Pediatrics of Lima, Inc. Registration Forms

Today's Date_____

****Please note: a driver's license from BOTH parents will be required at the first visit****

Child's First_____Middle_____Last _____

Sex o Male o Female **Date of Birth** _____/ _____/ _____ Nickname _____

Address of Child's Primary Residence:

_____**City** _____ St_____ **Zip**_____

Race:_____ o Decline to answer **Ethnicity**: o Not Hispanic/Latino o Hispanic/Latino o Decline to answer

TELEPHONE NUMBERS

- Primary phone (#1) is the one to be used first for messages and reminder calls. This does not have to be the home phone.
- Please list phone numbers in the order to be called.

1. ( )	o Home o Cell o Work	o Mother o Father o Other: Name: _____ Rel: _____
2. ( )	o Home o Cell o Work	o Mother o Father o Other: Name: _____ Rel: _____
3. ( )	o Home o Cell o Work	o Mother o Father o Other: Name: _____ Rel: _____

**By providing us with your wireless or land line phone number, you are giving us your prior express consent to call those numbers for business purposes. This includes the option of leaving a detailed message that may contain medical information regarding this patient. You may opt-out of messages by initialing _____.*

PARENT / GUARDIAN INFORMATION

Mother's Full Name: _____ **Date of Birth** _____/_____/_____

Social Security # _____ - _____ - _____ **Relationship:** o Mother o Foster o Legal Guardian o Step o Other:
Marital Status o Married o Divorced o Separated o Single o Remarried o Widowed

Address: o Same as Child_____**City** _____ St _____ **Zip** _____

Employer _____ **Phone:** ( ) _____ ext: _____

Occupation: _____ Email: _____@_____

Father's Full Name: _____ **Date of Birth** _____/_____/_____

Social Security # _____ - _____ - _____ **Relationship:** o Father o Foster o Legal Guardian o Step o Other:
Marital Status o Married o Divorced o Separated o Single o Remarried o Widowed

Address: o Same as Child_____**City** _____ St _____ **Zip** _____

Employer _____ **Phone:** ( ) _____ ext: _____

Occupation: _____ Email: _____@_____

Step parents' name(s), if applicable: _____

Custodial parent, if applicable: _____

SIBLING INFORMATION

Child's Brothers' & Sisters' First Names	Last Names	Dates of Birth	Sex
			o Male o Female
			o Male o Female
			o Male o Female
			o Male o Female

EMERGENCY / ALTERNATE CONTACT

Full Name _____Address/City/Zip_____

Relationship_____Ph# ( ) _____ or ( )_____

FINANCIAL RESPONSIBILITY

Invoices/Statements should be mailed to o Mother o Father o Other: _____ (must be listed above)
(Both parents or legal guardians are legally responsible for any charges regardless of where the statements are mailed)

Insurance Information

Child's Name: First_____Last_____**Date of Birth** _____

Primary Insurance

Cardholder's Full Name: First _____ Last _____

Social Security _____ Date of Birth _____ Relationship to child _____ Address (if different than child's) _____

City _____ State _____ Zip _____

Phone ( ) _____ Work ( ) _____

Employer _____ Business Phone ( ) _____

Employer Address_____City/State_____Zip_____

Insurance Company _____ID # _____ Group# _____

Effective Date of insurance _____

Secondary Insurance

Cardholder's Full Name: First _____ Last _____

Social Security _____ Date of Birth _____ Relationship to child _____

Address (if different than child's) _____ City _____ State _____ Zip _____

Phone ( ) _____ Work ( ) _____

Employer _____ Business Phone ( ) _____

Employer Address_____City/State_____Zip_____

Insurance Company _____ID # _____ Group# _____

Pharmacy Information _____

Name of Pharmacy: _____ **Address:** _____

PAYMENTS AND INSURANCE AUTHORIZATION / ASSIGNMENT OF BENEFITS

It is the policy of this office that all payments for medical services be made *at the time of your visit, or before in some cases*. This payment is required regardless of who brings the child in to be seen. In the case of separated or divorced parents, responsibility and payment shall belong to the guardian bringing the child in for treatment. For example, if parent #1 is financially responsible for medical expenses, and parent #2 is bringing that child in for treatment, payment will still be expected from parent #2 at the time of service.

