The PEDIATRIC CLINIC

KIDS are at the heart of everything we do

Annual Patient Registration Update

DOB: _____

Last Name: _____ **First Name:** _____

Address: _____

City: _____ **State:** _____ **ZIP** _____

Primary Phone: _____ **Mobile Phone:** _____

email address: _____

Emergency Contact

Name: _____ **Relationship:** _____

Home Phone: _____ **Mobile Phone:** _____

You are giving permission for us to discuss patient information with this contact.

Insurance Information

You are required to list all medical coverage.

	Primary		**Secondary**
Insurance Co:	_____	Insurance Co:	_____
Policy or ID No:	_____	Policy or ID No:	_____
Policy Holder Name:	_____	Policy Holder Name:	_____
Policy Holder DOB:	_____	Policy Holder DOB:	_____

Authorization

* I understand the payment of charges incurred or my co-payment/deductable as per my insurance contract is due at the time of services, unless prior financial arrangements have been made prior to treatment. I agree and understand to applicable finance charges on any balance over 30 days.

* I acknowledge full financial responsibility for *covered and non-covered services* rendered by The Pediatric Clinic. I further authorize and request that insurance payments be made directly to The Pediatric Clinic.

* I understand that The Pediatric Clinic uses an electronic prescription system which allows prescriptions and related information to be electronically sent between The Pediatric Clinic provider(s) and my pharmacy. I have been informed and understand that The Pediatric Clinic providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my Pediatric Clinic providers to see this health information.

* I understand that not showing up for a scheduled appointment or failure to cancel an appointment with appropriate *4-hour notice will result in a no-show fee charged to my account of $50.*

I have read and fully understand the above consent for treatment, financial responsibility, release of information, insurance authorization, privacy and cancellation policies.

Signature: _____ Date: _____

Printed Name:

Patient Name: **DOB:**

Allergies and Medications

Allergy to Nuts? Yes No **Allergy to Latex?** Yes No

Allergies: ◯ **No Known Drug Allergies**

Allergic to: _____ Reaction: _____ Mild Mod Severe

Allergic to: _____ Reaction: _____ Mild Mod Severe

Allergic to: _____ Reaction: _____ Mild Mod Severe

Allergic to: _____ Reaction: _____ Mild Mod Severe

Pharmacy Name *Arlington Apothecary - Kroger Arlington - Kroger Lakeland - Kroger Oakland - Walmart Oakland -*

Address: _____

Phone number: _____

Current Medications: ◯ **No medications**

Medication name _____ Dose: _____ Freq: _____

Medication name _____ Dose: _____ Freq: _____

Medication name _____ Dose: _____ Freq: _____

Medication name _____ Dose: _____ Freq: _____

Medication name _____ Dose: _____ Freq: _____

Any NEW Diagnosis: *Please circle all that apply* **No NEW History** _____

Acne ADD/ADHD AIDS/HIV Abuse/Domestic Violence Alcohol/Drug Use Allergies/Hayfever Anemia Asthma Autism Bedwetting Birth Defects Bladder/Kidney Problems Blood Diseases Breast Cancer Breast Problems Bronchiolitis/RSV Bronchitis Cancer _____ Chicken Pox Chronic Ear Infections Chronic Strep Throat Congenital Anomalies Cerebral Palsy Depression Developmental/Behavioral Disorders Diabetes Difficulty Swallowing/Eating Probs Ear or Hearing Problems Eczema Eye Problems Glasses/Contacts GI Problems Head Injury/Concussion Headaches Heart Disease Heart Problems Hepatitis Hernia _____ High Cholesterol Hypertension Jaundice Kidney Disorders Learning Disability Leukemia Liver Disease Lupus Menses <11 yrs of age Muscle/Joint/Bone Problems Overweight/Obesity Pneumonia Prematurity <37 wks Psoriasis Recurrent Strep Throat Reflux/GERD Seizures/Convulsions Seizures/Febrile Skin Problems Sickle Cell Disease (Hbg SS/SC) Sickle Cell Trait Sleep Apnea Smoking (active or passive) Speech Delay Speech Disturbance/Stutter Thyroid Problems Hyper/Hypo Tuberculosis Weight Gain (unexplained) Weight Loss (unexplained) Other:

Surgical History:

Procedure: _____ Date: _____

Procedure: _____ Date: _____

Procedure: _____ Date: _____

Procedure: _____ Date: _____