**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: _____

# PATIENT REGISTRATION FORM
## 0-12 years old

## 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**
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## 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 | _____ |

Submit