Initial_____ I understand that I may be charged a fee for all appointments not kept without a 24 hour advance notice.

Initial_____ I understand and agree that regardless of what benefits are quoted, or misquoted, by my insurance company when you check my insurance status, I am ultimately responsible for any deductible, co-insurance/copays, or any other balance not paid by my insurance company. This includes services provided that the insurance company deems not medically necessary.

Initial_____ I understand that I must pay my copay or co-insurance at the time of service, regardless of who accompanies my child to his/her visit. Without my copay or co-insurance, I may be charged a late-fee.

Initial_____ I understand that I must pay my deductible responsibility, if I have one, at the time of service. If I cannot pay the entire deductible balance, a $50 deductible deposit will be required at each visit until my deductible has been met. If I request to be billed for a deductible balance, I must pay within 30 days, or I will lose the privilege of being billed. I will then be required to pay in full at each visit.

Initial_____ I must have proof of insurance at every visit, or I will have to pay in full to be seen. If I have a newborn, I will have to present proof of application by the 30 day mark if I do not have my baby's proof of insurance by then.

Initial _____ I understand that I am responsible for any costs incurred in the collection of my child's account in case of default, including reasonable attorney fees, court fees and agency fees.

Initial_____ I understand that for bad checks, there will be a $30 charge from our office. Failure to pay the check and all fees could result in arrest and criminal prosecution.

Initial_____ I understand that well and sick benefits may be handled differently by my insurance company, and if during a well visit, my child is sick, or has an issue needing treatment and/or medical attention, my provider may bill for both services. Regardless of what the well visit benefits are, I will be responsible for any charges my insurance passes on to me for the sick visit portion.

I hereby grant permission to Pediatrics of Lima, Inc. to release any pertinent information to my insurance company upon request, and I also authorize transfer of benefits to Pediatrics of Lima, Inc. A photocopy of this authorization shall be considered as valid as the original.

Signature: _____Print Name _____ Date: _____

Pediatrics of Lima, Inc.

AUTHORIZATION FOR MEDICAL CARE

I (We)_____and_____authorize
PRINT NAME OF MOTHER/ LEGAL GUARDIAN(S) PRINT NAME OF FATHER/LEGAL GUARDIAN(S)
Pediatrics of Lima, Inc. and its personnel to deliver medical services to my child(ren):

PRINT CHILD'S NAME	DATE OF BIRTH	PRINT CHILD'S NAME	DATE OF BIRTH
PRINT CHILD'S NAME	DATE OF BIRTH	PRINT CHILD'S NAME	DATE OF BIRTH
PRINT CHILD'S NAME	DATE OF BIRTH	PRINT CHILD'S NAME	DATE OF BIRTH

I (We) authorize the following people to **bring my child in for, and consent to, treatment, or receive medical advice over the phone if they are taking care of my child in my absence**. This does not allow them to have access to protected health information that is not pertinent to the visit. Please check the boxes to give them additional specific authorizations.

Name:_____Relationship: _____ o May pick up prescriptions o May pick up shot records

Name:_____Relationship: _____ o May pick up prescriptions o May pick up shot records

Name:_____Relationship: _____ o May pick up prescriptions o May pick up shot records

Name:_____Relationship: _____ o May pick up prescriptions o May pick up shot records

*Any other type of documents to be picked up by someone other than the legal guardians listed above must have a separate written consent.

I (We) understand that telephone triage and advice services will ***not*** be extended to the above persons unless it is regarding direct patient care while the child is in their care. In the absence of written authorization for medical services, our office will try to reach you for verbal authorization. If, however, we cannot reach you, we will not refuse to treat your child. This serves as a consent for medical treatment that we deem as medically necessary and appropriate.

