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 Asian Black Hawaiian/Pacific Islander White Other (Multi-racial) Unknown Declined

Ethnicity (please circle) Hispanic/Latino Not Hispanic/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 HEALTH HISTORY

Date: _______________

Patient's name: ___________________________ Patient's Date of Birth: ____________________

Patient's school and current grade (or daycare): ____

Previous Health Care Provider:_________________________ Referred to by: ____________________

PREGNANCY AND BIRTH

Mother's age when patient was born: _______________

Any illness during pregnancy: _______________

Medications (other than vitamins/iron): _______________

Patient's birth weight: _______________

Delivery (circle one): Vaginal C-section

Baby's diet:

during the 1st six months: Breast Bottle

If bottle, what formula? _______________

Is child on a special diet? _______________

Does child take vitamins? Yes No

Herbal supplements? Yes No Fluoride? Yes No

Did baby go home within a couple of days with mom? Yes No

If no, please explain: ____

PAST MEDICAL HISTORY

Date and place of last check: _______________

Allergies to medication: Yes No

Any hospitalizations?: Yes No

Any medications taken regularly?: Yes No

Chronic illnesses: Yes No

Reactions to food or insects: Yes No

Any surgeries?: Yes No

If yes, please explain: ____

____

____

Family (not patient) History:

Age and General Health of Mom _______________

Dad _______________

Circle any diseases that the patient's parents, grandparents Brothers, sisters, aunts or uncles have had:

Anemia	Asthma	Learning difficulties
ADHD	Diabetes	Cancer
Bowel Problems	Seizures	Depression
Heart Trouble	Allergies	UTI's
High Blood Pressure	AIDS	Drug Problems
Alcohol problems	Autism	Tuberculosis

Siblings Name & Date of Birth:

_______________ _______________

_______________ _______________

_______________ _______________

_______________ _______________

Please list any additional medical problems: _______________

____

Learning Needs: Are there any needs (learning, ethnic, cultural, or spiritual) we should know about that might impact your child's care or your ability to understand treatments / procedures/ educational materials? ☐ No ☐ Yes Please explain: _______________

____

____

____

____

Review of Systems (patient):

Has patient ever had any of the following:

Frequent ear infection	Yes	No
Eye problems	Yes	No
Asthma	Yes	No
Allergies	Yes	No
Heart murmur/problem	Yes	No
Urinary tract infection	Yes	No
Chronic cough	Yes	No
Chronic diarrhea	Yes	No
Constipation	Yes	No
Seizures	Yes	No
Hearing problems	Yes	No
Eczema/skin problems	Yes	No
Anemia or Sickle Cell Trait	Yes	No
Developmental delays	Yes	No
Speech delay	Yes	No
Sleeping problems	Yes	No
School problems	Yes	No
ADHD	Yes	No
Hyperactivity	Yes	No
Bed wetting	Yes	No
Discipline problems	Yes	No

People assisting with paperwork:

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

Place patient sticker here or handwrite

Name: _______________________

DOB: _______________________

Patient and Provider need to Date/Time/Initial reviewed annually:

Initial review by Provider: _______ / _______ / _______
Date / Time / Initials

Patient: _______ / _______ / _______ Provider: _______ / _______ / _______
Date / Time / Initials Date / Time / Initials

Patient: _______ / _______ / _______ Provider: _______ / _______ / _______
Date / Time / Initials Date / Time / Initials

Complete both sides

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:

Last Name _________________________________ First Name ______________ Phone Number ___________

Address ____________________________________ City ______________ State _____________ Zip ________

Relationship to Patient ____

Place patient sticker here or handwrite
Name ____________________________

DOB: _____________________________

Insurance/HIPAA E3 Peds
Rev 05-19-2011
Form 0203

Complete both sides

PEDIATRIC PROTECTED HEALTH INFORMATION RELEASE, CONT.

Parental/Guardian Consent for Medical Treatment

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 sign in office)** ______________ Legal Primary Caregiver Signature ______________ 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 ______________

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)

Place patient sticker here or handwrite

Name ______________________

DOB: ______________________

Insurance/HIPAA E3 Peds
Rev 05-19-2011
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. It is 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 subsequent 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.

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: ________________________