Saint Alphonsus Medical Group

Complete both sides

# PEDIATRIC
# PATIENT REGISTRATION

**Date:** _____

## Patient

Last Name _____ First Name _____ Initial _____

Date of Birth _____ Gender: ☐ Female ☐ Male

Address _____

City _____ State _____ Zip _____

Phone – Home _____ Preferred Message/Contact Phone _____

Race (please circle) American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander White Other (Multi-racial) Unknown Declined

Ethnicity (please circle) Hispanic or Latino Not Hispanic or Latino Other _____

Preferred Language _____

Has patient been seen at a Saint Alphonsus Medical Group or Express Care Clinic in the past 3 years?
☐ Yes ☐ No

Who was the patient's last provider? _____

Preferred Pharmacy_____

Major Crossroads _____

## Health Insurance

**Primary Insurance** _____

Policy Holder Name _____ Date of Birth _____

Employer _____ Relationship to Patient _____

Employer Address _____ City _____ State _____ Zip _____

**Secondary Insurance** _____

Policy Holder Name _____ Date of Birth _____

Employer _____ Relationship to Patient _____

Employer Address _____ City _____ State _____ Zip _____

*Office Staff: if unable to scan card, make copy of card and attach to this form. If card unavailable, but patient has group & subscriber number, please write numbers on this form.*

People assisting with paperwork:

| | | |
|---|---|---|
| Interpreter's name | Interpreter's Signature and/or ID # | Date and Time |
| Office Staff name | Office Staff Signature | Date and Time |

Place patient sticker here or handwrite

Name _____

DOB: _____

Saint Alphonsus Medical Group

Complete both sides

**Guardian/ 1st Parent**

Last Name _____ First Name _____ Initial _____

Social Security Number _____ Date of Birth _____ Sex _____

Address (if different from patient) _____

City _____ State _____ Zip _____

Phone – Home _____ Work _____ Cell _____

Marital Status _____ Email _____

Employer _____ Relationship to Patient _____

Employer Address _____ City _____ State _____ Zip _____

**Additional Contact (not living with you)**

Last Name _____ First Name_____ Phone Number _____

Address _____ City _____ State _____ Zip _____

Relationship to Patient _____

**2nd Parent**

Last Name _____ First Name _____ Initial _____

Social Security Number _____ Date of Birth _____ Sex _____

Address (if different from patient) _____

City _____ State _____ Zip _____

Phone: Home _____ Work _____ Cell _____

Preferred Message/Contact Phone _____ Marital Status _____

Employer _____ Relationship to Patient _____

Employer Address _____ City _____ State _____ Zip _____

Place patient sticker here or handwrite

Name _____

DOB: _____

Saint Alphonsus Medical Group

# PEDIATRIC ANNUAL HISTORY

Place patient sticker or handwrite
Name: _____
DOB: _____

**Today's Date:** _____

**Name:** _____ **Date of Birth:** _____ **Age:** _____

**Preferred Pharmacy Name**: _____ **Pharmacy Location (Cross Streets):** _____

**Fall Risk: If your child is a competent walker:** Have they fallen in the last year? ☐ Yes ☐ No
Number of Falls/past year? _____
Do they have problems with walking or balance? ☐ Yes ☐ No

**If your child is over the age of 13, please answer the following questions:**
**Do they use Tobacco?** ☐ Yes, Currently ☐ No, never ☐ No, They are a former tobacco user
Type of Tobacco Used: ☐ Cigarettes ☐ Chewing ☐ Other _____ How much per day: _____
Years used: _____
Have they ever tried to quit? ☐ Yes ☐ No Year Quit: _____
Are they exposed to passive smoke? ☐ Yes ☐ No

**Depression Screening:** Over the last 2 weeks, how often have they been bothered by any of the following problems?
Little interest or pleasure in doing things ☐ Yes ☐ No
Feeling down, depressed, or hopeless ☐ Yes ☐ No

