AZKidsDoc Pediatrics

Patient Registration

Date _____

PATIENT INFORMATION

Last	First	MI	Gender ○ Male ○ Female	Age	DOB

Nickname	Preferred Language	Does the parent/legal guardian require an interpreter? ○ Yes ○ No	Student ○ Part-Time ○ Full-Time ○ Home-Schooled

Ethnicity ○ Hispanic or Latino ○ Not Hispanic or Latino ○ Decline to Answer

Race(s) ○ American Indian or Alaskan Native ○ Asian ○ Black ○ Hawaiian Native or Pacific Islander ○ White ○ Decline to Answer

If parents/legal guardians are separated; with whom does the child reside with? _____

MOTHER/ LEGAL GUARDIAN

Last	First	SSN	DOB

Primary Address	City/Town	State	Zip Code

Email	Employer	Occupation

Primary Phone (○ Same as Cell Phone)	Work Phone	Cell Phone

RELATION TO PATIENT ○ Mother ○ Step-Mother ○ Legal Guardian ○ Other_____

FATHER / LEGAL GUARDIAN

Last	First	SSN	DOB

Primary Address (○ Same as above)	City/Town	State	Zip Code

Email	Employer	Occupation

Primary Phone (○ Same as Cell Phone)	Work Phone	Cell Phone

RELATION TO PATIENT ○ Father ○ Step-Father ○ Legal Guardian ○ Other_____

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EMERGENCY CONTACT

Name of Relative/Friend (**Not** living at the same address with Patient)	Phone

PREFERRED CONTACT METHODS

Medical Issues ○ No Contact ○ Mail Address ○ Mother Phone ○ Father Phone ○ Mother Email ○ Father Email

Reminders ○ No Contact ○ Mother Phone ○ Father Phone ○ Mother Email ○ Father Email

Billing Statements ○ Mail Address ○ Mother Email ○ Father Email

Patient Portal ○ No Contact ○ Mother Email ○ Father Email ○ Mother Text to Cell ○ Father Text to Cell

PRIVACY

Contact Privacy Constraints ○ No Restrictions; OK to Leave Messages/Send Mail

○ Restricted: Person-to-Person with: ○ Mother / ○ Father / ○ Patient *and/or* ○ Legal Guardian

○ No Contact

○ Other Restrictions _____

PRIMARY INSURANCE POLICY INFORMATION

Insurance Carrier	Guarantor Name	Patient Relationship to Guarantor ○ Child ○ Other ○ Self
Subscriber ID	Group Number	Group Name

SECONDARY INSURANCE POLICY INFORMATION (If Applicable)

Insurance Carrier	Guarantor Name	Patient Relationship to Guarantor ○ Child ○ Other ○ Self
Subscriber ID	Group Number	Group Name

PREFERRED PHARMACY

Pharmacy Name	Address or Crossroads

HOW DID YOU HEAR ABOUT US?

_____

_____The information provided in this *Registration* is true to the best of my knowledge.
(Initialize)

Continue on next page >>

AZKidsDoc Pediatrics

Patient Health History

Immunization Records Available? ○ Yes ○ No ■ Past Medical Records Available? ○ Yes ○ No ○ Not Applicable

List primary reason(s) for visiting today _____

_____

MEDICAL HISTORY (Indicate any significant current complaints or past medical problems)

GENERAL
- ☐ Cancer
- ☐ Genetic Disease
- ☐ Loss of Appetite
- ☐ Problems Related to Sleep
- ☐ Recent Fevers, Chills or Sweats
- ☐ Significant Weight Loss or Gain
- ☐ Other _____

ENDOCRINE
- ☐ Always Too Cold or Hot
- ☐ Diabetes
- ☐ Early Onset Puberty
- ☐ Excessive Hunger
- ☐ Excessive Sweating
- ☐ Excessive Thirst and Urination
- ☐ Thyroid Problems
- ☐ Other _____

HEMATOLOGICAL
- ☐ Anemia
- ☐ Blood Transfusion
- ☐ Frequent or Easy Bruising
- ☐ HIV/AIDS
- ☐ Trouble Controlling Bleeding
- ☐ Other _____

