

Kidz Pediatrics
 728 North Raleigh St, Suite A-1
 Angier, NC 27501-9134
 Ph (919) 639-9995 Fax (919) 639-3518

PATIENT PROFILE Registration

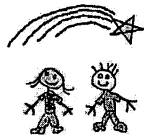
Patient Name _____	Today's Date _____
Address _____	Patient D.O.B. _____
City/Zip _____	Social Security _____
County _____	
Email address _____	Sex: M / F Adopted: Yes / No
Tel 1 _____	home cell work other
Tel 2 _____	home cell work other
Tel 3 _____	home cell work other

HEALTH INSURANCE INFO:

Primary Subscriber Policy Holder (include middle initial for patient & subscriber):

Name _____	Social Security _____
Address _____	Subscriber D.O.B. _____
_____	Policy Number _____
Insurance _____	Policy Group # _____
Employer _____	Policy Effective Date _____

**Please provide a COPY of Insurance Card
 also keep the office informed of ALL NEW CHANGES (phone/address/new insurance cards)**



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PATIENT PROFILE Registration

Acceptance of Privacy Policies

Patient Name: _____ Date of Birth _____

PATIENT PRIVACY PRACTICES

By signing below, I am acknowledging that I have received a copy of the "Kidz Pediatrics' Privacy Policy". *

I understand it is my responsibility to read, understand and abide by the policies presented to me.

PATIENT BILL OF RIGHTS

By signing below, I am acknowledging that I have received a copy of "Kidz Pediatrics' Patient Bill Of Rights". *

I understand it is my responsibility to read, understand and abide by the policies presented to me.

PATIENT RESPONSIBILITIES

By signing below, I am acknowledging that I have received a copy of "Kidz Pediatrics' Patient Responsibilities". *

I understand that it is my responsibility to read, understand and abide by the policies presented to me.

FINANCIAL RESPONSIBILITY

I understand that I am responsible for payment of this account and hereby assume and guarantee prompt payment of all expenses incurred. I am also aware that certain services may not be covered by my insurance carrier and Kidz Pediatrics will make every effort to inform me of these services, in the event these services are not covered. I will be solely responsible for payment of these services. I further understand that payment and copayment is due at the time of service. I give permission to Kidz Pediatrics to bill my insurance company on my behalf, and understand that any outstanding balance, after the insurance company has paid, will be my responsibility. In the event that my account becomes past due, there may be penalty charges and my account can be turned over to a collection agency and I will be responsible for any additional fees and penalties for such service.

CONSENT TO TREAT AND RECEIVE VACCINATION(S)

By signing below, I am consenting to treatment of myself, or dependent, by Kidz Pediatrics and receive vaccinations. I understand that my/their medical information may be viewed or shared amongst the staff of Kidz Pediatrics and their business associates. Every effort will be made to protect my privacy in accordance with the HIPPA regulations.

PERMISSION TO RELEASE MEDICAL INFORMATION

By signing below, I authorize Kidz Pediatrics to release information from my child's medical record, to my/their insurance company, third party payers or their reviewing agencies. This information will be limited to that which is necessary to expedite claim processing. This authorization is valid for every visit to Kidz Pediatrics until written notice revoking this authorization is provided.

* These policies are available for review at the office and furnished upon request.

Legal Guardian or Patient Signature

Date signed



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PATIENT PROFILE Registration
 Authorization When Parent/Guardian Is Not Present

I, THE PARENT/LEGAL GUARDIAN HEREBY GIVE PERMISSION TO:
 (Family/friends must be over 18 years of age and ID will be required at time of service):

	Full name	Relationship	Driver's License or ID#
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

TO BRING MY CHILD/CHILDREN TO KIDZ PEDIATRICS, P.A. AND TO RECEIVE MEDICAL TREATMENT AND ADVICE DURING MY ABSENCE.

	Child/Children's Name	Date of birth
1.	_____	_____
2.	_____	_____
3.	_____	_____

I am also providing my current insurance information along with my copayment or full payment for the services rendered. I also understand if Kidz Pediatrics is unable to obtain payment from my insurance, I am responsible for payment in full for services rendered to my child/children while under the care of above named person.

I also give permission for Kidz Pediatrics, P.A., to obtain any medical records from any previous physician/facility pertaining to the above named child/children.

Parent/Legal Guardian's Signature	Print Name (first/middle/last)	Date signed
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Witness Signature (Kidz Pediatrics staff)	Date signed
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PATIENT PROFILE Medical History

Patient Name: _____ Date of birth _____

PREGNANCY AND DELIVERY INFORMATION

How many pregnancies has patient's mother had _____ Live births _____ Stillborn _____ Miscarriages _____
 Were there any complications or infections during the pregnancy or at the time of delivery: _____

Smoking _____ cigarettes per day Alcoholic drinks per week _____ Any Drugs/Medicine _____
Where was patient born? _____ Cesarean / Natural / Forceps(Vacuum)
 Medication to mother during labor _____ Group B Strep: + / -
 Birth weight _____ Length _____ APGARs _____ / _____ Days in hospital _____
 Born at _____ weeks Hearing test: Passed / Failed R / L
 Newborn issues Jaundice Feeding Problems Vomiting Blueness Needed oxygen Fever
 Seizures Breathing problems Blood transfusions Other: _____

