AZKidsDoc Pediatrics

New Patient Registration

Date _____

PATIENT(S) INFORMATION

☐ Male
☐ Female

First MI Last DOB

☐ Male
☐ Female

First MI Last DOB

☐ Male
☐ Female

First MI Last DOB

Preferred Language ☐English ☐Spanish ☐Other_____ **Translator Needed?** ☐Yes ☐No

Ethnicity
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Decline to Specify

Race(s)
☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African-American
☐ Hawaiian Native or Pacific Islander
☐ White
☐ Decline to Specify

PARENT / LEGAL GUARDIAN 1

Last First SSN DOB

Primary Address City/Town State Zip Code

Email Employer Occupation

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

RELATION TO PATIENT(S) ☐ Mother ☐ Father ☐ Legal Guardian ☐ Other _____

PARENT / LEGAL GUARDIAN 2

Last First SSN DOB

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

Email Employer Occupation

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

RELATION TO PATIENT(S) ☐ Mother ☐ Father ☐ Legal Guardian ☐ Other _____

AZKidsDoc Pediatrics

New Patient Registration

If parents/legal guardians are divorced or separated, please fill out this section:

Who has custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child(ren) or from obtaining information about the child's medical treatment ☐ Yes ☐ No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

_____

_____

Settlement/financial responsibilities, such as divorce, must be resolved between the parents. We do not get involved with these issues.

EMERGENCY CONTACT

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

PREFERRED CONTACT METHODS

Medical Issues ☐ Parent 1 Phone ☐ Parent 2 Phone ☐ Parent 1 Email ☐ Parent 2 Email

Appointment Reminders ☐ Parent 1 Phone ☐ Parent 2 Phone ☐ Parent 1 Email ☐ Parent 2 Email ☐ Patient Portal

Patient Portal ☐ Parent 1 Email ☐ Parent 2 Email ☐ No Contact

PRIVACY

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

☐ Restricted: Person-to-Person with: ☐ Parent / Legal Guardian *and/or* ☐ Self/Patient

☐ No Contact

☐ Other Restrictions _____

PREFERRED PHARMACY

Pharmacy Name Address or Crossroads

INSURANCE

Primary Insurance_____ Secondary Insurance _____

Guarantor Name _____ Guarantor Name _____

Subscriber ID # _____ Subscriber ID # _____

Group # _____ Group # _____

HOW DID YOU HEAR ABOUT US?

Would you like to receive emails from AZKidsDoc Pediatrics for patient and practice communication only? ☐ Yes ☐ No

AZKidsDoc Pediatrics

Patient Health History

Name _____ DOB: _____

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 /Insomnia
- ☐ 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 _____

Continued on next page >>

AZKidsDoc Pediatrics

Patient Health History

Name _____ DOB: _____

MEDICATIONS CURRENTLY BEING TAKEN (If Applicable)

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

ALLERGIES (If Applicable)

☐ Medication _____

☐ Household Products_____

☐ Animals _____

☐ Environment _____

☐ Food _____

Latex ☐ Yes ☐ No

SURGERY OR HOSPITALIZATION HISTORY (If Applicable)

Date	Surgery or Hospitalization	Date	Surgery or Hospitalization

Last Physical _____ Last Dental Exam _____ Last Eye Exam _____

Any concerns about your child's behavior or development? _____

_____

Does your child have any trouble in school? _____

_____

Any concerns about your child's health? _____

_____

AZKidsDoc Pediatrics

Patient Health History

Name _____ DOB: _____

FAMILY SOCIAL HISTORY

Smoking Exposure at Home? ☐ 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

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	

Any other information that the doctor should be aware of? _____

_____

_____

_____

DWAYNE ST. JACQUES, MD, PLLC • 15215 South 48th Street, Suite 110 • Phoenix AZ 85044-9137

AZKidsDoc Pediatrics

Consent To Treat, Financial Policy and Notice of Privacy Practices Agreement

_____ _____
Name of Child DOB

_____ _____
Name of Child DOB

_____ _____
Name of Child DOB

_____ Consent To Treat

Initial

I hereby consent and authorize the performance of all appropriate procedures and course of treatments, the administration of immunizations, anesthetics, and any and all medications which in the judgment of my provider be considered necessary or advisable for my child(ren)'s diagnosis and/or treatment.

