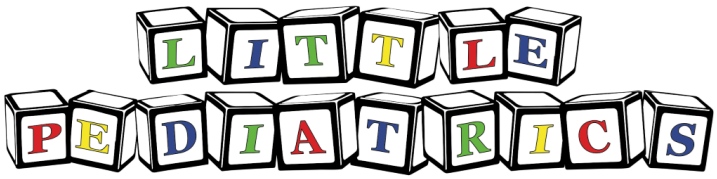

New Patient Registration Form

PATIENT INFORMATION			
Legal Last Name	Legal First Name	Middle	Male / Female
Preferred Name:		DOB:	SSN:
Home Address:			Phone number:
City:	State:	Zip:	Cell:
Email:			
Preferred Pharmacy:			

INSURANCE INFORMATION			
Primary Insurance:			ID#:
Subscriber Name:		Subscriber DOB:	
Relationship to Subscriber:			
Secondary Insurance (If applicable):			ID#:
Subscriber Name:		Subscriber DOB:	
Relationship to Subscriber:			
Responsible Party:			DOB:
Home Address:			Phone number: Home:
City:	State:	Zip:	Cell:

EMERGENCY CONTACT			
Name:		Relationship:	
Phone Number:			
	Home	Work	Cell

Child's Name:		**Date:**	
DOB:	**Allergies:**		
Medications:		**Herbs/home remedies:**	
Medical Problems:			

PREGNANCY AND BIRTH

Is your child Birthed Adopted Stepchild Other:	
Any Medical Problems during pregnancy? No Yes, Specify:	
Delivery via Vaginal Birth Caesarean, why?	
Birth Weight: lbs oz	Birth Length inches
Full Term Premature, Weeks Gestation:	
Medical problems during newborn period:	

NUTRITION AND FEEDING

Was your child breastfed? No Yes, how long?	
Any unusual feeding or dietary concerns?	
Milk Intake currently: ounces daily	What Type?

SLEEP

Hours of sleep per night	Naps
Sleeping problems/concerns?	

DEVELOPMENT

At what age did your child				
sit alone	Walk alone	Say Words	Toilet Train	

DENTAL HISTORY

Has your child been seen by a dentist?	No	Yes
Dentist Name:	Last Visit	

FAMILY HISTORY: (Please circle any of the following)				
Drug/Alcohol problems		Heart Attack	Stroke	Thyroid
Blood Pressure	Asthma	Allergies	Bleeding Disorder	
Psychiatric disorder		Seizures	Genetic Disorders	

SOCIAL HISTORY				
Child lives with:				
Name		Relationship		Age
Are the Parents	Married	Unmarried	Divorced	

EXPOSURES			
Do any household members smoke?		Yes	No
How many hours per day of TV	Computers	Video Games	
Any concerns about lead exposure? (old home)			
Any guns in the house?		Violence in house?	

SCHOOL HISTORY			
Current Grade:			
Problems with teachers or students at school?			
Name of School:	Concerns about Performance		
Sports	How often?	How long?	

AUTHORIZATION AND RELEASE

Authorization for Treatment: I voluntarily consent to the administration and cost of medical and surgical procedures for myself or my dependent. **Authorization for use of e-mail/cell phone:** I voluntarily consent to the use of my personal e-mail and/or cellular phone via voice or text to receive newsletters or notifications. This is NOT to be used for my private medical records or health information.

Assignment of Insurance Benefits: I authorize payment directly to Little Pediatrics, PC for all benefits otherwise payable to me.

Guarantee of Payment: I understand that I am financially responsible and agree to pay all charges that are not paid or billed to insurance or any other third party payer. I understand that I must pay in full today for all services rendered unless my insurance is accepted. I also understand that if my insurance is accepted, I must pay all applicable insurance co pays, coinsurances, and deductibles today. If you are unable to verify my insurance at time of service, I will pay in full for all services.

Release of Records: I authorize Little Pediatrics, PC to release (verbal or in writing) confidential medical information to any person or entity including my insurance carrier, employer if treatment is related to employment purposes, or other health care operations which may be liable to me or my practitioner(s) for charges for this treatment and for quality management, utilization review, transfer, and follow up purposes.

Receipt of Privacy Practices: I acknowledge that I have received and read the Notice of Privacy Practices of Little Pediatrics, PC. I understand that a copy of this agreement may be used with the same effectiveness as the original.

PATIENT SIGNATURE: _____ **DATE:** _____

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

CONSENT FOR NOTIFICATION OF TEST RESULTS/MEDICAL INFORMATION

I give permission to Little Pediatrics, PC **to**:

1. Follow-up phone calls or call backs in regards to care at Little Pediatrics, PC using this phone#:

2. Leave a message on my answering machine:(**circle one**) Yes/No

3. Discuss my health information with the following people:_____

PATIENT/PARENT SIGNATURE: _____ DATE:_____

Consent for Treatment of a Minor without Parent Present

I give permission for _____ (my child) to be medically evaluated and treated at Little Pediatrics in my absence. I understand that it may be necessary to perform diagnostic tests (for example, a throat culture or urine test) in the course of the evaluation. I accept responsibility for physician charges and laboratory fees.
This consent applies to:

1. complete physician examination
2. hearing, vision, scoliosis, and blood pressure screening
3. immunizations
4. first aid and emergency care
5. prescriptions and treatment for illness
6. referrals to an outside agency (for example: hospital, radiology) for services not provided at the office

If there are any services that you do not consent to in your absence, please

list: _____

My child will be accompanied by:
[ ] himself/ herself (must be 16 or older)
[ ] (name, relationship)_____
[ ] (name, relationship)_____
[ ] (name, relationship)_____

I give permission for the physician to share any relevant health information with the person who is accompanying my child.

_____
Child's name DOB

_____
Parent or Guardian Signature Date

_____
Parent or Guardian Name

_____
Phone number where parent or guardian can be reached