Patient Registration Form

Patient Information:

Last name: ______________________ First name: ______________________ Middle name: __________

Date of Birth: ______________________ SSN: ______________

Sex: Male Female **Special restrictions on Pt Info: Yes No**

Legal Guardian: Mother Father Grandparents Guardian ______________________

Mother's Information:

Name: ______________________ Date of Birth: ______________

SSN: ______________

Address: ______________________

City State ______________ Zip code ________

Home phone: ______________________

Cell phone: ______________________

Email address:

Father's Information:

Name: ______________________ Date of Birth: ______________

SSN: ______________________

Address: ______________________

City ______________ State ________ Zip code ________

Home phone: ______________________

Cell phone: ______________________

Email address:

Insurance Information:

Primary: Policy # ______________

Policy Holder: ______________________ Group # ______________

Policy Holder Date of Birth ______________ Insurance Phone # ______________

Policy Holder Sex: Male Female

Secondary:

Policy Holder: ______________________ Policy # ______________

Policy Holder Date of Birth ______________ Group # ______________

Policy Holder Sex: Male Female Insurance Phone # ______________

Emergency Contact Name: Phone #:

Primary Care Physcian: **Group Name:**

Authorization, assignment of Benefits and Referral Medical Release

I herby authorize the release of my medical information including complete medical records, test results and billing information to my insurance company, and to other medical professionals and medical care instutions that I may be referred to for treatment. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and complaint resolution. I authorize payment directly to Carolinas Physcians Network for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am finacially responsible for all co-payments, co-insurance, deductibles, and non-covered services. A photocopy of this authorization shall be considered as effective and as valid as the orginial.

Signature: ______________________ **Date:** ______________

Child History Form

Last name: ____________ **First name:** ____________ **Date of Birth:** ____________

Reason for Today's visit: ____________

Location: ____________ Quality: ____________ Modifying Factor: ______

Duration of problem: ____________ Associated sign/symptoms: ____________

List anything that improves/worsens the problem ____________ Severity:(1-10) ______

Referring MD/Group: ____________ Pharmacy: ____________

Medications (currently taking)

Name:	Amt	time/day

Child's medical history

Cerebral palsy	Y	N	Hepatitis	Y	N
prenatal hydronephrosis	Y	N	Asthma	Y	N
heart murmur	Y	N	Constipation	Y	N
Urinary Tract Infection	Y	N	Hypertension	Y	N
Developmental Delay	Y	N	Spinal Bifida	Y	N
Seizures Disorder	Y	N	VP Shunt	Y	N
Bleeding Disorders	Y	N			
Cancer	Y	N			
Type:					

Vitals

Height:	Weight:

List any Allergies

Latex: Y N

Medications:

Past Surgeries/ Hospitalizations

Type	Year

Family History

			List Family Member
Vesicoureteral Reflux	Y	N	
Kidney Disease	Y	N	
Nighttime wetting	Y	N	
Urinary Tract Infection	Y	N	
Kidney Failure	Y	N	
Diabetes	Y	N	
Kidney Stone	Y	N	
Cancer	Y	N	
Anesthesia Problems	Y	N	

Social History

Special Diet	Y	N
Special Needs	Y	N
Wheelchair/Brace:		
Age of toilet training:		
Who does child live with:		
Tobacco Exposure?	Y	N

Please answer all questions yes or no

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Abnormal Development	Y	N

Eyes

Blurred Vision	Y	N
Redness	Y	N
Pain	Y	N

Allergic/Immunologic

Hay Fever	Y	N
Drug Allergies	Y	N
Food	Y	N

Neurologic

Tremors	Y	N
Coordination Problems	Y	N
Abnormal Walk	Y	N

Ear/Nose/Throat/Mouth

Ear Infection	Y	N
Sore throat	Y	N
Sinus Problem	Y	N

Gastrointestinal

Abdominal pain	Y	N
Nausea/Vomiting	Y	N
Stool Incontinence	Y	N
Constipation	Y	N
Blood in stool	Y	N