**Health Maintenance:** Date of Well Child Exam:_____

**Past Medical History:** Please mark all that apply.

| | | | |
|---|---|---|---|
| ☐ ADD/ADHD | ☐ Bronchiolitis | ☐ Fracture | ☐ Prematurity |
| ☐ Abdominal Pain | ☐ Bronchitis | ☐ GERD | ☐ Pyelonephritis |
| ☐ Acne | ☐ Chickenpox | ☐ Headaches | ☐ Recurrent otitis media |
| ☐ Allergic Rhinitis | ☐ Concussion/CHI | ☐ Hearing Problems | ☐ Seizure Disorder |
| ☐ Allergies | ☐ Congenital heart disease | ☐ Heart Murmur | ☐ Seizure-Febrile |
| ☐ Anemia | ☐ Constipation | ☐ Menstrual Problems | ☐ UTI |
| ☐ Asthma | ☐ Diabetes | ☐ Migraines | ☐ Vesicoureteral reflux |
| ☐ Bleeding disorder | ☐Eczema | ☐ Pneumonia | ☐ Other _____ |

| **Past Surgical History:** | **Year:** | | **Year:** |
|---|---|---|---|
| ☐ Appendectomy | _____ | ☐ Tonsillectomy | _____ |
| ☐ Inguinal hernia repair | _____ | ☐ Adenoidectomy | _____ |
| ☐ Fracture with Surgical Reduction | _____ | ☐ PET placement | _____ |
| ☐ Dental surgery | _____ | ☐ Lymph node biopsy/excision | _____ |
| | | ☐ Umbilical hernia repair | _____ |

**Family History of (mark all that apply and indicate for Mother, Father, Siblings):**

| | | | |
|---|---|---|---|
| ☐ ADD/ADHD _____ | ☐ Deafness _____ | ☐ High Blood Pressure_____ | ☐ Thyroid disease _____ |
| ☐ Alcoholism _____ | ☐ Depression _____ | ☐ Learning Disability _____ | ☐ Other _____ |
| ☐ Allergies _____ | ☐ Developmental delay _____ | ☐ Mental retardation _____ | |
| ☐ Asthma _____ | ☐ Diabetes _____ | ☐ Migraines _____ | |
| ☐ Birth defects _____ | ☐ Eczema _____ | ☐ Scoliosis _____ | **Age/cause of death of:** |
| ☐ Cancer: Type _____ | ☐ Genetic Disorder _____ | ☐ Seizure Disorder _____ | Mother: ☐ n/a _____ |
| ☐ CAD _____ | ☐ Hemoglobinopathy_____ | ☐ SIDS _____ | Father: ☐ n/a _____ |
| ☐ DDH (Hip dysplasia)_____ | ☐ Hyperlipidemia_____ | ☐ Strabismus _____ | Siblings:☐ n/a _____ |

**Social History:**

**Resides with Primary:**
☐ Mother ☐ Father
☐ Grandparent ☐ Guardian
**Resides with Secondary:**
☐ Mother ☐ Father
☐ Grandparent ☐ Guardian
**Smokers at home?**
☐ Yes ☐ No
**Hand dominance:**
☐ Right ☐ Left ☐ Ambidextrous

**Home Environment**
**Water Source:**
☐ Municipal ☐ Well ☐ Bottle
**Is water chlorinated:** ☐ Yes ☐ No
**Is water fluoridated:** ☐ Yes ☐ No
**Is there lead in home**: ☐ unknown
☐ Yes ☐ No ☐ Removed

**Parents Marital Status:**
☐ Married ☐ Lives Together
☐ Divorced ☐Separated
☐ Other_____
**Child Care:** ☐ Yes ☐ No
Name of Caregiver:_____
#days/week in child care: _____

**Activity:**
**Exercise/sports**
Hours per day:_____
**TV/computer games**
Hours per day:_____
**Internet:**
Hours per day:_____
**Siblings**: Name & Date of Birth
_____
_____
_____
_____
_____
_____

**Safety**
**Uses bike/skating helmet:**
☐ Yes ☐ No
**Car restraints:**
☐ Rear face car seat
☐ Front face car seat
☐ Seatbelt ☐ Booster ☐ None
**Carbon monoxide detector**:
☐ Yes ☐ No
**Smoke detectors:** ☐ Yes ☐ No
**Radon in home:**
☐ Yes ☐ No
☐ Untested ☐ Treated
**Firearms in the home:**
☐ Yes ☐ No
**Pool/spa at home:**
☐ Yes ☐ No
**Pet/animals at home:**
☐ Yes ☐ No

