



PATIENT REGISTRATION FORM

Patient Name: _____ Social Security Number: _____

Date of Birth: _____ Gender: _____ Marital Status: _____

Race: _____ Ethnicity: _____ Language: _____

Address: _____

(Street, City, State, Zip)

Home Phone: _____ Cell Phone: _____

E-mail Address: _____ Employer: _____

RESPONSIBLE PARTY: (Complete only if different from patient)

Responsible Party Name: _____ Social Security Number: _____

Date of Birth: _____ Gender: _____ Relation to Patient: _____

Address (if different from patient): _____

(Street, City, State, Zip)

Home Phone: _____ Cell Phone: _____

E-mail Address: _____ Employer: _____

WHO TO CALL IN CASE OF EMERGENCY:

Name: _____ Relationship: _____

Address: _____

(Street)

(City/State/Zip)

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____

Cell Phone: (____) _____ - _____

PRIMARY INSURANCE INFORMATION

Plan Name: _____ Relation to Patient: _____

Member I.D. Number: _____ Group Number: _____

Policy Holder Name: _____ Policy Holder SSN: _____

Policy Holder DOB: _____ Policy Holder Gender: _____

Plan Address: _____

(Street, City, State, Zip)

SECONDARY INSURANCE INFORMATION

Plan Name: _____ Relation to Patient: _____

Member I.D. Number: _____ Group Number: _____

Policy Holder Name: _____ Policy Holder SSN: _____

Policy Holder DOB: _____ Policy Holder Gender: _____

Plan Address: _____
(Street, City, State, Zip)

IS YOUR VISIT DUE TO A JOB RELATED INJURY OR AUTOMOBILE ACCIDENT? Y___N___
IF YES, PLEASE NOTIFY THE RECEPTIONIST

ASSIGNMENT OF BENEFITS

I attest that the information I have provided to Kidsville Pediatrics, PA is correct and true to the best of my knowledge. I hereby assign any medical and/or surgical benefits to Kidsville Pediatrics, PA. This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges, whether or not paid by said insurance. I further authorize Kidsville Pediatrics, PA to release all information to secure payment.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize any physician, hospital, pharmacy, or medical care facility to provide all information regarding my medical or pharmaceutical history and treatment to Kidsville Pediatrics, PA. I furthermore will allow my pharmacy to supply verification of benefits. I also authorize Kidsville Pediatrics, PA to release my medical information to other physicians as needed to facilitate treatment.

Signature: _____ Date: _____

AUTHORIZATION FOR APPOINTMENT REMINDERS

By signing below, you are authorizing us to send you text reminders for your upcoming appointments. Providing us with your cell phone number above, you agree to any fees or charges you may incur from your cell phone company. There will not be any reimbursement from Kidsville Pediatrics if any charges apply.

Patient Name (Print): _____

Patient Signature: _____

Patient Authorization
Please read, initial and sign below.

(Initial)_____ **Financial Policy:** I acknowledge that I received, reviewed, and agree to comply with the most recent version of the Kidsville Pediatrics Policy as dated on August 1, 2018.

(Initial)_____ **Financial Responsibility:** I understand that I am ultimately responsible for payment of my account. Payment is expected at the time of service. I understand I am responsible to pay my co-pay, co-insurance, or deductible according to my insurance contract at the time of service.

(Initial)_____ **Insurance Coverage:** I understand that I am responsible to provide Kidsville Pediatrics with my current insurance coverage information and insurance card at each and every visit. I will be responsible for paying any balances due as a result of not providing my most current insurance information. I understand that Kidsville Pediatrics will not retroactively file claims due to my failure to provide current insurance information.

(Initial)_____ **Assignment of Benefits:** I hereby authorize payment directly to Kidsville Pediatrics, for medical benefits otherwise payable to me. I authorize my insurance company to disclose to Kidsville Pediatrics, information regarding my insurance coverage, including, but not limited to verification of my examination and/or treatment to my insurance company and/or other third party payor.

(Initial)_____ **No Show Fee:** I acknowledge that I received, reviewed, and agree to comply with the Kidsville Pediatrics No Show Policy and agree to pay any fees incurred from failure to comply.

(Initial)_____ **Fee for Forms:** I understand that I received notice about the fee for all forms to be completed by Kidsville Pediatrics and I agree to pay prior to receiving the completed form. (i.e. sports physicals, FMLA)

(Initial)_____ **Privacy Policy:** I acknowledge that I received, reviewed, and agree to comply with the Kidsville Pediatrics Privacy Policy.

(Initial)_____ **E-Prescribing:** I voluntarily authorize Kidsville Pediatrics to allow E-Prescribing for patient's prescription, which allows healthcare providers to electronically transmit prescriptions to the pharmacy of my choice; furthermore, I review pharmacy benefit information and medical dispense history as long as I am a patient at this office.

By signing my name below, I certify that I have read the above information. Any questions concerning these policies have been discussed. My signature also certifies my understanding of all agreement with the above policies. A photocopy of this document is as valid as the original.