_____ Financial Policy

Initial

- **ALL COPAYMENT, COINSURANCE AND DEDUCTIBLE AMOUNTS ARE DUE AT THE TIME OF SERVICE IS RENDERED.**
- AZKidsDoc Pediatrics' ("AKDP") *Financial Policy* ("Policy"), available at front desk, provides detailed information about AKDP's financial policies. You have the right to review our *Financial Policy* prior to signing this consent.
- I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at AKDP. I am responsible for any applicable deductible, co-insurance or co-payments prior to the provision of services.
- AZKidsDoc Pediatrics may file a claim for payment with my insurance company as required by contractual agreement. If the insurance company fails to pay AKDP in a timely manner fro any reason, then I understand I will be responsible for prompt payment of all amounts owed to AKDP. Should the account be referred to a collection agency or attorney for collection, the undersigned shall pay all costs of collection, including reasonable attorney's fee.
- A $25.00 fee will be applied to your account should your check be returned by the bank as unpaid.
- There is a $25.00 fee for FMLA forms or any physician dictated letters that need to be completed for personal use by the physician.
- The billing department and/or office manager handle financial matters, not the doctor. Please direct your questions accordingly.
- Settlements/financial responsibilities, such as divorce, must be resolved between the parents. We do not get involved with these issues.

_____ Responsibility To Provide Proof Of Insurance

Initial

I understand that it is my responsibility to provide AZKidsDoc Pediatrics with a copy of my child's current insurance card. If I do not have insurance, I will be considered a Self-Pay patient and I am financially responsible for the total amount of the services provided. I will notify AZKidsDoc Pediatrics immediately upon any change in my insurance.

_____ Protected Health Information (PHI) Acknowledgement

Initial

AZKidsDoc Pediatrics *Notice of Privacy Practices* ("Notice"), available at front desk, provides information about how AKDP may use and disclose protected health information 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.

I acknowledge that I have been offered a copy of the AZKidsDoc Pediatrics' *Notice of Privacy Practices*. I understand that I many revoke this authorization at any time by giving written notification to the office. I understand that I am responsible to read the *Notice* and notify AKDP, in writing, of any request for restrictions in the use or disclosure of my child's individually identifiable health information. I understand the notice included electronic access to my child's medical history. AKDP has the right to revise this *Notice* at anytime and will post a copy of the current *Notice* in the office in a visible location at all times and on their website at www.AZKidsDoc.com. AKDP will provide me with a copy of its most recent *Notice* upon my request.

_____ No-Show/Cancellation Policy

Initial

Effective August 13, 2018, we began implementing a "no-show" policy, which will affect all patients who do not keep their scheduled appointment or who cancel an appointment with less than a 24-hour notice.

- First occurrence –Parent/Patient will receive a notice advising of our policy.
- Second occurrence – Parent/Patient will receive a 2nd notice and a $25.00 no-show fee assessment
- Third and subsequent occurrences – May result in dismissal from practice and additional $25.00 no-show fee

Exceptions will be made case-to-case basis.

Acknowledgement

By signing this *Form*:

- You further acknowledge and understand that you accept the terms outline in each of the above terms and conditions.
- As guarantor of the patient, you agree to pay for all services rendered in accordance with the terms and conditions set forth in the *Financial Policy*.
- You agree to all the information listed above, authorize the release of any medical information necessary to process your child(ren)'s claims and authorize payment of medical benefits to Saguaro Pediatrics, AZKidsDoc Pediatrics and/or Dwayne St. Jacques, MD, PLLC.

_____ _____

Print Name | Signature of Parent / Legal Guardian

_____ _____

Relationship to Child(ren) | Date

Thank you for choosing AZKidsDoc Pediatrics.

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

AZKidsDoc Pediatrics

Request for Release of Medical Records TO AZKidsDoc Pediatrics

_____ _____
Name of Child DOB

_____ _____
Name of Child DOB

_____ _____
Name of Child DOB

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**