Prime Pediatrics Registration Form

(BOLD indicates required information)

****Please note: A driver's license from at least one parent will be required at the first visit****

Child's First Name: _____ **Middle:** _____ **Last:** _____

Sex: ☐ Male ☐ Female **Date of Birth:** ___/___/___ Nickname: _____

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic / Latino **Primary Language:** _____ **Race:** _____

Address of Child's Primary Residence: _____

City: _____ **State:** _____ **Zip:** _____

TELEPHONE NUMBERS

* Primary phone (#1) is 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. ( )	Home	Cell	Work	Other/Ext	Mother / Father	Other:	Name: / Relationship:	
2. ( )	Home	Cell	Work	Other/Ext	Mother / Father	Other:	Name: / Relationship:	
3. ( )	Home	Cell	Work	Other/Ext	Mother / Father	Other:	Name: / Relationship:	

By providing us with your wireless or landline phone number, you are giving your prior expressed consent to call the above listed numbers for business purposes.

PARENT / GUARDIAN INFORMATION

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

Social Security #: _____ **Relationship:** Mother Foster Legal Guardian Step Other

Marital Status: Married Divorced Seperated Single Remarried Widowed

Address: ☐ Same as child

_____ **City:** _____ **State:** _____ **Zip:** _____

Email: _____

Employer: _____ Phone: ( ) - Ext:

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

Social Security #: _____ **Relationship:** Father Foster Legal Guardian Step Other

Marital Status: Married Divorced Seperated Single Remarried Widowed

Address: ☐ Same as child

_____ **City:** _____ **State:** _____ **Zip:** _____

Email: _____

Employer: _____ Phone: ( ) - Ext:

Step Parent's names if applicable: _____

Custodial Parent if applicable: _____

SIBLING INFORMATION

Child's Brother's & Sister's First Names:	Last Names:	Dates of Birth	Sex

EMERGENCY / ALTERNATE CONTACT

Full Name: _____ Address / City / Zip: _____

Relationship: _____ Phone: ( ) _____ or ( ) _____

FINANCIAL RESPONSIBILITY

Invoices / Statements should be mailed to: **Mother** **Father** **Other:** _____ (must be listed above)

Both parents or legal guardians are legally responsible for any charges regardless where the statements are mailed.

Pediatric History

Date: ___/___/_____ Child's Last Name: _____ First: _____

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

_____

_____

_____

_____

_____

Is your child up to date with his/her immunizations ☐ **Yes** ☐ **No** Please provide 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:
Birth Weight: _____
Delivery was: ☐ On time ☐ Premature ☐ Late ☐ Normal ☐ Induced ☐ Prolonged ☐ Breech ☐ C-Section ☐ Fetal distress ☐ Use of forceps or vacuum section
☐ Other _____

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

☐ Birth Defects _____ ☐ Infection _____
☐ Breathing problems _____ ☐ Jaundice _____
☐ NICU _____
☐ Other _____

Current and Past Medical History:
Please describe if your child has any of the following. (Please write N/A if not applicable. Please use additional sheets if needed.)
Does your child receive therapy services? ☐ **Speech** ☐ **PT** ☐ **OT**

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 of the following specialists?

☐**Bone** ☐**Heart** ☐**Kidney** ☐**Ear/Nose/Throat** ☐**Allergy / Asthma** ☐**Other** _____
List all prescriptions, over- the- counter, vitamins, or herbal medications your child takes. Please include a) dosage and b) how/when medication is taken.

_____

_____

Has you child ever had?: ☐ **MRI** ☐ **CT scan**
Does your child smoke?: ☐ Yes since the age of _____ ☐ No ☐ Unknown

Please use additional sheets to describe any additional history you would like for us to know. Thank you!

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 from Child's) _____

City: _____ State: _____ Zip: _____

Phone: (___) _____ Work: (___) _____

Employer: _____ Bus. 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 from Child's) _____

City: _____ State: _____ Zip: _____

Phone: (___) _____ Work: (___) _____

Employer: _____ Bus. Phone: (___) _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Insurance Company: _____ ID #: _____ Group #: _____

Effective Date of Insurance: ___/___/___

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 for treatment. For example, if parent #1 is financially responsible for medical expenses, and parent #2 is bringing the child in for treatment, payment will still be expected from parent #2 at the time of service.

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, co pays or any other balances not paid by the insurance company.

Initial _____ I understand that I must pay my co pay or co-insurance at the time of service, regardless of who accompanies my child to his/her 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's fees, court fees, and agency fees.

Initial _____ I understand there is a $30.00 charge for checks returned unpaid or balances could be referred to collection services.

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

Signature: _____ Print Name: _____ Date: ___/___/___

Medical History

Family History

Has any of the child's blood relative's had any of the following?:

Deafness	☐ YES	☐ NO	WHO?		COMMENTS		
Nasal Allergies	☐ YES	☐ NO	WHO?		COMMENTS		
Asthma	☐ YES	☐ NO	WHO?		COMMENTS		
Tuberculosis	☐ YES	☐ NO	WHO?		COMMENTS		
Heart Disease (before 50 yrs. Old)	☐ YES	☐ NO	WHO?		COMMENTS		
High Blood pressure (before 50 yrs. old)	☐ YES	☐ NO	WHO?		COMMENTS		
High Cholesterol	☐ YES	☐ NO	WHO?		COMMENTS		
Anemia	☐ YES	☐ NO	WHO?		COMMENTS		
Bleeding Disorder	☐ YES	☐ NO	WHO?		COMMENTS		
Liver Disease	☐ YES	☐ NO	WHO?		COMMENTS		
Diabetes (before 50 yrs. Old)	☐ YES	☐ NO	WHO?		COMMENTS		
Bed - wetting (after 10 yrs. Old)	☐ YES	☐ NO	WHO?		COMMENTS		
Epilepsy or convulsions	☐ YES	☐ NO	WHO?		COMMENTS		
Alcohol abuse	☐ YES	☐ NO	WHO?		COMMENTS		
Drug abuse	☐ YES	☐ NO	WHO?		COMMENTS		
Mental illness	☐ YES	☐ NO	WHO?		COMMENTS		
Mental illness	☐ YES	☐ NO	WHO?		COMMENTS		
Immune problems, HIV, or AIDS	☐ YES	☐ NO	WHO?		COMMENTS		

