Christian Family Medicine & Pediatrics

PEDIATRIC PATIENT REGISTRATION FORM

Please Print Clearly

Patient Information

Legal Name_____ Date of Birth_____

Social Security Number_____

(Circle One) Sex: M F *(Circle One)* Race: African American Asian Caucasian Other *(Circle One)* Ethnicity: Hispanic Not Hispanic

Mailing Address_____

City/ State/ Zip _____

Home Phone_____Cell Phone_____

Email address:_____

Local Pharmacy of Choice_____ City_____ Phone:_____

Emergency Contact: _____Contact #_____Relationship:_____

Parent/ Guardian Information (Person who is legally responsible for above person)

Guardian Relationship: *(Circle One)* Mother Father Grandmother Grandfather Aunt Uncle Other: _____

Guardian Name_____ Guardian Date of Birth_____ _____

Guardian S. S. # _____Marital Status_____ (Circle One) Sex: M F

Address_____

City/State/Zip_____ Guardian Contact # _____

Guardian Employer_____ Employer Phone Number_____

Insurance Information

Primary Insurance

Name of Ins. Co_____ Effective Date _____

Policy # _____ Group/ Plan # _____

Policy Holder's Name_____ Copay $_____

Policy Holder's S. S. # _____ Policy Holder's DOB_____

Policy Holder's Address_____

Policy Holder's Relationship to Patient _____Phone #: _____

Secondary Insurance

Name of Ins. Co_____ Effective Date _____

Policy # _____ Group/ Plan # _____

Policy Holder's Name_____ Copay $_____

Policy Holder's S. S. # _____ Policy Holder's DOB_____

Policy Holder's Address_____

Policy Holder's Relationship to Patient _____Phone #:_____

Patient Responsibilities Notification

We will submit all charges to all insurance (primary, secondary, etc.) as a courtesy to you. However, we do require payment at the time of service for all co-payments, deductibles, and co-insurance. We cannot bill your insurance unless you bring all current insurance information with you. It is your responsibility to provide us with complete and accurate information at EACH office visit. Failure to do so will result in the patient incurring complete and total financial responsibility for all charges. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some services provided may be "non-covered" under the terms of your contract and, therefore, not paid by insurance. You are responsible for the payment of your deductible and co-pay if there is no secondary insurance. Copies of your information will be made for our files.

It is the patient's responsibility to inform us of any special requirements or specific facilities associated with your benefit plan. If we inadvertently order services, such as lab work, diagnostic tests, etc. that are not covered or ordered at an out of network facility, we or the selected medical facility will have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility.

All patients are expected to provide their insurance card at the time of check in at each visit. All patients are responsible for making sure they know what benefits are included under their insurance plan and ensure they are following all regulations/ rules defined in their plan.

A deposit will be required for all patients that do not have insurance coverage prior to seeing the provider. Payment in full is expected at the time of service unless billing arrangements have been made by our billing staff PRIOR to the visit.

Adult Patients: Adult patients are responsible for full payment of their accounts.

Minor Patients: Patients under the age of 18 years will not be seen unless accompanied by a guardian or a signed authorization from that guardian allowing our physicians to provide medical treatment. The adult, parent or guardian accompanying a minor will be responsible for full payment of the account.

There is a $50.00 form fee for any forms presented to the office for completion not presented during a regular visit. Examples include: Disability, Adoption forms, Insurance claim forms, etc.

Payment in full or payment arrangements can be made on any outstanding balance. No payment activity within 120 days from the date of service will result in the account being turned over to an outside collection agency. The patient will be responsible for all collection fees, cost, interest, and/or attorney fees and will be applied to the outstanding balance.

Any account that has been turned over to a collection agency **MUST** be paid fully before any treatment is rendered. Failure to meet your financial responsibilities may result in discharge from the practice.

I authorize release of any information concerning my child's health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the primary care provider. I understand if there are any changes in my child's insurance coverage, I will notify my child's primary care provider immediately. I hereby give consent for treatment of my child to the primary care provider at Christian Family Medicine.