PATIENT'S PAST MEDICAL HISTORY

Previous medical clinic/physician: _____

Date of last physical: _____

Has patient been hospitalized Yes / No If yes, for what and when _____

Previous surgeries _____

Has patient ever been or is currently being treated for the following illnesses

Mumps	Hepatitis	Measles	Whooping cough (Pertussis)	Chicken Pox (Date) _____	Broken bones
Ear infections	Pneumonia	Head Injury	Urine infection	Allergies	Skin problems
Lead poisoning		Behavior problems	Learning problems	Developmental problems	Headaches
Reflux		Seizures	Heart murmur	Depression/anxiety	Vision problems
Hearing problems		Other		Diabetes	Speech problems
					Cancer

Medications (including over-the-counter, natural (herbal), etc.): _____

Medication allergies: _____ **Type of reaction:** _____

Food/Fruit allergies: _____ **Type of reaction:** _____

Is patient being seen by any specialist? (if yes, please explain) _____
 Where _____

SOCIAL HISTORY

Mother: Age: _____ Occupation: _____

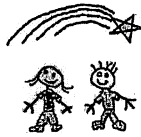
Father: Age: _____ Occupation: _____

Who lives in the home (list first name & age) _____

Pets (inside/outside) _____ Does anyone smoke Inside/outside _____

Primary language _____ Daycare Y / N Religious preference _____

If there is a history of patient smoking, do you need a referral to stop Y / N



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PATIENT PROFILE Medical History

Patient Name: _____ Date of birth: _____

FAMILY HISTORY (Please indicate the relationship to the child, Maternal/Paternal side)

Diabetes _____	Kidney/Urinary Disease _____
Cancer _____	Mental Illness _____
Seizures _____	Developmental Delay _____
Allergies/Asthma _____	Heart Disease/Stroke _____
Bleeding problems _____	High Blood Pressure _____
Lung Disease _____	Lead Poisoning _____
Learning Problems _____	Sickle Cell Disease _____
Behavior Problems _____	Immune/Autoimmune Disease _____
Other: _____	

SAFETY INFORMATION

Seat belt/car seat used	Yes / No	Cigarette smoking	Yes / No
Firearms at home	Yes / No Locked? Yes/No	Domestic violence	Yes / No
Working smoke detectors	Yes / No	Wears a helmet when riding a bike	Yes / No
Where are the medicines kept	_____	Where are cleaning solutions kept	_____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship _____

Phone Number _____

May we leave test results on your home voicemail or answering machine/fax _____ Yes / No

May we leave test results on your cell phone voicemail _____ Yes / No

Any restrictions to where we may leave lab results _____

How did you hear about Kidz Pediatrics _____

Do you have any concerns or questions for the doctor today _____

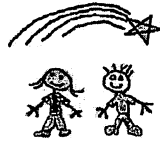
By signing below, I hereby certify that the information furnished on this form is complete, true and accurate to the best of my knowledge.

Sign & Print _____ Relationship _____

Revised by Staff _____ Date Signed _____

AUTHORIZATION REQUEST OF MEDICAL RECORDS

Please Mail/Fax
Information to:



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Name of previous clinic/doctor _____ Nombre de clinica/doctor anterior
Address _____ Direccion
City/State/Zip code _____ Ciudad/Codigo postal
Tel/Fax _____ Tel/Fax

I give permission for the release of medical record information or disclose protected health information for:

Patient Name _____ Nombre de Paciente
Date of Birth _____ Fecha de Nacimiento
(mm/dd/yy) (Mes/Dia/Año)
Social Security Number _____ Numero Seguro Social
Dates of care from/to _____ Fechas de cuidado medico
Purpose of Disclosure _____ CONTINUED MEDICAL CARE _____ Por la razon de

Check ONE of the following choices:

- A complete copy of my medical records OR
 Specified protected health information necessary for continued treatment: (Check all that apply)
 Immunizations History & Physical Examination Growth Charts
 Labs & X-Ray Reports Specialist Consultation
 Other (specify) _____

I understand the medical information to be disclosed may include psychological or psychiatric impairment, a communicable disease (such as sexually transmitted disease, HIV/Aids, tuberculosis or hepatitis), mental illness, alcohol or substance abuse. I understand that I may revoke this authorization at any time except to the extent that the information has already been released pursuant to this authorization and before I have revoked my authorization. I have taken the time to read and think about the content of this authorization form and agree with all statements made in this authorization. I understand that treatment will not be conditioned upon my completion of this authorization. This authorization will automatically expire 90 days from date signed.

(Si usted no comprende estos detalles, pida que alguien se los expliquen antes de firmar)

With my signature, I hereby certify and attest that I am the duly authorized personal representative of the above patient and that I have the lawful authority to enter into this authorization on behalf of such patient. I have read the provisions set forth in this authorization and agree that the above listed medical facility may disclose the medical record information requested above of such patient for the purposes set forth herein.

Signed by / Firmado por

Print Name/Nombre en imprenta

Date/Fecha

Relation to Patient / Parentesco

Tel No.