____

Policy # _____ Group # _____ Co-payment \$ _____

Name of Insured _____ DoB ___ / ___ / ___ Relation _____

Medicaid / Champus / Other _____ Current Card # _____

Physician Listed on Card _____ Phone _____

Authorization of Treatment and Assignment of Benefit

I authorize _____ to treat my child. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to _____ for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original. Medical care or immunizations cannot be given unless my child is accompanied by one of the following: _____

I understand that if my child's physician, or any person employed by or under the direction and control of my child's physician(s), is directly exposed to my child's body fluids in any manner which may, according to the then current guidelines for the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or hepatitis B or C viruses, that I am deemed by law to have consented to testing for infection with HIV or hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to the release of these test results to the person who is exposed to my child's body fluids.

May we contact you by email for results, schedule changes or other information? _____ YES _____ NO (PARENT/GUARDIAN INITIAL)

Please read and sign attached financial agreement form.

Parent / Guardian's signature _____ Relationship _____ Date _____

Witness signature _____ Relationship _____ Date _____

I prefer to do my own insurance filing. Signed _____ Date _____

HIPPA Authorization Statement

Please complete and sign the attached privacy agreement.

New Patient Record *(Pediatric)*

Family Information

Date ___/___/___ Chart No.

Patient's Name _____ DoB ___/___/___ Sex: M F

Mother's Name _____ Age _____ Ph (H) _____ Ph (W) _____

Home Address _____ Mother's Employer _____

Father's Name _____ Age _____ Ph (H) _____ Ph (W) _____

Home Address _____ Father's Employer _____

Referred by _____

Current Medical History

Is your child having any medical problems? Yes No

Is he/she taking any medications? Yes No

Are immunizations current? Yes No

Maternal and Newborn History

Pregnancy *(check problem areas)*

Excessive wt. gain Urinary infections Excessive swelling
 Rubella Toxemia Venereal disease

Alcohol / recreational drugs used during pregnancy? Yes No

Birth Delivery: Vaginal Caesarean Section _____

Baby was Full term Premature Birth Wt. _____

Was labor difficult or prolonged? Yes No _____

Was delivery difficult or complicated? Yes No _____

Newborn Breast Formula _____

Feeding problems Colic Multiple formula changes
 Blood in stools Slow wt. gain Recurring vomiting
 Recurrent diarrhea Jaundice Other _____

Important Medical Problems or Diagnosis

Drug Allergies

Past Medical and Family History

Has the patient or any family member been hospitalized for a medical or surgical problem? Yes No _____

If the patient or any family member has or has had any of the following problems, check the appropriate box and list the family member's initial?

P-Patient M-Mother GM-Grandmother
S-Sibling F-Father GF-Grandfather

- | | |
|---|--|
| 1. <input type="checkbox"/> Trauma: Broken Bones, loss of consciousness _____ | 14. <input type="checkbox"/> Anemia/Blood disorders _____ |
| 2. <input type="checkbox"/> Allergies _____ | 15. <input type="checkbox"/> Diabetes _____ |
| 3. <input type="checkbox"/> Drug allergies _____ | 16. <input type="checkbox"/> Obesity _____ |
| 4. <input type="checkbox"/> Asthma _____ | 17. <input type="checkbox"/> Bladder / Kidney _____ |
| 5. <input type="checkbox"/> Eczema _____ | 18. <input type="checkbox"/> Stomach / GI _____ |
| 6. <input type="checkbox"/> Resp. infect. _____ | 19. <input type="checkbox"/> Cancer _____ |
| 7. <input type="checkbox"/> Ear infections _____ | 20. <input type="checkbox"/> Seizures _____ |
| 8. <input type="checkbox"/> Tuberculosis _____ | 21. <input type="checkbox"/> Growth _____ |
| 9. <input type="checkbox"/> Immunity prob. / HIV _____ | 22. <input type="checkbox"/> Hereditary _____ |
| 10. <input type="checkbox"/> High cholesterol _____ | 23. <input type="checkbox"/> Learning Problems _____ |
| 11. <input type="checkbox"/> High blood pressure _____ | 24. <input type="checkbox"/> Attention Deficit / Hyperactivity _____ |
| 12. <input type="checkbox"/> Heart attach / Stroke before age 55 _____ | 25. <input type="checkbox"/> Emotional/Behavioral _____ |
| 13. <input type="checkbox"/> Other heart problems _____ | 26. <input type="checkbox"/> Psychiatric _____ |
| | 27. <input type="checkbox"/> Alcohol or Drugs _____ |

Do you have any other concerns you wish to discuss? Yes No

Parent's signature _____ Date _____

Provider's Comments:

Provider's signature _____ Date _____

History Update

