PATIENT REGISTRATION FORM
0-12 years old

Partners in Pediatrics & FAMILY HEALTH

PATIENT

Patient Name: _____DOB: _____

Sex: __Female __ Male Birth Hospital: _____

Home Address: _____

_____

Ethnicity: _____Hispanic or Latino _____Not Hispanic or Latino _____Decline to specify

Race: _____American Indian _____ Asian _____ Black/African American

_____ Pacific Islander _____ White _____ Decline to specify

How did you hear about us: _____

GUARDIAN/RESPONSIBLE PARTY

Primary Guardian Name:_____ Relation:_____

Contact Number: _____ Email: _____

Secondary Guardian Name: _____ Relation: _____

Contact Number: _____ Email: _____

EMERGENCY CONTACT

Name: _____ Relation: _____

Contact Number: _____

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PRIMARY INSURANCE

Insurance Company Name: _____

Member ID# _____ Group # _____

Provider Phone Number: _____ PCP Copay Amount: $_____

Subscriber Name: _____ DOB: _____

Relation to Patient: _____

COORDINATION OF CARE

Preferred Pharmacy Name: _____

Location: _____

Dentist Office Name: _____

Date of last visit: _____

Known Allergies: _____

AUTHORIZED RELEASE

I authorize Partners in Pediatrics and Family Health to release medical information to the following people.
Without consent no HIPAA protected information can be provided to anyone, regardless of relation to patient.

Name: _____ Name: _____

Relation: _____ Relation: _____

Phone: _____ Phone: _____

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SECONDARY INSURANCE

Insurance Company Name: _____

Member ID# _____ Group # _____

Provider Phone Number: _____ PCP Copay Amount: $_____

Subscriber Name: _____ DOB: _____

Relation to Patient: _____

TERTIARY INSURANCE

Insurance Company Name: _____

Member ID# _____ Group # _____

Provider Phone Number: _____ PCP Copay Amount: $_____

Subscriber Name: _____ DOB: _____

Relation to Patient: _____

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OFFICE POLICIES

- Photo ID and valid insurance cards **must** be presented at each visit _____
- Appointments cancellations require 24 hour notice, otherwise a **$25 missed appointment fee applies** _____
- Being more than 10 minutes late may require the appointment to be rescheduled _____
- Medical records requests, school paperwork, immunization records and worker's comp paperwork has a 5-7 day turnaround time _____
- Some paperwork including medical records requires a $15 preparation fee _____
- Failure to comply with any of the office's policies may result in the patient being discharged from the practice _____

NOTICE OF PRIVACY PRACTICE

A paper copy of the notice of privacy practice has been offered to me

I accept _____ or decline _____ my paper copy, aware that a master copy is always on file at the office for my review at any requested time *(also available in Spanish)*

Guardian Signature: _____ Date: _____

CONSENT FOR TREATMENT

ASSIGNMENT OF BENEFITS

I certify that this registration information is true and accurate. I certify that this medical information is accurate and true to the best of my knowledge. I authorize Partners in Pediatrics and Family Health to treat my child, listed above as patient.

I authorize Partners in Pediatrics and Family Health to bill my medical insurance for services rendered on my behalf. I authorize payment of health insurance benefits directly to Dej Med Practice LLC dba Partners in Pediatrics and Family Health under the terms of my insurance.

I understand that failure to provide valid insurance information at the time of service will result in full financial responsibility on my part. I understand that I am responsible for all copays, deductibles and coinsurance amounts as per my insurance company agreement.

Guardian Signature: _____ Date: _____

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SOCIAL HISTORY

Home Life

Lives with both biological parents _____ Split custody between parents _____

Sole custody of one parent _____ Sole custody of a guardian _____

Foster guardian(s) _____ Adoptive guardian(s) _____

Number of siblings _____

Do animals live in the home Yes _____ No _____

Any smoking inside the home Yes _____ No _____

Are guns present in home Yes _____ No _____

Have you ever smoked Yes _____ No _____

Have you ever drank alcohol Yes _____ No _____

Have you ever done recreational drugs Yes _____ No _____

Have you experienced physical or sexual abuse Yes _____ No _____

Daycare

In home daycare _____ Preschool/Facility _____ Relative _____

Home with Guardian _____

Daily Routine

Brushes teeth daily	Yes _____	No _____
Home water is fluoridated	Yes _____	No_____
Seat belts used each time	Yes _____	No _____
Smoke detectors in home	Yes _____	No _____
Daily vitamins/chewable	Yes _____	No _____

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PATIENT MEDICAL HISTORY

Check if your child has had any of the following

ADD _____	ADHD _____	Allergies _____
Anemia _____	Autism _____	Constipation _____
Asthma _____	Diabetes _____	Frequent sore throat _____
Depression _____	Diarrhea _____	Ear Infection _____
Eczema _____	Hearing loss _____	Heart Disease _____
Pneumonia _____	Rash _____	Reflux _____
Seizures _____	Urinary problems _____	Bed wetting _____
Chicken Pox _____	Cancer _____	Other _____

Please list any hospital stays or surgeries _____

OFFICE USE ONLY

PATIENT REGISTRATION FORM
0-12 years old

FAMILY HISTORY

Please check any that apply to blood relatives of the patient and list the relation to the patient

(mother, father, maternal grandmother/grandfather, paternal grandmother/grandfather, aunt, uncle, etc.)

DISEASE	RELATION TO PATIENT	DISEASE	RELATION TO PATIENT
AID/HIV	_____	Alcoholism	_____
Allergies	_____	Anemia	_____
Arthritis	_____	Asthma	_____
Genetic Disorders	_____	Depression	_____
Mental Illness	_____	Cancer	_____
Diabetes	_____	Drug Abuse	_____
GI Disease	_____	Hearing Loss	_____
Heart Disease	_____	High Blood Pressure	_____
High Cholesterol	_____	Kidney/Liver Disease	_____
Migraines	_____	Seizures	_____
SIDS	_____	Stroke	_____
Thyroid Disease	_____	Tuberculosis	_____
Multiple Sclerosis	_____	Obesity	_____
Sleep Disorders	_____	Epilepsy	_____
COPD	_____	Alzheimer's Disease	_____
Physical Abuse	_____	Sexual Abuse	_____