Patient Registration *(Pediatric)*

Patient Information

Date _____ Chart No. _____

Patient _____ Sex: ☐M ☐F DoB___/___/___ SS# _____

Mother/Guardian _____ DoB___/___/___ SS# _____

Address _____ Home Phone _____

City/State/Zip _____ Occupation _____

Employer _____ Work Phone _____

Father/Guardian _____ DoB___/___/___ SS# _____

Address _____ Home Phone _____

City/State/Zip _____ 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 _____

How did you hear about our practice? ☐ Referral _____

☐ Friend/Family ☐ Phone Directory ☐ Internet ☐ Newspaper ☐ Magazine ☐ Other _____

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.

Parent/Guardian's signature _____ Relationship _____ Date _____

Witness' signature _____ Date _____

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

HIPPA Authorization Statement

Complete and sign the section on the back regarding confidential release of information.

Please complete the following so that we may contact you properly and securely.

- Please list the family members or other persons, if any, whom we may inform about your child's general medical condition and diagnoses (including treatment, payment and health care operations).

Name_____
Phone_____
Name_____
Phone_____

- Please list the family members or significant others, if any, whom we may inform about your child's medical condition ONLY IN AN EMERGENCY.

Name_____
Phone_____
Name_____
Phone_____

- Please print the address of where you would like your billing statements and / or correspondence from our office to be sent if other than your home.

_____
_____
_____

- Please print the telephone number where you want to receive calls about your appointments, lab and X-ray results, or other health care information if other than your home telephone number.

_____
_____
_____
_____

Please be aware that a cell phone is not a secure and private line.

- Please indicate if you want all correspondence from our office sent in a sealed envelope marked CONFIDENTIAL". ☐ Yes ☐ No

- Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail? ☐ Yes ☐ No

_____
PATIENT NAME *print* (Parent / Guardian, if under 18 years)

_____ Date _____
PATIENT SIGNATURE (Parent / Guardian, if under 18 years)

Notes

Name of Patient_____ Date ___/___/___ Chart #_____

Development *Are you concerned about the patient's...*

	Yes	No	
1. physical development?	☐	☐	_____
2. mental or emotional development?	☐	☐	_____
3. learning ability?	☐	☐	_____
4. attention span or activity level?	☐	☐	_____

If in school, has the patient had...

1. tutoring outside of the classroom?	☐	☐	_____
2. placement in a special or resource class?	☐	☐	_____
3. to repeat a grade?	☐	☐	_____
4. educational or psychological testing?	☐	☐	_____
5. behavioral problems?	☐	☐	_____

Maternal and Newborn History

Pregnancy *Check if the mother had any of the following problems:*

☐ excessive wt. gain ☐ urinary infections ☐ excessive swelling ☐ toxemia ☐ rubella ☐ venereal disease ☐ other ☐ none

_____

_____

Did the mother smoke, use drugs or alcohol during pregnacy? ☐ Yes ☐ No

Birth

Birth Weight _____ Length _____ Apgar _____ Was baby born at: ☐ Term ☐ Early ☐ Late

If early, how many weeks gestation? _____ Was labor difficult or prolonged? ☐ Yes ☐ No

Was delivery difficult or complicated? ☐ Yes ☐ No _____

_____

_____

Newborn *Check if the patient had any of the following problems:*

☐ feeding problems: ☐ Breast _____ ☐ Formula _____

☐ slow weight gain ☐ multiple formula changes ☐ colic ☐ jaundice ☐ recurring vomiting ☐ recurring diarrhea

☐ blood in stools ☐ other ☐ none _____

_____

Family History

If a family member has or has had any of the following problems, check the appropriate box and list the family member:
M-Mother F-Father S-Sibling GM-Grandmother GF-Grandfather A-Aunt U-Uncle

1. ☐ _____ Allergies	12. ☐ _____ Ear infections /tubes	23. ☐ _____ Learning prob. /Attent. span
2. ☐ _____ Anemia / Blood disorders	13. ☐ _____ Eczema	24. ☐ _____ Liver disease
3. ☐ _____ Arthritis	14. ☐ _____ Emotional / Behavioral	25. ☐ _____ Mental illness
4. ☐ _____ Asthma	15. ☐ _____ Epilepsy or convulsions	26. ☐ _____ Mental retardation
5. ☐ _____ Birth defects	16. ☐ _____ Eye or visual problems	27. ☐ _____ Migraine Headaches
6. ☐ _____ Bladder / Kidney	17. ☐ _____ Heart attack / stroke before 50 yrs	28. ☐ _____ Obesity
7. ☐ _____ Cancer	18. ☐ _____ Heart problems, other	29. ☐ _____ Respiratory infections
8. ☐ _____ Deafness	19. ☐ _____ Hereditary problems	30. ☐ _____ Stomach / GI
9. ☐ _____ Diabetes before 50 yrs	20. ☐ _____ High blood pressure before 50 yrs	31. ☐ _____ Thyroid or other endocrine prob.
10. ☐ _____ Drug / Alcohol abuse	21. ☐ _____ High cholesterol	32. ☐ _____ Tuberculosis
11. ☐ _____ Drug allergies	22. ☐ _____ Immunity problems / HIV	33. ☐ _____ Other

Provider Comments

History Reviewed by_____

Name of Patient_____ Sex: ___Male ___Female DoB ___ /___ /___ Chart #

Form Completed by _____ Relation to patient _____ Date ___ /___ /___

Family

Are mother and father ☐ married ☐ separated /divorced ☐ other?

If separated / divorced, what is the patient's custody status?_____

_____

If one or both parents are not living in the home, how often does child see that parent(s)?_____

_____

Are there siblings living away from home? ☐ Yes ☐ No

If yes, give name, age and where they live:_____

_____

List all family members living in the patient's home

Name	Relation	Birth Date	Health Problems
		___ /___ /___	
		___ /___ /___	
		___ /___ /___	
		___ /___ /___	
		___ /___ /___	
		___ / ___	

Current Medical History

Are immunizations up to date? ☐ Yes ☐ No

Is your child having any medical problems? ☐ Yes ☐ No

Do you consider your child to be in good health? ☐ Yes ☐ No

Current Medications:

Drug Allergies? ☐ Yes ☐ No

Review of Systems and Past Medical History

Does the patient have or has ever had any of the following:	Yes	No	*Explain*
1. a serious medical problem?	☐	☐	
2. been hospitalized or had surgery?	☐	☐	
3. had a serious injury or accident?	☐	☐	
4. chickenpox? When?_____	☐	☐	
5. allergies, asthma, bronchitis, respiratory infections?	☐	☐	
6. repeated ear infections, tubes, difficulty with hearing?	☐	☐	
7. problems with eyes or vision?	☐	☐	
8. heart problems or a heart murmur?	☐	☐	
9. anemia, bleeding problems or blood transfusion?	☐	☐	
10. abdominal pain, constipation requiring doctor visits?	☐	☐	
11. recurrent vomiting, recurrent diarrhea, blood in stools?	☐	☐	
12. bladder or kidney infections, bed-wetting after 5 yrs.?	☐	☐	
13. recurrent skin problems (acne, eczema, etc)?	☐	☐	
14. headaches, convulsions, other neurologic problems?	☐	☐	
15. diabetes, thyroid or other endocrine problems?	☐	☐	
16 . If female, has she started her menstrual periods?	☐	☐	
If yes, is she having any problems?	☐	☐	

History Update *(date / initial) Changes in history noted in chart on day of update.*

_____ ___ _____ ___ _____ ___ _____ ___ _____ ___ _____ ___

_____ ___ _____ ___ _____ ___ _____ ___ _____ ___ _____ ___