PEDIATRIC REGISTRATION FORM

*****Today's Date:*** ________________________
PATIENT INFORMATION: (Please use full legal name, no nicknames)

***Last Name:** ____________________________ ***First Name:** __________________________ **Middle Initial:** ____________

***Address:** ________________________________ **City:** _________________________ **State:** _________ **Zip:** ____________

***Sex:** _______ ***Date of Birth:** ________________________ **Age:** _________

Primary Contact: ____

***Mothers Name:** ___________________________________ ***Fathers Name:**_____________________________________

***Mothers Cell:** _____________________________________ ***Fathers Cell:** ______________________________________

Email:: _______________________________ **Preferred Pharmacy:**____

Emergency Contact Name: ____________________________________ **Phone #:** (________) ___________-____________

GUARANTOR INFORMATION: (List person or insured name responsible for bill - use full legal name, no nicknames)

IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS ***Relationship of Guarantor to Patient: Mother ____ Father: _____Legal Guardian: _________ Other: _________**

***Last Name:** _____________________________ ***First Name:** _______________________ **Middle Initial:** _____________

***Address:** _________________________________**City:** ________________________ **State:** __________ **Zip:** __________

Home Phone #: (__________) ______________-________________***Social Security #:** ______________________________

***Date of Birth:** _________________________ **Age:** ________________________ ***Sex: Female** _______ **Male** ________

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)
PRIMARY INSURANCE:
Plan Name: ____ ***Insured's Name:** __________________________________

Insured's Social Security #: _____________________________ ***Insured's Date of Birth:** ____________________________

***Policy / ID #:** _________________________________ ***Group #:** __________________ **Eff Date:** ____________________

Claims Address & Phone:
____

SECONDARY INSURANCE:
Plan Name: ____***Insured's Name:** ___________________________________

Insured's Social Security #:** ____________________________Insured's Date of Birth:** ____________________________

***Policy / ID #:** ______________________________ ***Group #:** _____________________ *** Eff Date:** ___________________

Claims Address & Phone: ____
***REQUIRED FIELDS-PLEASE COMPLETE FOR BILLING. *ATTACH COPY OF INSURANCE CARDS.**

Appointment Policies

Child's Name: ______________________________ Date of Birth: __________

Parent's Name: ____

Welcome to our office! We are pleased that you have chosen us to take care of your child's medical needs. To make our time together most efficient and enjoyable, we have listed several office policies. Please read them carefully.

1. **YOUR APPOINTMENT**: Be on time for your appointments, preferably 10-15 minutes early. If you are late, you risk cancellation of your appointment.
2. **CANCEL OR RESCHEDULE POLICY**: We require a minimum of 24 hour notice to cancel or reschedule your appointment. All no show, cancellation or reschedules less than 24 hours will have a $35 charge per child applied to their account. Your next appointment will not be scheduled unless all fees are paid.
3. **BROKEN APPOINTMENT POLICY**: If a confirmed appointment is missed without proper cancellation or rescheduling you are provided a one- time notice and reminder of the policy. Any appointment missed without proper cancellation or rescheduling thereafter could result in a $35 charge or dismissal from the office.
4. **PROOF OF INSURANCE**: Bring your insurance card to every appointment. We cannot file a claim without a current Insurance or Medicaid card on file.

I acknowledge that I am fully responsible for making and keeping my appointments as well as providing proof of insurance at every appointment.

I have read and completely understand my obligations to the office policies.

Signature: __________________________________ Date: ________________

Relationship to child: ______________________________

PRESTIGE MEDICAL, P.A.

LEKSHMI NAIR, M.D

In our efforts to comply with the Health Insurance Portability and Accountability Act (HIPAA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and co-workers.

Please circle your response to the following:

May we leave **messages** on a voice mail at work? Yes No N/A Ph.:#______________________________

May we leave messages concerning your child's **appointments** with another person at your place of work?
Yes No N/A

If yes, please specify whom: ____

May we discuss your child's **appointments/treatment** with any other family member (grandparent, etc.)?
Yes No N/A

If yes, please specify whom: ____

Relationship to patient: ____

I have received a copy of the Notice of Patient information Privacy. Yes No

This form must be signed by the child's legal guardian. All legal guardians of the child must be listed on the rear of this form. You must inform us, **in writing**, of any changes in your directives. This record will be kept in your file along with your acknowledgement of receipt of your Notice of Privacy Practices.

Patient's Name: ______________________________________

Date of Birth ____

Signature: ____

Printed Name: _______________________________________ Date: _______________________

Relationship to Patient: ________________________________

PRESTIGE MEDICAL, P.A.