Cardiovascular

Hear Murmur	Y	N
High Blood Pressure	Y	N

Integumentary

Skin Rash	Y	N
Persistent Itching	Y	N
Easy Bruising	Y	N

Musculoskeletal

Joint Pain	Y	N
Neck Pain	Y	N
Back Pain	Y	N

Genitourinary

Painful Urination	Y	N
Blood in Urine/ Underwear	Y	N
Urinary Retention	Y	N
Frequent Urination	Y	N
Urgency to Urinate	Y	N
Daytime Wetting	Y	N
Nighttime Wetting	Y	N

Respiratory (Lungs)

Wheezing	Y	N
Frequent cough	Y	N
Shortness of Breath	Y	N

Hematologic/Lymphatic

Swollen Glands	Y	N
Blood Clotting problems	Y	N

Endocrine

Excessive Thirst	Y	N
Too Hot/Cold	Y	N
Tired/Sluggish	Y	N
Abnormal Hair Growth	Y	N

Does your child have a siblings?

Names	Ages

Has your child had any X-rays?

Type	Date	Hospital

Does your child have any other Medical Problems we should know about?
please List:

____

____

____

Physician: ______________________ Date: ______________

Health Insurance Portability and Accountability Act

(HIPAA)

Patient's Name: ____________________________ Date of Birth _____/_____/_____

We are required by law to provide you with our Notice of Privacy Practices which explain how we use and disclose your health information. We are also required to obtain your signature acknowledging that this notice has been made available to you.

Signature ______________________________________ **Date:** ____________________________

Relationship to Patient: Self Parent Spouse Other ______________________

Reason Patient unable/Unwilling to sign:

____

____

Responsibility for Charges Incurred during Today's Visit

We at Pediatric Urology Associates would like to thank you for trusting us with your child's medical care. We are always conscious of high cost of medical care and do our best to keep these costs as low as possible. However during your child's visit he/she may require testing or procedures such as Ultrasounds, Uroflow, or a small procedure (lysis of penile /labial adhesions) that are not covered under your office copay. You will be responsible for the cost of these procedures and those of you with Health Care savings accounts and Flexible savings accounts will be asked to pay for these tests/procedures at today's visit.

By signing below you are confirming that we have made you aware of this policy and your financial responsibility.

Signature: ________________________________ **Date:** ____________________

Authorizations, Assignment of Benefits and Referral Medical Release

I hereby authorize the release of my medical information including complete medical records, test results and billing information to my insurance company, and to other medical professionals and medical care instructions that I may be referred to for treatment, I understand that this information will be used to review, investigate, or make payment of claim, and to review records or quality improvement initiatives, audit compliance, utilization management, and complaint resolution. I authorize payment directly to Pediatric Urology Associates for all my 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, co-insurance, deductibles, and non-covered services. A photocopy of this authorization shall be considered as effective and as valid as the orginal.

Signature: ________________________________ **Date:** ____________________

Parental Consent to Treat for Minor or Incapable Adults

Signing this form gives Pediatric Urology Associates permission to treat the patient indicated for items specified below. This consent form will be valid for one (1) year, or until our practice is notified otherwise.

As the Parent or legal guardian, I ______________________________ (your name), give permission for ______________________________ (patient's name) to be seen at Pediatric Urology Associates to the guidelines below:

- May visit the Physicians' office with a responsible adult.

Name of responsible adult: ____

____

I give permission for the following:

- Urine testing/lab test
- Uroflow (office speed measurement of urination)
- Ultrasound
- Prescribed Medication
- Other: ______________________________

If additional treatment is needed I am to be contacted to give verbal consent. I can be reached at: ____________________ (phone number) or ____________________ (phone number)

Parent/legal guardian Signature: ______________________________ **Date:** ____________