PediatricUrology
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Patient Registration Form

Patient Information:

Last name: _____ First name: _____ Middle name: _____

SSN: _____ Date of Birth: _____

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 Holder: _____ Policy # _____

Policy Holder Date of Birth _____ Group # _____

Policy Holder Sex: Male Female Insurance Phone # _____

Secondary:

Policy Holder: _____ Policy # _____

Policy Holder Date of Birth _____ Group # _____

Policy Holder Sex: Male Female Insurance Phone # _____

Emergency Contact (Other than Parent)

Name: Phone #:

Primary Care Physcian: **Group Name:**

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Child History Form

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

Chief Complaint: (Reason for visit today) _____

Location: _____ Quality _____ Modifying Factors: _____

Duration of Problem: _____ Associated Signs/Symptoms: _____

List anything that *Improves* or *Worsens* the problem: _____ Severity (scale from 1-10) _____

Referring Doctor/Group: _____ Pharmacy: _____

Medications (Currently Taking)

Name	Amount	Times/Day

Vitals

Height	Weight

List Any Allergies

Latex Y N

Medication Allergies: None: _____

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 Infections	Y	N	Hypertension	Y	N
Developmental Delay	Y	N	Spina Bifida	Y	N
Seizure Disorder	Y	N	VP Shunt	Y	N
Bleeding Disorders	Y	N			
Cancer	Y	N			

Type of Cancer: _____

List any Past Surgeries / Hospitalizations

Type	Date (Year Only)

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 Stones	Y	N	
Cancer	Y	N	
Anesthesia Problems	Y	N	

Social History

Special Diet?	Y	N
Special Needs (wheelchair, braces, etc.)	Y	N

Age of Toilet Training: _____

Who does child live with? _____

Tobacco Exposure?

Please answer all questions yes or no

Constitutional Symptoms

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

Gastrointestinal

Abdominal Pain	Y	N
Nausea/Vomiting	Y	N
Stool Incontinence	Y	N
Constipation	Y	N
Blood in Stool	Y	N

Respiratory (Lungs)

Wheezing	Y	N
Frequent Cough	Y	N
Shortness of Breath	Y	N

Eyes

Blurred Vision	Y	N
Redness	Y	N
Pain	Y	N

Cardiovascular

Heart Murmur	Y	N
High Blood Pressure	Y	N

Hematologic/Lymphatic

Swollen Glands	Y	N
Blood Clotting Problems	Y	N

Allergic/Immunologic

Hay Fever	Y	N
Drug Allergies	Y	N
Foods	Y	N

Integumentary

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

Endocrine

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

Neurologic

Tremors	Y	N
Coordination Problems	Y	N
Abnormal Walk	Y	N

Musculoskeletal

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

Ear/Nose/Throat/Mouth

Ear Infection	Y	N
Sore Throat	Y	N
Sinus Problem	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

Does your child have any siblings?

Names	Ages

Has your child had any X-rays? (Type of test, Date, & Hospital where performed)

TYPE	DATE	HOSPITAL

Does your child have any other *Medical Problems* we should know about? Y N

Please list below:

_____

_____

_____

Physician: _____ Date: _____

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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:

_____

_____

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Responsibility for Charges Incurred during Today's Visit

We at Pediatric Urology Associates would like to thank you for trusting us with your childs medical care. We are always conscious of hihg cost of medical care and do our best to keep these cost as low as possible. However during your childs 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 test/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 insurnce 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 fInacially responsible for all co-payments, co-insurance, deductibles, and non-covered services. A photocopy of this authorization shal be considered as effective and as alid as the orginal.

Signature: _____ **Date:** _____

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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: _____