**Sleep**
Takes naps: ☐ Yes ☐ No
Sleeps with Parents: ☐ Yes ☐ No
Sleeps through the night:
☐ Yes ☐ No
Minimum 8.5 hours sleep nightly:
☐ Yes ☐ No
Nightmares/sleep problems:
☐ Yes ☐ No

**Education**
**School Name:**_____
**Grade in School:**_____
**Learning disability:**
☐ Yes ☐ No
**Special Needs:**
☐ Yes ☐ No
**Gifted Program:**
☐ Yes ☐ No

| | |
|---|---|
| **Reviewed by:** | **Entered by:** |
| **Date:** | **Date:** |

Complete both sides

Saint Alphonsus Medical Group

**PEDIATRIC**

**PROTECTED HEALTH INFORMATION RELEASE**

***Please check all applicable boxes and fill in any blank spaces where information is requested.***

☐ Only release information to me personally.

☐ You have my permission to speak with my Spouse (Stepparent/Significant Other) about my child's medical care.

Spouse (Stepparent/Significant Other)'s Name _____

Phone _____

☐ You have my permission to leave information on my answering machine regarding my child's medical care and test results.

☐ You have my permission to talk with these family members or caregivers about my child's care.

Name _____ Phone _____

Relationship _____

Name _____ Phone _____

Relationship _____

Name _____ Phone _____

Relationship _____

Name _____ Phone _____

Relationship _____

☐ Other, please describe: _____

Are there currently any legal proceedings concerning the custody of this child? No ☐ Yes ☐

If yes, please explain: _____

## *Emergency Contact:*

First Name _____ Last Name _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

Relationship to Patient _____

Place patient sticker here or handwrite

Name _____

DOB: _____



Insurance/HIPAA E3 Peds
Rev 02-28-2012
Form 0203

Complete both sides

Saint Alphonsus Medical Group

## PEDIATRIC PROTECTED HEALTH INFORMATION RELEASE, CONT.

***OPTIONAL:***

**Parental/Guardian Consent for Medical Treatment when Parent/Guardian is not present:**

***Child's Information***

Child's Name _____ Date of Birth _____ Home Phone Number _____

Home Address _____ City, State, Zip Code _____

Parent/Guardian Name _____ Parent/Guardian Phone _____

***Caregiver Information***

The following named person(s) shall be authorized to bring my child to medical appointments **in my absence**.
Please attempt to contact me at the following telephone number: _____ if you need any further authorizations.

Caregiver's Name and Relation _____ Phone Number _____

Caregiver's Name and Relation _____ Phone Number _____

Caregiver's Name and Relation _____ Phone Number _____

I agree to pay for all services provided to my child in my absence.

This authorization shall be effective from _____ (Month, Day, Year) until _____ (Month, Day, Year) or up to one year from the date below**.

By signing below I certify that I am the Legal Primary Caregiver of:

Patient's Name _____ Relationship to patient _____

Legal Primary Caregiver Name **(Please print)** _____ Legal Primary Caregiver Signature **(Please sign in office)** _____ Date and Time ** _____

Witness Name (Staff) _____ Witness Signature (Staff) _____ Date and Time _____

People assisting with paperwork:

Interpreter's name _____ Interpreter's Signature and/or ID # _____ Date and Time _____

Office Staff's name _____ Office Staff Signature _____ Date and Time _____

Place patient sticker here or handwrite

Name _____

DOB: _____

HAVE LEGAL PRIMARY CAREGIVER DATE AND INITIAL:

Reviewed _____/_____/_____ Date/Time/Initials
Reviewed _____/_____/_____ Date/Time/Initials
Reviewed _____/_____/_____ Date/Time/Initials
Reviewed _____/_____/_____ Date/Time/Initials
Reviewed _____/_____/_____ Date/Time/Initials
Reviewed _____/_____/_____ Date/Time/Initials



Insurance/HIPAA E3 Peds
Rev 02-28-2012
Form 0203

Saint Alphonsus Medical Group

# Financial Policy

We will file your insurance claims for you. We do request a copy of your current insurance card to ensure accurate billing. Please keep in mind we do not accept all insurances. If you do not have insurance or if your insurance does not cover the services you need from our clinic, payment is your responsibility. It is also your responsibility to confirm directly with your insurance company to find out whether or not we participate with them, and if they will cover the medical services being provided to you. If your insurance requires a referral, co-pay, deductible, or coinsurance, it is your responsibility to have it with you at the time of service. Failure to do so may result in us having to reschedule your appointment.