Additional Family History _____

Child's Personal History

Does your child currently have or has ever had the following?:

Chickenpox	☐ YES	☐ NO	WHEN?	
Frequent ear infections	☐ YES	☐ NO	EXPLAIN	
Problems with ears or hearing	☐ YES	☐ NO	EXPLAIN	
Nasal Allergies	☐ YES	☐ NO	EXPLAIN	
Problems with eyes or vision	☐ YES	☐ NO	EXPLAIN	
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ YES	☐ NO	EXPLAIN	
Any heart problem or heart murmur	☐ YES	☐ NO	EXPLAIN	
Anemia or bleeding problem	☐ YES	☐ NO	EXPLAIN	
Blood transfusion	☐ YES	☐ NO	EXPLAIN	
Frequent abdominal pain	☐ YES	☐ NO	EXPLAIN	
Constipation requiring doctors visits	☐ YES	☐ NO	EXPLAIN	
Bladdar or kidney infections	☐ YES	☐ NO	EXPLAIN	
Bed-wetting(after 5 yrs. Old)	☐ YES	☐ NO	EXPLAIN	
(For girls) has she started her menstrual periods?	☐ YES	☐ NO	EXPLAIN	
(For girls) Are there problems with her period?	☐ YES	☐ NO	EXPLAIN	
Any chronic or recurrent skin problem	☐ YES	☐ NO	EXPLAIN	
Acne, Eczema, ect.	☐ YES	☐ NO	EXPLAIN	
Frequent headaches	☐ YES	☐ NO	EXPLAIN	
Convulsions or other nwurological problems	☐ YES	☐ NO	EXPLAIN	
Diabetes	☐ YES	☐ NO	EXPLAIN	
Thyroid or other Endocrine problem	☐ YES	☐ NO	EXPLAIN	
Use of Alcohol or drugs	☐ YES	☐ NO	EXPLAIN	
Any other significant problems	☐ YES	☐ NO	EXPLAIN	

Prime Pediatrics

Authorization for Medical Care

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: _____ ☐ May pick up prescriptions ☐ May pick up shot records

Name: _____ Relationship: _____ ☐ May pick up prescriptions ☐ May pick up shot records

Name: _____ Relationship: _____ ☐ May pick up prescriptions ☐ May pick up shot records

Name: _____ Relationship: _____ ☐ May pick up prescriptions ☐ 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 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 absense of written authorization for medical services, out 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.

_____ / / _____

Signature of Legal Guardian Date Relationship to patient

OUR PRIVACY POLICY

I, as legal guardian of the above named child(ren), have been made aware of, read and understand the Prime Pediatrics Notice of Privacy Practices. I am also aware that I may obtain additional copies of the Notice simply by asking the front office staff.

_____ / / _____

Signature of Legal Guardian Date

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

PRIVATE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

I, the undersigned, authorize payment of medical benefits directly to Prime Pediatrics for any services furnished to me. I understand that I am financially responsible for any amount not covered by my insurance. I also authorize you to release to my insurance company any information concerning healthcare treatment, or supplies provided to me. I permit a copy of this authorization to be used in place of the original.

Signature: _____ Print Name: _____ Date: ____/____/____

MEDICAL SERVICES AUTHORIZATION

I, authorize Prime Pediatrics to give me reasonable and proper medical care by today's standards.

Signature: _____ Print Name: _____ Date: ____/____/____

PAYMENT AGREEMENT

It is the policy of Prime Pediatrics that charges for services rendered by our physician(s) and staff including contractural co pays and deductibles are paid at the time of service unless other formal arrangements have

For your convenience, Prime Pediatrics will file electronic insurance claims; however, it will be your responsibility to provide our office with the necessary information and sign authorization for filing insurance. This information and authorization must be provided to our office at your first visit, accompanied with a copy of your health insurance card(s).

Arrangements for monthly payments may be made with our business staff for any patient account balance. A minimum is required each month to keep your account(s) active. You are responsible for making the monthly payment by the 5th working day of each month regardless is a statement has been sent to you or not. A patient's account that becomes delinquent (monthly payment has not been made within 30 days of the last payment) will be processed in our collections department, and the complete balance will be due immediately. In addition to the complete account balance, you will also be responsible for all attorney fees, court costs, and any collection fee(s) that are incurred.

I agree to the above financial agreement for any services provided to me by Prime Pediatrics.

Signature: Print Name: Date: / /

Prime Pediatrics, P.C.

Pediatrics and Adolescent Medicine
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Payment for services is due in full at the time service is provided. In the event your account is delinquent and placed with a collection agency you are responsible for the collection fee of 30% of the account balance as liquidated damages, and if an attorney is hired to collect, after maturity, 15% of unpaid principal and interest owing on said account as attorneys' fees. Please sign below stating you have received and read this statement.

Sign Here_____.

Please list Children names._____

_____