Patient Name: _____ DOB: _____ Date: _____

Patient Signature: _____

Medical History

Patient Name:	Date of Birth:	Age:	Today's Date:
	Birth Place:	Gender:	

Patient's Medical History: Has the patient ever had? (Circle all that apply)

- | | | | |
|--------------------|---------------|---------------------|--------------------|
| Alcohol/Drug Abuse | Emphysema | High Blood Pressure | Psychiatric |
| Asthma | Epilepsy | High Cholesterol | Seasonal Allergies |
| Cancer | Heart Disease | Infectious Disease | Stomach Disorders |
| Colitis | Headaches | Kidney Disease | Thyroid Disease |
| Diabetes | | | |

Immediate Family's Medical History: Blood relatives currently have or have ever had? (Circle all that apply)

- | | | | |
|--------------------|---------------|---------------------|--------------------|
| Alcohol/Drug Abuse | Emphysema | High Blood Pressure | Psychiatric |
| Asthma | Epilepsy | High Cholesterol | Seasonal Allergies |
| Cancer | Heart Disease | Infectious Disease | Stomach Disorders |
| Colitis | Headaches | Kidney Disease | Thyroid Disease |
| Diabetes | | | |

Family History:

	Age(s)	Living?	Age at Death	Cause of Death or Current Condition
Father	_____	Y / N	_____	_____
Mother	_____	Y / N	_____	_____
Brothers	_____	Y / N	_____	_____
Sisters	_____	Y / N	_____	_____
Child(ren)	_____	Y / N	_____	_____

List All Surgeries and Serious Illnesses:

Surgery/Serious Illness	Year	Hospital/Location
_____	_____	_____
_____	_____	_____

Medication/Food Allergies:

Medication	Reaction
_____	_____
_____	_____
Food	Reaction
_____	_____
_____	_____
_____	_____

Medications you are Currently Taking: (Including birth control, over the counter, and herbal medications).

Medication	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Dates of your last:

Blood test/Cholesterol Level: _____	EKG: _____
Pap Smear: _____	Chest X-ray: _____
Prostate Check: _____	Mammogram: _____
Physical Exam: _____	Tetanus Booster: _____
Glaucoma Check: _____	Pneumovax: _____
Sigmoidoscopy/Stool Check: _____	Skin Test for TB: _____

Social History:

Marital Status: _____ Occupation: _____ Spouse's Occupation: _____

Do you smoke? Y or N

If yes, age you started smoking: _____ Year you quit: _____ Packs per day: _____

Illicit drug use? Never Remote Recent Current

How much caffeine do you drink? (Average number of drinks per day)

None 1 2 3 4 ≥5

How much alcohol do you drink? (Average number of drinks per day)

None Rare (<1) Moderate (1-2) High (>2)

Do you exercise?

None Occasional Moderate Frequent

Seat Belt Use? Y or N

Smoke Detector in Home? Y or N

Bike Helmet Use? Y or N

Fire Extinguisher in Home? Y or N

Have you ever completed an Advance Directive or Living Will? Y or N

Have you requested your medical records from your previous Physician's office? Y or N

If not, please request a release of records form at our front desk.

Thank you for taking the time to complete this form.



NAME: _____

DATE: _____

**Notice of Privacy Practices Acknowledgment Form
Consent To Use or Disclose Protected Health Information**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (“PHI”) about you. You have the right to review our Notice before signing this form. Your signature below acknowledges that you have received a copy of our Notice of Privacy Practices. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting any Kidsville Pediatrics, PA staff. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of PHI about you for treatment, payment and health care operations as described in our Notice. These disclosures may be by phone, mail, fax, or electronic transmission, Unless you indicate otherwise in writing (by completing the form: Request for Restrictions on Use and Disclosure of Protected Health information), if you allow a third party other than one of our practice’s physicians or staff to be in the exam room while one of our physicians or staff is examining you or discussing your care, treatment or medical condition with you, by signing this Consent Form you are consenting to the disclosure of you PHI to that third party. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. If you refuse to sign this consent or revoke this consent, Kidsville Pediatrics, PA may refuse treatment or provide further treatment as of the time of the revocation, except to the extent that treatment is required by law.

I am consenting to the disclosure of my protected health information (“PHI”) to the following individuals:

- Name _____ Relationship _____
- Name _____ Relationship _____
- Name _____ Relationship _____
- Name _____ Relationship _____

I have read and understand the information in this acknowledgment. I am the patient or am authorized to act on behalf of the patient to sign this document.

By signing below, I acknowledge and agree to the above conditions.

Signature of Patient
(OR AUTHORIZED REPRESENTATIVE)

Print Name of Patient
(OR AUTHORIZED REPRESENTATIVE)

* Please explain: Representative relationship to Patient and include a description of Representative authority to act on behalf of Patient



**Privacy Practice
HIPAA Acknowledgment Form**

Patient's Name: _____

D.O.B. _____

I have received the Notice of Privacy Practices for the office of **Kidsville Pediatrics, PA** and I have been afforded an opportunity to review it. I acknowledge that this law allows our office to share and disclose protected medical information regarding myself as a patient:

- (1) Another physician, (such as a specialist our providers can refer me too), a hospital (where I may be admitted), pharmacy, or other provider of medical care, such as a therapist (PT, OT, Speech, etc), or DME company for medical equipment that I may require.
- (2) Insurance companies (to process claims or obtain referrals).
- (3) For the day to day internal operations of our office (evaluating employee performance, training, etc.)

I understand that in order for me to request a copy of patient medical records due to (moving, switching to another PCP, etc), I must complete a different release of information form, which may be provided by our office, or I may submit a letter which includes patient name, date of birth, reason for release, and the patients signature.

Patient/Responsible Party Signature: _____

Date: _____