- **Medicaid Patients**: You must have a valid Medicaid card, presumptive eligibility, or letter/printout from your caseworker at every visit. We also require photo ID, which will be scanned into our computer system. Lack of this information may result in us having to reschedule your appointment.

- **Minors**: The parent/guardian accompanying the minor at the time of service is responsible for payment.

- We will request payment at the time of service. If this is not possible, we will expect you to make acceptable payment arrangements, prior to receiving service.

- You will receive at least two statements after to your visit at our clinic. If your account is not paid in full, or if you have not established an acceptable payment plan, we will refer your account to a professional credit bureau.

- The credit bureau will send you a notification that a payment is due. The letter will arrive at your last known address. You must respond to this letter, to avoid damage to your credit record. If you do not respond to this letter, your account will be listed for collection and your credit will be adversely affected.

- I understand and agree that if I fail to pay for services for which I am responsible, after such default and upon referral to a collection agency by Saint Alphonsus Medical Group, I will be responsible for all cost of collecting monies owed, including court costs, and collection agency fees.

We are disclosing our policy to you now to avoid misunderstanding in the future.

Saint Alphonsus Medical Group

## AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND/OR MEDICAL RECORDS

**Patient Name** _____ **Date of Birth** _____

**(Please print)**

I authorize ("the Clinic") to use or disclose Protected Health Information ("PHI") contained in my medical records in the following manner:

**From:** _____

Physician/Institution that presently has data

_____

Street Address

_____

City State Zip Phone Fax

**To:** _____

Physician/Institution requesting data

_____

Street Address

_____

City State Zip Phone Fax

**Release the following Protected Health Information**:

____ All Records _____ Chart Notes _____ X-Rays _____ Labs _____ Substance Abuse Info _____Mental Health _____ HIV _____ Other (please specify): _____

(Describe the information to be used or disclosed, including date of service, type of service, level of detail to be released or specific information) Transfer of care_____

The Protected Health Information is being used or disclosed for the following purpose(s): [If the patient is requesting the release, this may state "at patient's request"]

_____

(List specific purposes the Protected Health Information will be utilized)

_____ Please FAX requested information to the fax number listed above.

(Maximum of 10 pages may be faxed, if request is more, records will be sent to the address indicated above.)

This authorization is in full force and effect until _____ (Date) or until _____ (List specific event)

If I fail to specify an expiration date/event, this authorization will expire in twenty-four (24) months.

I understand that I have the right to revoke this authorization in writing by sending notification to:

CLINIC NAME:

ATTN: Privacy Officer

ADDRESS:

I understand that when I revoke this authorization, it is not effective to the extent that the Clinic has already relied on the use or disclosure of the Protected Health Information. I understand the Protected Health Information released pursuant to this authorization might be re-disclosed by the party who receives that information and may no longer be protected by federal or state law. The Clinic will not base my treatment or payment on whether I provide an authorization for the requested use or disclosure, unless the provision of health care is solely for the purpose of creating Protected Health Information for disclosure to a third-party (such as fitness for work exam). I understand that I have a right to inspect or copy the protected health information to be used or disclosed. I understand that I have a right to refuse to sign this authorization. If you have any questions concerning this form, please phone: ( - )

SPECIFIC AUTHORIZATION: I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information, unless I have crossed it out and initialed. YES_____ NO_____ (initials)

_____ _____

Patient Signature Date and Time

_____ _____ _____

Legal Representative Name/Relationship to patient Legal Representative Signature Date and Time

People assisting with paperwork:

_____ _____ _____

Interpreter's name Interpreter's Signature and/or ID # Date and Time

_____ _____ _____

Office Staff name Office Staff Signature Date and Time

Place patient sticker here or handwrite

Name: _____

DOB: _____