HUNTINGTON PLAZA PEDIATRIC GROUP

PATIENT REGISTRATION FORM
Thank you for completing in full

DATE: _____

PERSONAL DATA:

CHILD'S NAME: _____ DOB: _____ SEX:
(Last) (First) (Middle)

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ HOME PHONE: _____

PARENT #1 NAME: _____ Date of Birth: _____ SS# _____

Occupation: _____ Work Phone: _____ Cell Phone: _____

PARENT #2 NAME: _____ Date of Birth: _____ SS# _____

Occupation: _____ Work Phone: _____ Cell Phone: _____

Child's parents are: Married: _____ Divorced: _____ Never married: _____ Separated: _____ Widow(er): _____ Other _____

SIBLINGS:

Name	Date of Birth	Name	Date of Birth

If child is from a previous relationship:

OTHER PARENT(S) NAME: _____ Date of Birth: _____

Occupation: _____ Work Phone: _____

Custody relationship: _____

EMERGENCY CONTACT _____ PHONE _____

INSURANCE INFORMATION:

Name of Insurance Company: _____

Address of Insurance Company: _____

Who is the Policy Holder? _____ DOB: _____

ID #: _____ Group #: _____

PLEASE BE SURE TO HAVE OUR FRONT OFFICE COPY YOUR CURRENT INSURANCE I.D. CARD. IT IS YOUR RESPONSIBILITY TO NOTIFY US OF ANY CHANGES. THANK YOU

HUNTINGTON PLAZA PEDIATRIC GROUP

PATIENT REGISTRATION FORM
Thank you for completing in full

MEDICAL HISTORY

NAME: _____

DATE OF BIRTH:_____ PLACE OF BIRTH:_____

BIRTH WEIGHT:_____ BIRTH LENGTH: _____

PROBLEMS: (E.G. JAUNDICE, PREMATURITY)

_____

FAMILY HISTORY:

DIABETES	YES	NO	COMMENTS _____
SEIZURES	YES	NO	COMMENTS _____
ALLERGIES	YES	NO	COMMENTS _____
HEART DISEASE	YES	NO	COMMENTS _____
HIGH BLOOD PRESSURE	YES	NO	COMMENTS _____
ELEVATED CHOLESTEROL	YES	NO	COMMENTS _____
CANCER	YES	NO	COMMENTS _____

DEVELOPMENTAL HISTORY (if applicable) At what ages did the following occur?

Sat up without help _____Fed Self _____ Crawled _____ Bladder Control _____

Walked _____ Bowel Control _____ Spoke 1st words _____ Dressed Self _____

Used simple sentences _____Was child breast or bottle fed?_____Any problem? _____

HEALTH AND MEDICAL HISTORY (if applicable)

Childhood Illnesses (Fill in circle if yes-note frequency & age)

O Multiple Ear Infections_____ 0 Tubes in Ears_____
O Asthma _____ 0 Allergies (to what?) _____
O Seizures (when was last one?) _____

Please list & describe any other important injuries, illnesses, major operations or developmental problems & when they occurred:
Please list medications child is currently taking and what they are being taken for:

Name of Medication, for What
_____

Has vision been examined?_____ Results: Does child wear glasses?_____ At what age were they prescribed?_____

Has hearing been tested? _____ Results:_____ Does child wear hearing aid? _____ At what age was it prescribed?____

HUNTINGTON PLAZA PEDIATRIC GROUP

PATIENT REGISTRATION FORM
Thank you for completing in full

I hereby authorize examination and whatever services deemed necessary by Huntington Plaza Pediatric Group.

I have read and understand the office policies. I hereby authorize all insurance benefits to be paid directly to Huntington Plaza Pediatric Group for services rendered. I understand that I am financially responsible for charges as designated by my insurance company (e.g. deductibles, coinsurances and co-pays). I am also responsible for charges not covered by insurance, including but not limited to, school or camp forms, emergency medications administered in the office, telephone management, and finance fees incurred on unpaid balances. I authorize Huntington Plaza Pediatric Group to release information to my insurance company when requested. I have also received a copy of my privacy notice that describes how medical information about my child may be used and disclosed and how I can access this information.

Name of Guarantor/Parent

Signature

Date

Name of Child

Name of Child

Name of Child

Name of Child

Name of Child

HUNTINGTON PLAZA PEDIATRIC GROUP

PATIENT REGISTRATION FORM
Thank you for completing in full

As a courtesy to our patients we submit incurred charges to individuals' health care carriers. If we do not receive payment from your carrier of choice, you become responsible for all incurred charges. We do not bill secondary insurances and all co-pays are due at time of service.

By signing below you acknowledge that you have read and understood our billing and collection protocol.

I _____ understand that I am ultimately responsible for all incurred charges.

Patient's name:_____ DOB: _____

Patient's name:_____ DOB: _____

Patient's name:_____ DOB: _____

Signature: _____ Date: _____