CARDIO-RESPIRATORY
- ☐ Allergies
- ☐ Apnea (Breathing Stops)
- ☐ Asthma
- ☐ Blueness Around the Mouth
- ☐ Breathing Problems
- ☐ Chest Pain
- ☐ Congestion
- ☐ Coughing
- ☐ Heart Defects/Disease
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Respiratory Syncytial Virus (RSV)
- ☐ Tuberculosis
- ☐ Wheezing
- ☐ Other _____

EYES
- ☐ Cross Eyed or Lazy Eye
- ☐ Decreased Vision or Blurred Vision
- ☐ Double Vision
- ☐ Wears Glasses or Contacts
- ☐ Other _____

GASTROINTESTINAL
- ☐ Constipation or Diarrhea
- ☐ Feeding Problems
- ☐ Gastro-Esophageal Reflux
- ☐ Loss or Change in Bowel Control
- ☐ Nausea and/or Vomiting
- ☐ Stomach Pain or Discomfort
- ☐ Other _____

EARS, NOSE & THROAT
- ☐ Change in Voice
- ☐ Difficulty Swallowing
- ☐ Drooling
- ☐ Ear Infections or Drainage
- ☐ Frequent or Worsening Gagging
- ☐ Hearing Loss
- ☐ Nasal Discharge or Congestion
- ☐ Regurgitation Through Nose
- ☐ Ringing in Ears
- ☐ Snoring
- ☐ Other _____

SLEEP PROBLEMS
- ☐ Excessive Daytime Sleeping
- ☐ Night Terrors
- ☐ Nightmares
- ☐ Sleeplessness
- ☐ Sleepwalking
- ☐ Teeth Grinding
- ☐ Tiredness or Drowsiness
- ☐ Other _____

SKIN
- ☐ Acne
- ☐ Eczema/Rash
- ☐ Sores/Boils
- ☐ Other _____

URINARY
- ☐ Bedwetting
- ☐ Blood in Urine
- ☐ Frequent or Excessive Urination
- ☐ Loss or Change in Bladder Control
- ☐ Pain with Urination
- ☐ Urinary Tract Infections
- ☐ Other _____

MUSCLES AND BONES
- ☐ Broken Bones
- ☐ Excessive Tightness of Muscles
- ☐ Joint Pain or Swelling
- ☐ Muscle Spasms or Cramps
- ☐ Scoliosis - Curvature of Spine
- ☐ Tremors or Tics
- ☐ Uncontrollable Movements
- ☐ Weakness, Excessive Falling
- ☐ Other _____

DEVELOPMENT/BEHAVIOR
- ☐ Anxiety
- ☐ Autism
- ☐ Change in School Performance
- ☐ Changes in Behavior
- ☐ Depression
- ☐ Hyperactivity
- ☐ Lack of Interest in Play
- ☐ Mental Illness
- ☐ Mood Swings
- ☐ Speech Problems
- ☐ Substance Abuse
- ☐ Tantrums
- ☐ Other _____

NEUROLOGICAL
- ☐ Change in Gait or Walk
- ☐ Change in Strength or Coordination
- ☐ Confusion or Disorientation
- ☐ Dizziness with Exercise
- ☐ Dizziness/Light-Headedness
- ☐ Fainting
- ☐ Neck or Back Pain
- ☐ Numbness or Tingling
- ☐ Prior Head Injury
- ☐ Prior Neck Injury
- ☐ Prior Trauma or Abuse
- ☐ Problem with Concentration
- ☐ Problem with Memory
- ☐ Problem with Understanding Speech
- ☐ Problems with Balance
- ☐ Seizures/Epilepsy
- ☐ Staring Spells
- ☐ Tremors
- ☐ Other _____

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MEDICATIONS (If Applicable)

Name of Medication	Dosage	How many times per day?	Date Started	Prescribed By

ALLERGIES (If Applicable)

○ Medication _____ ○ Household Products _____

○ Animals_____ ○ Environment _____

○ Latex ○ Food _____

SURGERY OR HOSPITALIZATION HISTORY (If Applicable)