LEKSHMI NAIR, MD

Listing of Legal Guardians

Patient

____ Name

(last, first MI) Date of Birth

Legal Guardians (fill out for all guardians, otherwise leave blank):

Mother: ____

Name Date of birth Driver's License #

( ) ______________________ ( ) ______________________

Phone Second contact number if applicable

Father: ____

Name Date of birth Driver's License #

( ) ______________________ ( ) ______________________

Phone Second contact number if applicable

Other: ____

Name Date of birth Driver's License #

( ) ______________________ ( ) ______________________

Phone Second contact number if applicable

Only people listed above will be permitted to request release of medical records

Please list non-guardians authorized to bring patient to Prestige Medical, P.A. for medical treatment:

____

Name Relationship

____

Name Relationship

____

Name Relationship

Signature

____

PRESTIGE MEDICAL, P. A.
FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name: ____ **Date of Birth:** ________________
First Name M.I. Last Name

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any Medical service or visit, Preventative exam or physical, Lab testing, X-ray, EKG, and any other Screening service or Diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility and not the responsibility of the Physician or Clinic to know if my insurance will pay for my Medical service or visit, Preventative exam or physical, Lab testing, X-ray, EKG, or any other Screening service or Diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility to know if my insurance has any Deductible, Co-payment, Co-insurance, Out-of-Network amount, Usual and Customary Limit, or any other type of benefit limitation for the services I receive, and I agree to make full payment.

I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.

I understand and agree it is my responsibility to know if my PCP choice has been processed by my insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment.

Signature: ____ **Date:** __________________
(Please sign here – Patient or Responsible Party)

Responsible Party Name: ____
(Please print name of Responsibility Party if different from Patient)

Name: ____

DOB: ____/____/______ Age: ________ ☐ M ☐ F

Form Completed by: ______________________ Date Completed: ____/____/______

HOUSEHOLD

Please list all those living in child's home.

Name	Relationship to	DOB	Health Problems

If mother and father are not living together or if child does not live with parents, what is the child's custody status?

____

____

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home?

____

____

BIRTH HISTORY

Birth weight: ___________ Born at which hospital? ______________________________________

Was the baby born: ☐ At term ☐ Full Term ☐ Early ☐ Late

Did the mother have any or illness with her pregnancy? ☐ Yes ☐ No

Explain: ____

During the pregnancy, did mother smoke: ☐ Yes ☐ No

Drink alcohol: ☐ Yes ☐ No Use drugs or medications: ☐ Yes ☐ No

Was the delivery ☐ Vaginal? ☐ Cesarean?

If cesarean, why? ____

Did your baby have any problems right after birth: ☐ Yes ☐ No

Explain: ____

Did your baby go home with the mother from the hospital? : ☐ Yes ☐ No

Explain: ____

GENERAL

Do you consider your child to be in good health? : ☐ Yes ☐ No

Explain: ____

Does your child have any serious illness or medical condition? : ☐ Yes ☐ No

Explain: ____

Has your child had serious injuries or accidents? : ☐ Yes ☐ No

Explain: ____

Has your child had any surgery? : ☐ Yes ☐ No

Explain: ____

Is your child allergic to any medicines or drugs? : ☐ Yes ☐ No

Explain: ____

Any admissions to a hospital? : ☐ Yes ☐ No

Explain: ____

DEVELOPMENT

Are you concerned about your child's physical development? : ☐ Yes ☐ No

Explain: ____

Are you concerned about your child's mental or emotional development? : ☐ Yes ☐ No

Explain: ____

Are you concerned about your child's attention span? : ☐ Yes ☐ No

Explain: ____

If your child is in school:

How is his/her behavior in school? ____

Has he/she failed or repeated a grade in school? ______________________________________

How is he/she doing in academic subjects? ____

Is he/she in special or resource classes? ____

FAMILY HISTORY

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 years old): ☐ Yes ☐ No

Who: _____________Comments:_______________________________

High blood pressure (before 50 years 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: ____

Kidney disease: ☐ Yes ☐ No

Who: ______________ Comments: ____

Diabetes (before 50 years old): ☐ Yes ☐ No

Who: _____________ Comments: ____

Bed-wetting (after 10 years 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 retardation: ☐ Yes ☐ No

Who: _________________ Comments: ____

Immune problems, HIV, or AIDS: ☐ Yes ☐ No

Who: _______________ Comments: ____

Additional family history: ☐ Yes ☐ No

Who: _________________ Comments: ____

PAST HISTORY

Does your child have, or has he/she ever had:

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 doctor visits: ☐ Yes ☐ No Explain:

____

Bladder or kidney infection: ☐ Yes ☐ No Explain:

____

Bed-wetting (after 5-years old): ☐ Yes ☐ No Explain:

____

(For girls) Has she started her menstrual periods? : ☐ Yes ☐ No Explain:

____

(For girls) Are there problems with her periods? : ☐ Yes ☐ No Explain:

Any chronic or recurrent skin problem (acne, eczema, etc.): ☐ Yes ☐ No Explain:

Frequent headaches: ☐ Yes ☐ No Explain:

Convulsions or other neurologic problem: ☐ Yes ☐ No Explain:

Diabetes: ☐ Yes ☐ No Explain: ______________________________

Thyroid or other endocrine problem: ☐ Yes ☐ No Explain:

Any other significant problem: ☐ Yes ☐ No Explain:

Use of alcohol or drugs: ☐ Yes ☐ No Explain: