Patient Registration

Child 1 - Last name:_____ First name_____ MI:____ Sex_____ DOB:_____
Primary Language:_____
Ethnicity: Hispanic/Non-Hispanic/Unknown
Race: White/Black/Hawaiian/Asian

Child 2- Last name:_____ First name_____ MI:____ Sex_____ DOB:_____
Primary Language:_____
Ethnicity: Hispanic/Non-Hispanic/Unknown
Race: White/Black/Hawaiian/Asian

Child 3 - Last name:_____ First name_____ MI:____ Sex_____ DOB:_____
Primary Language:_____
Ethnicity: Hispanic/Non-Hispanic/Unknown
Race: White/Black/Hawaiian/Asian

Mailing Address:
Street:_____City:_____State:_____Zip_____
Home Phone:_____

Billing Address (if different from mailing address):
Street:_____City:_____State:_____Zip_____
Home Phone:_____

Insurance:
Primary Insurance Carrier:_____**ID#**_____**Group#**_____
Primary Insurance Policy Holder:
Last name:_____ First name_____MI:____Sex_____DOB:_____SS#_____

Secondary Insurance Carrier:_____**ID#**_____**Group#**_____
Secondary Insurance Policy Holder:
Last name:_____ First name_____MI:____Sex_____DOB:_____SS#_____

I hereby assign all medical benefits to which I am entitled, including all government and private insurance plans to this office. This assignment will remain in effect until revoked by me in writing. I understand that I am responsible for all charges not paid by insurance. I hereby voluntarily consent to treatment at Stepping Stones Pediatrics and authorize such treatments, examinations, medications, and diagnostic procedures (including, but not limited to the use of lab and radiographic studies as ordered by attending physicians).

Signature of Parent or Legal Guardian: _____Date:_____

IF PARENTS ARE DIVORCED OR SEPARATED, PLEASE FILL OUT THIS SECTION:

Who has custody of the child/children? _____

Are there any legal considerations that might restrict the non-custodial parent from consenting to medical treatment?

YES_____NO_____

If yes, please explain and provide legal documentation that supports that restriction_____

_____

_____

CONTACTS

Parent Contact 1:

Last name: _____ First name_____ MI: _____

Sex_____ DOB: _____SS#_____

Relationship to patient: _____ Resides With Patient?_____

Employer:_____Occupation:_____

Primary Phone:_____ Secondary Phone:_____

Primary Email:_____ Secondary Email:_____

NOTIFICATIONS: How would you prefer to be contacted regarding the following (circle one):

Medical issues: Primary Phone / Secondary Phone / Primary Email / Secondary Email

Appointment Reminders: Primary Phone / Secondary Phone / Primary Email / Secondary Email

Billing Statements: Primary Phone / Secondary Phone / Primary Email / Secondary Email

General Practice Notices: Primary Phone / Secondary Phone / Primary Email / Secondary Email

Patient Portal Notifications: Primary Phone / Secondary Phone / Primary Email / Secondary Email

Parent Contact 2:

Last name: _____ First name_____ MI: _____

Sex_____ DOB : _____SS#_____

Relationship to patient:_____ Resides With Patient?_____

Employer:_____Occupation:_____

Primary Phone:_____ Secondary Phone:_____

Primary Email:_____ Secondary Email:_____

NOTIFICATIONS: How would you prefer to be contacted regarding the following (circle one):

Medical issues: Primary Phone / Secondary Phone / Primary Email / Secondary Email

Appointment Reminders: Primary Phone / Secondary Phone / Primary Email / Secondary Email

Billing Statements: Primary Phone / Secondary Phone /Primary Email / Secondary Email

General Practice Notices: Primary Phone / Secondary Phone / Primary Email/ Secondary Email

Patient Portal Notifications: Primary Phone / Secondary Phone / Primary Email / Secondary Email

Additional Contact Questions:

Which of the provided contacts should receive billing statements? _____

Should both of the provided contacts be able to access patient's records electronically? _____