Date	Surgery or Hospitalization	Date	Surgery or Hospitalization

FAMILY SOCIAL HISTORY

Smoking Exposure at Home? ○ Yes ○ No ■ Attending Day Care? ○ Yes ○ No ■ Diet ○ Meat ○ Vegetarian ○ Vegan

Firearms in House? ○ Yes ○ No ■ Lead Exposure House Built Before 1960? ○ Yes ○ No ■ Parents Work with Lead? ○ Yes ○ No

Last Physical _____ Last Dental Exam _____ Last Eye Exam _____

Are you concerned about your child's behavior or development? _____

_____

Does your child have trouble in school? _____

_____

Do you have any concerns about your child's health?_____

_____

Continued on next page >>

AZKidsDoc Pediatrics

FAMILY HEALTH HISTORY

○ No Known Family Health Problems ■ ○ Unknown, Child Is ○ Adopted ○ Foster

Do parents, siblings, grandparents, aunts, uncles and/or cousins have any of the following? If so, who?

	Condition(s)	Family Member(s)		Condition(s)	Family Member(s)
	ADHD/Attention Problems			Genetic/Metabolic Disorder	
	Alcoholism			Headaches/Migraines	
	Anxiety/OCD			Heart Disease	
	Asthma			Hyperactivity	
	Bipolar Disorder			Hypertension	
	Birth Defects			Learning Disabilities	
	Bleeding/Clotting Disorder			Liver Disease	
	Blind/Deaf			Mental Retardation	
	Brain or Spinal Tumor			Movement Disorders	
	Cancer			Nerve or Muscle Disease	
	Cerebral Palsy			Neurofibromatosis	
	Craniosynostosis			Seizures/Epilepsy	
	Depression			Sleep Disorder	
	Developmental Delays			Spina Bifida	
	Diabetes			Substance Abuse	
	Down Syndrome			Thyroid	
	Early or Sudden Death			Tics/Tourette Syndrome	
	Fears/Phobias			Tuberous Sclerosis	

_____ The information provided in the in this *Patient History* is true to the best of my knowledge.
(Initialize)

Continued on next page >>

AZKidsDoc Pediatrics

Consent To Treat / Authorizations / Attestations

- I am the Parent/Legal Guardian of _____. I have the legal right
  (Name of Patient – Last, First and MI)
  to consent to medical and surgical treatment for this patient. I voluntarily authorize and consent to medical care, treatment, and diagnostic tests that the pediatricians and nurse practitioners at AZKidsDoc Pediatrics believe are necessary for this patient.

- In my absence and in case of emergency, I give my permission to any provider at AZKidsDoc Pediatrics to treat my child (patient).
- I hereby assign all of my or my child's medical benefits including Medicaid, AHCCCS, Private Insurance and other health plans to AZKidsDoc Pediatrics. I hereby authorize AZKidsDoc Pediatrics to apply for benefits on my behalf for covered services rendered or ordered and release any medical or other information necessary to process claims. I request that payment from my insurance company be made directly to AZKidsDoc Pediatrics.
- I understand that I am responsible for all charges regardless of insurance coverage. I agree to pay my account with this office in accordance with the regular rates and payment terms of this office. If my account is referred for collection, I agree to pay reasonable collection expenses including attorney's fees.
- All copays and/or payments are due at the time of the visit.
- In the event that I am entitled to health insurance or other benefits available to cover the costs of treatment provided by this office, I hereby assign those benefits to this office to be applied to my bill.
- I authorize AZKidsDoc Pediatrics to use e-prescribing (electronic prescriptions) to transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and dispensed medication history. I understand that a complete and accurate medication list is essential to effective and safe medical care.
- This office may release records pertaining to my treatment including those that relate to communicable diseases to my insurance company or other third parties responsible for payment of my medical charges.

Consent for Use and Disclosure of Protected Health Information

AZKidsDoc Pediatrics (AKDP) *Notice of Privacy Practices* provides information about how AKDP may use and disclose protected health information (PHI) about your child to carry out treatment, payment and healthcare operations (TPO). You have the right to review our *Notice of Privacy Practices* prior to signing this consent. AKDP reserves the right to revise its *Notice of Privacy Practices* at anytime. If we change our *Notice*, you may obtain a revised copy by contacting our office.

