PATIENT REGISTRATION FORM

Patient Last Name: _____ **First Name:** _____

Date of Birth: _____ Gender: Male / Female SSN: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Patient Referred By: _____

Parent/Guardian

Last Name: _____ First Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____Work phone: _____ SSN: _____

Parent/Guardian

Last Name: _____ First Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____Work phone: _____ SSN: _____

Sibling: _____ DOB: _____ Patient here? Yes No

Sibling: _____ DOB: _____ Patient here? Yes No

Sibling: _____ DOB: _____ Patient here? Yes No

Primary Insurance Company: _____ ID#: _____

Subscriber Name: _____ Subscriber DOB: _____ Group #: _____

Secondary Insurance Company: _____ ID#: _____

Subscriber Name: _____ Subscriber DOB: _____ Group #: _____

In case of emergency, local relative or friend (not living at same address) to be notified:

Name: _____ Relationship: _____ Phone number: _____

The above information is complete and accurate to the best of my knowledge. I hereby authorize my insurance benefits to be paid directly to the healthcare provider, as well as release of any information by provider or insurance company required for this account. I am financially responsible for any balance.

_____ _____

Parent/Guardian Signature **Date**

15808 Mill Creek Blvd., Suite 201 Mill Creek, WA 98012
Telephone (425) 338-5668 Fax (425) 338-4366

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient's Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The Patient has the right to restrict the uses of their information.
- The Patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon execution of this Consent. No insurance can be billed on the patient's behalf without this signed HIPAA consent form, therefore same day of service payment in full for any services will be required.

Patient name: _____

Signature of patient or guardian: _____

Relationship to the patient (if other than patient): _____

Today's Date: _____

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PATIENT HEALTH HISTORY

Patient's Last Name: _____ Patient's First Name: _____ DOB: _____

Mother's Name: _____Age: _____Health: _____Occupation: _____

Father's Name: _____Age: _____Health: _____Occupation: _____

Patient's Brothers' Names and Birth Dates: _____

Patient's Sisters' Names and Birth Dates: _____

CHILD'S (PATIENT) BIRTH HISTORY

While pregnant did Mother:

Use alcohol, drugs or smoke? *Yes* ____ *No* ____
Was sick? *Yes* ____ *No* ____
Special tests needed? *Yes* ____ *No* ____
Normal labor? *Yes* ____ *No* ____
Health problems after labor? *Yes* ____ *No* ____
Have any significant problems? *Yes* ____ *No* ____
** Explain:* _____
_____
Prenatal care at: _____
Date of first prenatal visit: _____
Length of pregnancy: _____
Gave birth at: _____
Birth weight: _____ Birth height: _____
Length of hospital stay: _____

FAMILY HEALTH HISTORY

Check if any family members have or had:

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Disease under the age of 55
- ☐ Asthma, Hay Fever, or Allergies
- ☐ Depression or Mental Illness
- ☐ Tuberculosis (TB)
- ☐ Epilepsy
- ☐ Violent behaviors
- ☐ Deafness
- ☐ Sudden Infant Death Syndrome (SIDS)
- ☐ Alcohol or Drug Abuse
- ☐ Cancer
- ☐ Sickle Cell Disease
- ☐ Learning Disabilities
- ☐ Parent Cholesterol over 240/mg/dl
- ☐ Obesity
- ☐ Other _____

Parent/Guardian Printed Name:

_____

Parent/Guardian Signature:

_____

CHILD'S (PATIENT) BIRTH HISTORY

Is this child taking any medications on a regular basis? *Yes* ____ *No* ____
* Name of medication(s): _____
_____
Immunizations up to date? *Yes* ____ *No* ____
On the WIC Program? *Yes* ____ *No* ____
Rides in a car seat or seat belt? *Yes* ____ *No* ____
Does anyone in the home, daycare, or caregiver smoke? *Yes*___ *No*___
Had surgery?
* Date and Problem: _____
Any hospitalizations?
* Date and Problem: _____
Date of last Well Child Exam: _____
Date of last Dental Exam: _____

Check all that apply to this child (patient)

- ☐ Vision or hearing problems
- ☐ Ear infections
- ☐ Pneumonia or Bronchitis
- ☐ Asthma or breathing problems
- ☐ Hay Fever
- ☐ Seizures
- ☐ Bed wetting
- ☐ Anemia
- ☐ Kidney or bladder problems
- ☐ Injury or abuse
- ☐ Obesity
- ☐ Substance abuse (age 12-18)
- ☐ Allergies: _____
- ☐ Other: _____

PARENTAL CONCERNS ABOUT THIS CHILD (PATIENT)

Behavior? _____
Development? _____
Nutrition? _____
Substance abuse? _____
Other?_____

Date: _____

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NORTH SOUND PEDIATRICS **Stephen Shlafer, M.D.**

EPSDT LEAD SCREENING QUESTIONNAIRE

Child's Name: _____ Date of Birth: _____

Beginning at six months of age and at each visit thereafter, children should be assessed for risk of lead exposure. Ask the following questions at a minimum. If the answer to any question is positive, a child is potentially at high risk for lead exposure. A blood lead test may be obtained at the time a child is determined to be high risk.

YES (Only check if applies)

- ☐ Does your child live in or frequently visit a house built before 1970 that has peeling or chipping paint?
- ☐ Does your child live in a house built before 1970 with recent, ongoing or planned renovation or remodeling?
- ☐ Have any of your children or their playmates had lead poisoning?
- ☐ Does your child frequently come in contact with an adult who works with lead (examples are: construction, welding, pottery, etc.)?
- ☐ Does your child live near a lead smelter, battery recycling plant or other industry likely to release lead?
- ☐ Do you give your child any home or folk remedies that may contain lead?
- ☐ Does your child live near a heavily traveled major highway where soil and dust may be contaminated with lead?
- ☐ Does your home plumbing have lead pipes or copper with lead solder joints?

PARENT SIGNATURE: _____ DATE: _____

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NORTH SOUND PEDIATRICS **Stephen Shlafer, M.D.**

MEDICAL RELEASE/AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

Patient's Name: _____Date of Birth: _____
Address: _____
City/State/Zip: _____
Patient's Phone #: _____

☐ I authorize North Sound Pediatrics to release/obtain information:
☐ To ***OR*** ☐ From:

_____
Name of Provider/Facility/Individual

_____
Address

_____
City/State/Zip

_____
Phone # / Fax #

TYPE OF RECORDS REQUESTED:

☐ All Medical Records ☐ Immunization Records ☐ Billing Records
☐ Records related to a specific illness or injury: _____
☐ Records for the following date(s): _____
☐ Other: _____

PURPOSE FOR THIS REQUEST:

☐ Transfer of care ☐ Healthcare collaboration ☐ School ☐ Legal ☐ Personal ☐ Other: _____

I UNDERSTAND THAT:

- My right to healthcare treatment is not conditioned on this authorization.
- Authorizing the disclosure of this healthcare information is voluntary.
- I may cancel this authorization at any time by submitting a written request to North Sound Pediatrics.
- Once the information has been released according to the terms of this authorization, the information cannot be recalled.
- Any disclosure of information carries with it the potential for further distribution by the recipient that may not be protected by confidentiality laws.
- There may be a charge for the requested records.
- This authorization will expire one year from the date of signing, unless revoked.

_____ _____
Printed Name of Person Completing Form **Relationship to Patient**

_____ _____
Signature of Person Completing Form **Date**

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