If not, please specify which of the above contacts should be given access. _____

EMERGENCY CONTACTS: (other than parents)

1: Name:_____Relationship:_____Phone:_____

2: Name:_____Relationship:_____Phone:_____

3: Name:_____Relationship:_____Phone:_____

4: Name:_____Relationship:_____Phone:_____

Family History

Patient's Name:_____

DOB:_____

	Mother Name:	Father Name:	Sibling Name:	Sibling Name:	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other:
No known medical condition									
Age of Death									
Cause of Death									
Alcohol Abuse									
Arthritis									
Asthma									
Birth Defects									
Cancer (type)									
COPD									
Depression									
Diabetes									
Drug Abuse									
Early Death									
Hearing Loss									
Heart Disease									
High Cholesterol									
High Blood Pressure									
Kidney Disease									
Learning Disability									
Mental Illness									
Mental Retardation									
Miscarriages									
Stroke									
Vision Loss									
Other:									
Other:									

Please List additional Siblings and their medical history below:

Patient's Medical History

Please check all that apply

_____ ADD/ADHD
_____ Allergies
_____ Anemia
_____ Asthma
_____ Autism Spectrum disorder
_____ Cancer
_____ Cerebral Palsy
_____ Congenital heart disease
_____ Developmental delay
_____ Diabetes mellitus
_____ Eating disorder
_____ GERD
_____ GYN problems
_____ Headaches
_____ Inflammatory bowel disease
_____ Mental disorder
_____ Otitis Media
_____ Pneumonia
_____ Scoliosis
_____ Seizures
_____ Sickle cell anemia
_____ UTI
_____ Vision problems

Other significant medical history:

_____
_____
_____
_____

Surgical History

Please check all that apply:

_____ Adenoidectomy
_____ Appendectomy
_____ Circumcision
_____ Ear tubes
_____ Fracture surgery
_____ Heart surgery
_____ Inguinal hernia repair
_____ Lymph node biopsy
_____ Tonsillectomy

Other significant surgical history:

_____
_____
_____
_____

Medical Disclosure Authorization

I hereby certify that I am the patient or the legal parent/guardian of:

Patient #1. _____
Patient #2. _____
Patient #3. _____
Patient #4. _____

In addition, I authorize the following person(s) to act as my legal proxy with regard to disclosure of confidential medical information and **authorization of treatment** for the above mentioned patient. I also agree to waive, on behalf of myself, and any of the person(s) listed below, all provisions of law relating to such.

Name:_____ Telephone:_____ Relationship:_____
Name:_____ Telephone:_____ Relationship:_____
Name: _____ Telephone:_____ Relationship:_____

Medical Information/Results May Be Released To:

Name:_____ Telephone:_____ Relationship:_____
Name:_____ Telephone:_____ Relationship:_____
Name: _____ Telephone:_____ Relationship:_____

Financial Information May Be Released To:

Name:_____ Telephone:_____ Relationship:_____
Name:_____ Telephone:_____ Relationship:_____
Name:_____ Telephone:_____ Relationship:_____

I understand that I have the right as the legal parent/guardian of the above mentioned child to amend this proxy listing at any time upon written notification to Stepping Stone Pediatrics.

Signature: _____ **Witness:**_____

Messages:
Please reach me at the following preferred phone number: _____
If I am unavailable to answer calls at this number (please check one):
( ) You may leave a detailed message.
( ) Please leave a message asking me to return your call.
( ) Please do not leave any message.
( ) Other_____

Privacy Practices Notice
Acknowledgment of Receipt

By signing below I acknowledge that I have received a copy of Stepping Stone Pediatrics' Notice of Privacy Practices for protected health information.

Date: _____

Patient #1:

NAME_____DOB_____

Patient #2:

NAME_____DOB_____

Patient #3

NAME_____DOB_____

Patient #4:

NAME_____DOB_____

Signature of Parent:

_____

Relationship to Patient(s):

_____