Patient/Parent/Legal Guardian Rights:

- I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Pediatrics of Lima, Inc.
- I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I consent to the use of my medical information necessary for transmission of prescriptions to the pharmacy and as needed for the coordination of formulary and/or benefits eligibility with my insurance provider. I consent to the query of my external prescription history as necessary to manage my healthcare and related services.

_____ _____ _____
Signature of Legal Guardian Date Relationship to patient

Printed name: _____

Pediatrics of Lima, Inc.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date of birth: _____

I have received a copy of the Notice of Privacy Practices from Pediatrics of Lima.

_____	_____	_____
Printed Name of Parent/Legal Guardian	Signature	Date

FOR OFFICE USE ONLY

We were unable to obtain a written acknowledgment of receipt of NPP because:

- o An emergency existed and a signature was not possible at the time
- o The individual refused to sign
- o A copy was mailed with a request for a signature by return mail
- o Unable to communicate with the parent/guardian for the following reason:

- o _____
  Other

_____

Prepared by: _____

Signature:_____Date: _____

Pediatric History

Date:_____Child's Last Name_____First _____

Sex: o M o F Date of Birth _____Age_____ Primary Language: _____

Child's Dentist _____ Pharmacy & Ph#_____ Medication

Allergies: Please list the substance and the reaction. If no known allergies, please write "no known allergies."

_____

Is your child up-to-date with his or her immunizations? o Yes o No Please bring us the most recent vaccine card or certificate.

Has your child ever had any reaction to any immunizations? If so, which vaccine and what was the reaction? If none, please write "none."

_____

Delivery and Birth History:

Delivery was: o On time o Premature o Late o Normal o Induced o Prolonged o Breech o C-Section

o Fetal distress o Use of forceps or vacuum suction o Other _____

Your newborn had: (Please describe in the space provided or write N/A)

o Birth Defects _____ o Infection _____ o Transfusion _____

o Breathing Problems _____ o Jaundice _____ o Other _____

Current and Past Medical History:

Please describe if your child has any of the following (write N/A if there is nothing to report). Please use additional sheets if needed.

Chronic (long-term) diseases/illnesses? _____ Developmental delays? If so, a) what kind of delay(s) and b) how is it being treated (i.e. by which kind of therapist or doctor):

_____ Previous hospitalizations? If so, please describe a) for what reason, b) when and c) for how long:

_____ Previous surgeries? If so, please describe a) for what reason and b) when:

_____ Previous fractures (broken bones)? If so, please describe a) which bone, b) how it happened, and c) when:

_____ Does your child see any specialists? If so, please give the a) name, b) the specialty, c) the reason you see him/her and d) their phone number:

_____ List all the prescription, over-the-counter, vitamins or herbal medication your child takes. Please include the a) dosage and b) how/when it is taken.

_____

Does your child smoke? o Yes since the age of _____ o No o Unknown

Family History:

Please give the following information about your child's blood relatives:

Biological father's name _____ Current Age _____ If deceased: what age and how:_____ Biological mother's name _____ Current Age _____ If deceased: what age and how:_____ Biological Brothers/Sisters Names:

_____ Age _____ Medical problems _____

_____ Age _____ Medical problems _____

Have any children in your family died? _____ If yes, please explain how: _____

Are there smokers in your house? o Yes How many people? _____ o No/Do not suspect it o Maybe/Unknown

Please check the conditions that any of the child's **blood relatives** have, and state their relationship to the child as well as on whose side they come from (mom vs. dad's). So as an example: If you write "grandma" add an 'M' to indicate that mom's mom has the condition. Please mark the N/A box if applicable.

Condition	Relationship to child	Condition	Relationship to child	
				o N/A
				o N/A
				o N/A
				o N/A
				o N/A
				o N/A
				o N/A
				o N/A
				o N/A
				o N/A
				o N/A

Please use an additional sheet to describe what else you would like us to know. Thank you.