PATIENT REGISTRATION FORM

Patient Name (Last, First, MI) _____ Nickname _____

Date of Birth _____ Gender: __M __F Referred by _____

Guardian / Parent # 1 (__Mother / __Stepmother) Check One Guarantor _Y __N

Name (Last, First, MI) _____SS# _____ Hm. Ph. _____

Date of Birth _____ Gender: __M __F Email _____Wk. Ph. _____

Employer _____ Cell ph. _____

Home Address _____ City _____ST____Zip _____

Guardian / Parent # 2 (__Father / __Stepfather) Check One Guarantor _Y __N

Name (Last, First, MI) _____SS# _____ Hm. Ph. _____

Date of Birth _____ Gender: __M __F Email _____Wk. Ph. _____

Employer _____ Cell ph. _____

Home Address _____ City _____ST____Zip _____

Guardian / Parent # 3 (Other _____) Check One Guarantor _Y __N

Name (Last, First, MI) _____SS# _____ Hm. Ph. _____

Date of Birth _____ Gender: __M __F Email _____Wk. Ph. _____

Employer _____ Cell ph. _____

Home Address _____ City _____ST____Zip _____

Insurance Company

Policy Holder / Insured _____ Relationship to Patient _____

Policy # _____Group # _____

Patient Responsibility Statement and Medical Release Information

I/we the undersigned understand that we are responsible for any unpaid balance on this account. ADVANCED PEDIATRIC CARE will file the necessary insurance claims, excluding secondary insurance claims, but I/we understand that we are responsible for any balance left unpaid after 120 days of the date of service. Failure to satisfy this obligation may cause the entire balance to be placed with a collection agency or attorney. I/we will be responsible for any charges incurred for collecting this debt, this includes, but is not limited to, collection fees, credit bureau fees, and any legal expense. I/we herby authorize you to release any and all information which you may possess relating to my child's examination and illnesses. I understand I may revoke this consent in writing at any time.

Signed _____ Date _____

Relationship if other than patient _____

PATIENT REGISTRATION FORM

Date _____

Child's Name _____ **DOB** _____

Parents' Names _____

Mother's Maiden Name _____

Siblings' Names _____

If Twin (check one) __Twin A / __Twin B

FAMILY HISTORY

Check all diseases below that have occurred in this child's brothers, sisters, parents, grandparents, aunts uncles or first cousins.

Please **specify who** (in relationship to the child) in the space next to the illness and their approximate age at diagnosis.

__Asthma
__Sinus Allergies
__Eczema
__Cystic fibrosis
__Birth defects
__Seizures
__ADHD

__High blood pressure
__High cholesterol
__Heart attack / stroke
__Diabetes
__Kidney problems
__Digestive problems
__Liver problems

__Anemia
__Bleeding disorder
__Anesthesia reactions
__Depression / anxiety
__Substance abuse
__Cancer (specify type)
__Other _____

BIRTH HISTORY – **check italicized options** that apply.

Did mother receive prenatal care? __*Yes* __*No*

Was baby born __*full term* (37-42 weeks) or __*premature* (if preemie, how early? _____)

Was it a __*vaginal delivery* or __*cesarean section* (if c-section, state reason _____)

Did mom have any problems or complications during pregnancy? __*Yes* __*No*
__*Diabetes,* __*high blood pressure,* __ *preeclampsia,* __*preterm labor,* __*other* _____

Did mom have any of the following infections during pregnancy?__*Yes* __*No*
__*Yeast,* __*herpes,* __ *gonorrhea,* __*chlamydia,* __*syphilis ,*__*HIV,* __ *urinary tract infection*

Did mom test positive for group B strep (GBS) during this or a previous pregnancy?__*Yes* __*No*
If yes, did she receive antibiotics during labor?__*Yes* __*No* __ *Don't know*

What was the baby's birth weight? _____ Mom's blood type _____

Did baby have any problems in the newborn nursery before hospital discharge?__*Yes* __*No*

__ *Jaundice,* __ *low blood sugar,* __ *feeding problems,*__ *breathing problems or needed oxygen,*
__ *Heart murmur,* __ *suspicion of infection,* __ *sepsis,*__ *pneumonia,* __ *other* _____

Did he / she have to go to the NICU or special intensive care unit for newborns? __*Yes* __*No*

Was baby at leat 48 hours old when the newborn metabolic screen (PKU) was done?__*Yes* __*No*

Did he / she pass the newborn hearing screen with both ears?__*Yes* __*No*

PAST MEDICAL HISTORY - Please explain any 'Yes' answers

Any hospitalizations?	No	Yes
Any surgeries?	No	Yes
Any serious injuries, concussions, or broken bones?	No	Yes
Taking any medications, vitamins, herbals, or fluoride?	No	Yes
Any allergies to medications?	No	Yes
Any allergies to foods?	No	Yes
Any reactions to any immunizations?	No	Yes
Any chronic cough or recurrent wheezing or pneumonia?	No	Yes
Ever diagnosed with asthma or reactive airway disease?	No	Yes
Any nasal or sinus allergies?	No	Yes
Any eczema or skin problems?	No	Yes
Any vision or hearing impairments?	No	Yes
History of frequent ear infections?	No	Yes
Any heart problems or heart murmur?	No	Yes
Any stomach or digestive problems?	No	Yes
Any kidney or urinary tract problems?	No	Yes
Any seizures, tics, or migraines?	No	Yes
Any developmental delays or learning disabilities?	No	Yes
Any severe behavioral problems or psychiatric illness?	No	Yes

LEAD RISK ASSESSMENT (Check all that apply)

___ Home or daycare built before 1970 ___ before 1950 ___ has chipping / peeling paint

___ Child eats dirt, clay, or paint chips ___ likes to suck on windowsills or blinds

____ Child's friends, playmates, or neighbors with high lead levels

____ Parent's job / hobby involves lead exposure ____ Folk remedy with lead (Azarcon)

___ None of the above

TB RISK ASSESSMENT (Check if your child has close contact with an adult who . . .)

___ Is homeless or living in a shelter

___ Is living or working in a prison

___ Is living or working in a nursing home

___ Has TB, HIV, AIDS, or abuses drugs

___ Immigrated from Central or S. America, Haiti, Russia, E. Europe, India, or SE Asia

___ Is a healthcare worker (If yes, are they screened regularly? _____)

___ None of the above.