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: ____

____

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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: _________________________

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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: ____________

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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

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Do you smoke Yes __________ How much __________ No ___________

Do you drink alcohol Daily _________ Occacionaly ___________ 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 ________
Catiracts ________	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

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(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