



New Patient Registration Form

Today's Date: _____

Account# _____

Patient Last Name:	Name of Guarantor (Responsible Party):
Patient First Name:	Address:
Patient Middle Name:	City: State: Zip Code:
Address:	Relationship to the patient:
City: State: Zip Code:	Date of Birth:
Social Security No.:	Social Security No.:
Mom cell:	Phone: () _____ - _____
Dad cell:	Emergency Contact Information:
Home phone:	Name:
Sex (circle one): M F	Relationship to the patient:
Date of Birth:	Phone: () _____ - _____
Primary contact (circle one) : MOM DAD	Insurance Information:
Require by Government Mandate (although you may Decline):	Insurance Plan name:
Language:	Policy number:
Race:	Preferred Pharmacy:
Ethnicity:	E-mail address:
Other:	Patient Referred by:

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.

Parent Name (Print): _____

Parent Signature: _____

Patient Name: _____ DOB: _____ Account#: _____

Immunization Schedule

Birth to 4 years:

Hepatitis B:

Dose 1 is given at the hospital when the child is born

Dose 2 is given at one month

Dose 3 is given 6mo or 9mo

DTaP is given at 2mo, 4mo, 6mo, 15mo and 4 years of age

IPV is given 2mo, 4mo, 6mo and 4 years of age

HIB is given at 2mo, 4mo, 6mo, 15mo

PCV is given at 2mo, 4mo, 6mo, 15mo

Rotavirus is given at 2mo, 4mo, 6mo

MMR is given at 12mo and 4 years

Varicella is given at 12mo and 4 years of age

Hepatitis A is given at 12mo/#2 is given 6mo from the first dose

11 years and up:

Tdap is given 11 yrs of age

Menveo (Meningitis vaccine) is given at 11 years and 16 years of age

Men B is given at 16years/#2 given one month after first dose

HPV (Gardasil9) 11 years to 18 years/#2 dose 6 mo after (**recommended vaccine**)

Influenza Vaccine 6mo and up (**recommended vaccine**)

Immunization Policy:

At **Kidsville Pediatrics** we strive to provide the highest quality care, while respecting the wishes of our parents. Should a family desire to alter the schedule or withhold all recommended vaccines, Kidsville Pediatrics feels that this decision not only puts your child at risk of serious preventable disease, but also contributes to the health risk of others. Please be advised that if you desire an "alternate" vaccine schedule, or if you intend to refuse vaccines, you do so against the advice of Kidsville Pediatrics, the AAP, the AAFP, the CDC and the ACIP. As this decision is believed to put your child at risk for vaccine preventable disease and increases health risks for others.

I have read and understood the following immunization schedule and agree to vaccinate accordingly.

Parent name (Print): _____

Parent signature: _____

Date signed: _____

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 on my child's/children's 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)_____ **Immunization Policy & Consent:** I acknowledge that I received, reviewed, and agree to comply with the Kidsville Pediatrics Immunization Policy. **Please inform the doctor if the patient had any severe reaction to any medications, including vaccines. Also, if patient has any know allergies (i.e. peanuts, eggs, etc) and/or has a condition for which he/she is receiving medical treatment or has previous treatment. Vaccines may contain minute traces of animal products and other components. If you have any concerns you may address it with your physician. By initialing and signing this form, you will be giving consent for your child to have the vaccines described at the time of the visit and as recommended by the immunization schedule.**

(Initial)_____ **Consent to Treat:** I have the legal right to consent to medical and surgical treatment for this patient. I voluntarily authorize and consent to the medical care, treatment and diagnostic tests that providers of Kidsville Pediatrics believe are necessary for my child. I understand that by signing this form, I am giving permission to the doctors, nurses, and other healthcare providers in this medical office to provide treatment to this child as long as my child/children are a patient in this practice. **In the absence of the legal guardian the following person is authorized to bring the minor for medical treatment EXCEPT for routine physicals and vaccines.**

Name (other than parent): _____ Relationship _____

Name (other than parent): _____ Relationship _____

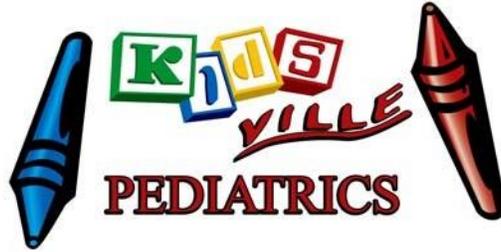
Name (other than parent): _____ Relationship _____

(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 this child is 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: _____

Parent Name (Print): _____ Parent Signature: _____



**Privacy Practice
HIPAA Acknowledgment Form**

Patient Name: _____ D.O.B. _____

I have received the Notice of Privacy Practices for the office of **Kidsville Pediatrics** 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 your child with:

- (1) Another physician, (such as a specialist our Providers refer your child to), a hospital (where your child may be admitted), pharmacy, or other provider of medical care, such as a therapist (PT, OT, Speech, etc), or DME company for medical equipment your child 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 my child's medical records (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 my child's name, date of birth, reason for release, and one of the parent's signature.

Parent/Guardian Signature

Date