Patient Registration

LaRue & LaRue Pediatrics, P.A.

Patient Information Date_____ Chart No. _____

Patient _____ Sex ☐ M ☐ F DoB___/___/___ SS#_____

Mother/Guardian _____ DoB___/___/___ SS#_____

Address _____ Home Phone_____

City/State/Zip _____ Occupation_____

Employer _____ Work Phone_____

Father/Guardian _____ DoB___/___/___ SS#_____

Address _____ Home Phone_____

City/State/Zip _____ Occupation_____

Employer _____ Work Phone_____

Sibling _____ Sex ☐ M ☐ F DoB___/___/___ SS#_____

Sibling _____ Sex ☐ M ☐ F DoB___/___/___ SS#_____

Sibling _____ Sex ☐ M ☐ F DoB___/___/___ SS#_____

Children live with: ☐ Mother ☐ Father ☐ Guardian_____

Emergency Contact Person _____ Relation _____Phone_____

Party Responsible for Payment of Medical Services: ☐ Father ☐ Mother ☐ Guardian ☐ Both_____

How did you hear about our practice? ☐ Referral_____

☐ Friend/Family ☐ Phone Directory ☐ Internet ☐ Newspaper ☐ Magazine ☐ Other_____

Insurance Information

Primary _____ Claims Address_____

Policy # _____ Group #_____Co-payment $_____

Secondary _____ Claims Address_____

Policy # _____ Group #_____Co-payment $_____

Name of Insured _____ DoB___/___/___ Relation_____

Medicaid/Champus/Other _____ Current Card #_____

Physician Listed on Card_____ Phone_____

Authorization of Treatment and Assignment of Benefit

I authorize _____ to treat my child. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to _____for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original. Medical care of immunizations cannot be given unless my child is accompanied by one of the following: _____.

I understand that if my child's physician, or any person by or under the direction and control of my child's physician(s), is directly exposed to my child's body fluids in any manner which may, according to the then current guidelines for the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or hepatitis B or C viruses, that I am deemed by law to have consented to testing for infection with HIV or hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to the release of these test results to the person who is exposed to my child's body fluids.

Parent/Guardian's Signature_____Relationship_____Date_____

Witness' Signature _____ Date_____

☐ I prefer to do my own insurance filing. Signed_____ Date_____

HIPPA Authorization Statement Email Address_____

Complete and sign the section on the back regarding confidential release of information.

Please complete the following so that we may contact you properly and securely.

- Please list the family members or other persons, if any, whom we may inform about your child's general medical condition and diagnose (including treatment, payment and health care operations).

Name_____
Phone_____
Name_____
Phone_____

- Please list the family members or significant others, if any, whom we may inform about your child's medical condition ONLY IN AN EMERGENCY.

Name_____
Phone_____
Name_____
Phone_____

- Please print the address of where you would like your billing statements and / or correspondence from our office to be sent if other than your home.

_____
_____
_____

- Please print the telephone number where you want to receive calls about your appointments, lab and X-ray results, or other health care information if other than your home telephone number.

_____
_____
_____
_____

Please be aware that a cell phone is not a secure and private line.

- Please indicate if you want all correspondence from our office sent in a sealed envelope marked CONFIDENTIAL. ☐Yes ☐No

- Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail? ☐Yes ☐No

_____
PATIENT NAME print (Parent / Guardian, if under 18 years)

_____ Date_____
PATIENT SIGNATURE (Parent / Guardian, if under 18 years)

Notes

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Name of Patient_____ Sex:___Male ___Female DoB__/___/___ Chart # |_____|

Form Completed by _____ Relation to patient _____ Date__/__/__

Family

Are mother and father ☐ married ☐ separated / divorced ☐ other?
If separated / divorced, what is the patient's custody status?_____
_____
If one or both parents are not living in the home, how often does child see that parent(s)?_____
_____
Are there siblings living away from home? ☐ Yes ☐ No
If yes, give name, age and where they live:_____
_____

List all family members living in the patient's home

Name	Relation	Birth Date	Health Problems
		/ /	
		/ /	
		/ /	
		/ /	
		/ /	
		/ /	

_____

Current Medical History

Are immunizations up to date? ☐ Yes ☐ No

Is your child having any medical problems? ☐ Yes ☐ No

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

Current Medications:

