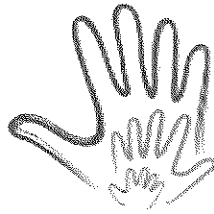


PATIENT REGISTRATION FORM

>12 years old



**Partners in
Pediatrics
& FAMILY HEALTH**

PATIENT

Patient Name: _____ DOB: _____

Sex: Female Male

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: _____

EMERGENCY CONTACT

Name: _____ Relation: _____

Contact Number: _____

COORDINATION OF CARE

Preferred Pharmacy Name: _____

Location: _____

Known Allergies: _____

Daily Medications: _____

PATIENT REGISTRATION FORM
>12 years old

PRIMARY INSURANCE

Insurance Company Name: _____

Member ID# _____ Group # _____

Provider Phone Number: _____ PCP Copay Amount: \$ _____

Subscriber Name: _____ DOB: _____

Relation to Patient: _____

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: _____

PATIENT REGISTRATION FORM

>12 years old

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: _____

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)*

Signature: _____

Date: _____

PATIENT REGISTRATION FORM

>12 years old

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 myself.

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.

Signature: _____

Date: _____

SOCIAL HISTORY

PATIENT REGISTRATION FORM

>12 years old

Do you smoke Yes _____ How much _____ No _____

Do you drink alcohol Daily _____ Occasionaly _____ No _____

Do you use recreational drugs Yes _____ No _____

Have you ever been sexual abused Yes _____ No _____

Have you ever been physically abused Yes _____ No _____

Do you drink water daily Yes _____ How much _____ No _____

Do you exercise Daily _____ Frequently _____ Rarely _____ Never _____

Do you have a healthy support system at home Yes _____ No _____

Do you regularly attend social events with family and friends Yes _____ No _____

PATIENT MEDICAL HISTORY

Check any and all that you have had or currently have

ADD/ADHD _____

Asthma _____

Allergies _____

Anemia _____

Autism _____

Constipation _____

Cataracts _____

Diabetes _____

Frequent sore throat _____

Depression _____

Diarrhea _____

Ear Infection _____

Eczema _____

Hearing loss _____

Heart Disease _____

Pneumonia _____

Rash _____

Reflux _____

Seizures _____

Urinary problems _____

Cancer _____

Please list any hospital stays or surgeries _____

Please list all current medications _____

FAMILY HISTORY

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

PATIENT REGISTRATION FORM

>12 years old

(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	_____

NOTES