I request payment of authorized Insurance/Medicare benefits be paid to Christian Family Medicine, Inc. on my behalf. I authorize any holder of medical information about me to release to the Healthcare Financing Administration, any information needed to determine these benefits. I understand my signature authorizes the physician to furnish information to insurance carrier concerning my illness necessary to pay my medical claims and I hereby irrevocably assign payments to Christian Family Medicine, Inc. I understand I am financially responsible for all charges, whether or not covered by insurance. I also understand my medical records may not be released if I am not financially in good standing with Christian Family Medicine, Inc. A copy of this authorization shall be considered as valid as the original.

_____

Signature of Patient or Responsible Party (state relationship)

_____

Date

Christian Family Medicine & Pediatrics

Patient Disclosure Authorization Form

Christian Family Medicine Inc. has provided me notification of their Privacy Practice for protected health information. I authorize Christian Family Medicine, Inc. to discuss with the following person(s) regarding my visits, care, and/or account:

_____

Name *Relation*

_____

Name *Relation*

_____

Name *Relation*

In the above section please list ALL persons that you wish to have access to your personal health information. Under no circumstance will this information be released except by court order to anyone who is not listed above.

Please indicate your permission for our communication with you regarding your personal health information.
Check all that apply

- □ Telephone call to your home or cell
- □ Telephone call to your place of employment
- □ Leave a message at your home with someone
- □ Answering machine
- □ Fax

_____ _____

Signature of patient or guardian *Date*

Christian Family Medicine & Pediatrics

Authorization for Release of Medical Records

Please send a copy of this release with the requested records.

PATIENT INFORMATION (Please print)			
Patient Name	Date of Birth	Social Security Number	
Address	City	Zip	Phone

RELEASE FROM (Name of physician or facility releasing information)

I authorize release of my medical record from

Physician/ Facility			
Address	City	Zip	Phone

RELEASE TO (Name of physician or facility receiving information)

Please send my medical record to:

Physician/ Facility	Christian Family Medicine			
Address 79 Hwy 51 South	City Ripley	Zip 38063	Phone 731-635-8189	Fax 731-635-8126

RELEASE INFORMATION

Reason: ( ) Change of Insurance ( ) Transfer of Care ( ) Personal File ( ) ER Visit
( ) Moving out of area ( ) Specialist consultation ( ) Legal ( ) Other : _____

Please release the following (check all that apply)

RECENT H&P		LAST 3 OFFICE VISITS	
LAB REPORTS		RADIOLOGY REPORTS	
HOSPITAL REPORTS		OTHER:	

- Please allow 15 days for processing.
- Incomplete information will delay processing.
- Use of this information for any other than the stated purpose is prohibited.
- This information is for the use of the designated recipient only and cannot be provided to any other agency.

CONSENT

I authorize the release of all information indicated, and I am aware that the records released may contain information relating to psychiatric or psychological testing, physical abuse, or drug and alcohol abuse. I authorize the release of HIV/HTLV/AIDS test results.

Signature of patient, parent, guardian, conservator, or patient representative. (Please circle)	Date
Witnessed by:	Date

Note: This consent is valid for 90 days. It may be revoked by the signer at any time.
This release is not valid retroactively.

Christian Family Medicine & Pediatrics

Pediatric Patient Health History

Child's Legal Name:_____ Date of Birth: _____

Your Name: _____ Relationship to Child: _____

MEDICATIONS: Please list (or show us a printed record) of ALL prescriptions and non-prescription medications. This includes vitamins, supplements, and over the counter pain pills (Advil, Aleve, Tylenol, etc).

□ Check box if you do not take any prescription or over the counter medications.

□ Check box if you brought a printed record of your medications (give it to the nurse and don't write in medications below).

Medication	Dose (e.g. mg/pill)	How often?