By signing this form, you consent to our use and disclosure of protected health information (PHI) about your child for treatment, payment and health care operations (TPO). You have the right to revoke this consent, in writing, signed by you (Parent/Legal Guardian). However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. AKDP provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

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AZKidsDoc Pediatrics

You, the Parent/Legal Guardian understands that:

1. AKDP has a *Notice of Privacy Practices* and that as the Parent/Legal Guardian you have the opportunity to review the a *Notice of Privacy Practices*.
2. AKDP reserves the right to change the *Notice of Privacy Practices*.
3. The Parent/Legal Guardian has the right to restrict the uses of their child's information but AKDP does not have to agree to those restrictions, except in certain limited instances.
4. The Parent/Legal Guardian may revoke this *Consent* in writing at any time and all future disclosures will then cease.

- With my consent, AKDP may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out health care operations, such as appointment reminders, insurance items and any call pertaining to my child's clinical care, including laboratory results among others.
- With my consent, AKDP may mail to my home or other designated location any items that assist the practice in carrying out health care operations, such as patient statements, collection letters and any other correspondence or related material.
- However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.
- By signing this form, I am consenting to AKDP's use and disclosure of my child's PHI to carry out TPO.
- I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, AKDP may decline to provide treatment to my child.
- I have received and reviewed a copy of AZKidsDoc Pediatrics' *Notice of Privacy Practices Policy*.

A copy of this consent may be used in place of the original *Consent to Treat* and *Acknowledgement of Notice of Privacy Practices* and will remain in effect as long as my child remains a patient at this practice or until I withdraw my consent.

_____ _____

Print Name Signature of Parent / Legal Guardian

_____ _____

Relationship to Patient Date

Thank you for choosing AZKidsDoc Pediatrics.

Note: This *Consent* will remain in effect until you notify us of a change.

AZKidsDoc Pediatrics

Request for Release of Medical Records **TO** AZKidsDoc Pediatrics

Patient's Last Name	**First Name**	**M.I.**	**Birthdate**

Release **FROM** _____ Fax _____

Address _____

Release **TO:** AZKidsDoc Pediatrics • 15215 South 48th Street, Suite 110 • Phoenix, AZ 85044 • (480) 783-8964

Method of Delivery: Mail Paper (Pick up)
Fax (480) 783-8967 Email: kids@azkidsdoc.com

Information Requested: Clinic Visit Notes Immunization Records Lab Reports
X-Ray Reports Other (Specify): _____

☐ All information regarding care received by patient between the dates of _____ and _____

Certain information is covered by additional protection and requires specific authorization. To authorize release or discussion of the following type of information, the Patient or Parent/Legal Guardian of the Patient named above must initial and date each item. If the item is NOT initialed and dated, the information, if such information exists, cannot be released or discussed.

Initial	Date		From	To
_____	_____	HIV/STD Related Information	_____	_____
_____	_____	Communicable Disease Related Information	_____	_____
_____	_____	Alcohol and Drug Abuse Related Information	_____	_____
_____	_____	Mental Health Diagnosis/Treatment Information	_____	_____
_____	_____	Genetic Testing	_____	_____

I authorize the release of photocopies of the following medical records to the possession or control to AZKidsDoc Pediatrics, the physicians and their employees and/or agents.

I hereby release you, your physician and your employees from any kind of liability for fulfilling the authorization request for release of medical information. The consent will expire 90 days after the signed date below. I have given my consent freely, voluntarily and without coercion.

I may revoke this authorization at any time providing I notify you in writing to that effect. I understand that any releases which were made prior to my revocation in compliance with this authorization at any time providing I notify you in writing to that effect.

I understand that any releases which were made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality.

I understand that a photocopy/facsimile of this authorization is considered acceptable in lieu of the original.

_____

Patient or Parent/Legal Guardian Signature **Date**

_____

Patient or Parent/Legal Guarding Print **Relationship to Patient**