Drug Allergies? ☐ Yes ☐ No

_____

Review of Systems and Past Medical History

Does the patient have or has ever had any of the following:	Yes	No	Explain
1. A serious medical problem?	☐	☐	_____
2. Been hospitalized or had surgery?	☐	☐	_____
3. Had a serious injury or accident?	☐	☐	_____
4. Chickenpox? When?_____	☐	☐	_____
5. Allergies, asthma, bronchitis, respiratory infections?	☐	☐	_____
6. Repeated ear infections, tubes, difficulty with hearing?	☐	☐	_____
7. Problems with eyes or vision?	☐	☐	_____
8. Heart problems or a heart murmur?	☐	☐	_____
9. Anemia, bleeding problems or blood transfusions?	☐	☐	_____
10. Abdominal pain, constipation requiring doctor visits?	☐	☐	_____
11. Recurrent vomiting, recurrent diarrhea, blood in stools?	☐	☐	_____
12. Bladder or kidney infections, bed-wetting after 5 yrs.?	☐	☐	_____
13. Recurrent skin problems (acne, eczema, etc)?	☐	☐	_____
14. Headaches, convulsions, other neurological problems?	☐	☐	_____
15. Diabetes, thyroid or other endocrine problems?	☐	☐	_____
16. If Female, has she started her menstrual periods?	☐	☐	_____
If yes, is she having problems?	☐	☐	_____

_____

History Update (date / initial) Changes in history noted in chart on day of update.

_____ ___ _____ ___ _____ ___ _____ ___ _____ ___ _____ ___

_____ ___ _____ ___ _____ ___ _____ ___ _____ ___ _____ ___

Name of Patient_____ Date___/___/___ Chart#_____

Development Are you concerned about the patient's… ☐Yes ☐No

1. Physical development? _____
2. Mental or emotional development? _____
3. Learning ability? _____
4. Attention span or activity level? _____

If in school, has the patient had…

1. Tutoring outside of the classroom? _____
2. Placement in a special or resource class? _____
3. To repeat a grade? _____
4. Educational or psychological testing? _____
5. Behavioral problems? _____

Maternal and Newborn History

Pregnancy Check if the mother had any of the following problems:

☐ Excessive Wt. gain ☐ Urinary infections ☐ excessive swelling ☐ toxemia ☐ rubella ☐ venereal ☐ disease ☐ other ☐ none

_____

_____

Did the mother smoke, use drugs or alcohol during pregnancy? ☐Yes ☐No

Birth

Birth Weight_____ Length_____ Apgar_____ Was baby born at: ☐Term ☐Early ☐ Late

If early, how many weeks gestation?_____ Was labor difficult or prolonged? ☐Yes ☐No

Was delivery difficult or complicated? ☐Yes ☐No _____

_____

_____

Newborn Check if the patient had any of the following problems:

☐ Feeding problems ☐Breast_____ ☐ Formula_____

☐ Slow weight gain ☐Multiple formula changes ☐ Colic ☐ Jaundice ☐ Recurring vomiting ☐ Recurring diarrhea

☐ Blood in stools ☐ Other _____

_____

Family History If a family member had or has had any of the following problems, please list the family member using the Symbol:

M-Mother F-Father S-Sibling GM-Grandmother GF-Grandfather A-Aunt U-Uncle

1. _____ Allergies
2. _____ Anemia/Blood
3. _____ Arthritis
4. _____ Asthma
5. _____ Birth defects
6. _____ Bladder/Kidney
7. _____ Cancer
8. _____ Deafness
9. _____ Diabetes before 50 yrs
10. _____ Drug/Alcohol abuse
11. _____ Drug allergies
12. _____ Ear infections/tubes
13. _____ Eczema
14. _____ Emotional/Behavioral
15. _____ Epilepsy or convulsions
16. _____ Eye or visual problems
17. _____ Heart attack/stroke before 50 yrs
18. _____ Heart problems, other
19. _____ Hereditary problems
20. _____ High blood pressure before 50 yrs
21. _____ High cholesterol
22. _____ Immunity problems/HIV
23. _____ Learning prob./Attent. Span
24. _____ Liver disease
25. _____ Mental illness
26. _____ Mental retardation
27. _____ Migraine Headaches
28. _____ Obesity
29. _____ Respiratory infections
30. _____ Stomach/GI
31. _____ Thyroid or other endocrine prob
32. _____ Tuberculosis
33. _____ Other

Provider Comments

History Reviewed by _____