ALLERGIES or intolerance to medications? □ None (If yes, to what & what reaction?) _____

_____

Child's Past Medical History

Where was your child born? _____ Gestational Age at Birth: _____ Birth Weight: _____ Length: _____

Is the child yours by: *(Circle One)* Birth Adoption Step Child Other: _____

Pregnancy Complications: _____ Delivery by: *(Circle One)* Vaginal C-section Reason for C-section: _____

Any problems in the Newborn period: _____

Infancy/ Childhood/ Adolescence

Has your child ever been treated for or diagnosed with any of the following? If yes, please explain.

Asthma or reactive airway disease: _____ Genetic Syndrome:_____

Wheezing or Bronchiolitis: _____ Seizures:_____

Seasonal Allergies or Eczema: _____ Anemia:_____

Food Allergies: _____ Broken Bone:_____

Medication Allergies: _____ Intellectual Disability or Developmental Delay: _____

Ear Infections: _____ _____

Pneumonia: _____ Depression/ Anxiety:_____

Urinary Tract Infection: _____ Other Chronic Medical Condition(s):_____

Has your child ever been hospitalized? If Yes, please explain. *(Circle One)* No Yes, _____

Previous Surgeries Including Dates: _____

Please List any Specialist(s) Your Child is Currently Seeing and Reason: _____

Development/ Nutrition

At what age did your child: Sit Alone ____ Walk alone ____ Say words ____ Toilet Train ____ 1st period (females) _____

Was your child Breastfed? *(Circle One)* No Yes, How Long? _____

Has your child had any unusual feeding/ dietary problems? *(Circle One)* No Yes, Explain: _____

Current milk intake: *Milk Type*: 2% Whole 1% Soy Other: _____ *Formula Type*: Similac Enfamil Gerber Other: _____

Amount _____ounces per day

Social History

Who lives in the household with the child? *(Circle all that apply)*

Mom Dad Stepmom Stepdad Siblings (#)_____ Grandparent(s) Other: _____

Child's parents are: (Circle One) Married Unmarried Divorced Other: _____

Childcare: *(Circle One)* Parent(s) Daycare Relative(s) Babysitter/Nanny Days per week: _____

Do any household members smoke? *(Circle One)* Yes No

How many hours per day does your child: Watch TV _____ Play Video Games _____ On the Computer _____

Name of Child's School: _____ Current Grade Level: _____

Any Concerns Regarding Child's Performance at School: No Yes, _____

Sports/ Exercise: Type: _____ How often? _____

Family History

Do any family members have any of the following conditions? *(Mark all that apply)*

Condition	Mother	Father	Sibling	Grandparent
Alcoholism				
ADD/ ADHD				
Asthma				
Anemia				
Blood Disorder				
Cancer				
Depression/ Anxiety				
Diabetes				
Heart Disease				
High Cholesterol				
High Blood Pressure				
Kidney Disease				
Migraines				
Seizures				
Stroke				
Thyroid Disease				

Please explain all positive responses: _____

_____

Current Problems *(Circle all that apply)*

Constitutional: Fever, Chills Fatigue Unexplained Weight Loss/ Gain Excessive Thirst

Ear, Nose, Throat: Loud Voice, Hearing Problems Mouth Breathing, Snoring Ear Pain Frequent Runny Nose

Respiratory: Cough, Shortness of Breath Chest Tightness, Wheeze

Musculoskeletal: Muscle Pain, Weakness Joint Pain, Swelling Bone Pain

Eye, Skin, Blood: Blurry Vision "Crossed" Eyes Abnormal Bruising, Bleed Squinting Itchy Eyes

Gastrointestinal: Nausea, Vomiting, Diarrhea Constipation, Blood in Stool Abdominal Pain

Cardiovascular: Chest Pain, Palpitations Tires Easily with Exertion Fainting

Genitourinary: Frequent or Painful Urination Bed wetting, Frequent Accidents Vaginal or Penile Discharge

Neurological: Headaches Seizures Clumsiness Milestone Delay

Psychiatric/ Emotional: Anxiety/ Stress Sleep Problem Depression Anger Concern Concerns with attention, Impulsivity

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform Christian Family Medicine, Inc. of any changes in my child's medical status. I also authorize the health care staff to perform the necessary services my child may need.

_____

Signature of patient/parent/guardian Date