

REGISTRATION FORM – PEDIATRICS

PATIENT INFORMATION

CHILD'S – Last Name		First Name (Full legal name)	Middle Name
Date of Birth	<input type="checkbox"/> Boy <input type="checkbox"/> Girl	Social Security # <i>(if applicable)</i>	Race <i>(for statistical use only)</i>
Child's Pediatrician <i>(First and Last Name)</i>			
Did this doctor refer you? <input type="checkbox"/> Yes <input type="checkbox"/> No		If NO , please list First and Last Name of referring doctor:	

RESPONSIBLE PARTY INFORMATION

MOTHER'S – Last Name		First Name	Middle Name
Home Phone	Work Phone	Cell Phone	Date of Birth
Home Address		City	State
Occupation	Employer Name	Employer Address	
FATHER'S – Last Name		First Name	Middle Name
Home Phone	Work Phone	Cell Phone	Date of Birth
Home Address		City	State
Occupation	Employer Name	Employer Address	

MARITAL STATUS OF PARENTS:

IF DIVORCED/SEPARATED, CHILD LIVES PRIMARILY WITH:

Married Separated Divorced Other

Mother Father Other *(please explain)*

Please use the following space to explain any "other" information we may need to know:

INSURANCE INFORMATION

Primary Insurance Company	Contract Number	
Subscriber's Full Name + Date of Birth	Employer's Name	Group Number
Secondary Insurance Company	Contract Number	
Subscriber's Full Name + Date of Birth	Employer's Name	Group Number
Tertiary Insurance Company	Contract Number	
Subscriber's Full Name + Date of Birth	Employer's Name	Group Number

Automobile Claim: *Please ask to speak with our billing department before your appointment.*

SIGNATURE REQUIRED ON BACK →

UROLOGIC CONSULTANTS, P.C.
ADULT AND PEDIATRIC UROLOGY

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Our Financial Policy

We are dedicated to providing the best possible care to your family, and we want you to completely understand our financial policies.

1. Payment is due at the time of service unless arrangements have been made in advance by your carrier. We accept Cash, Check, Visa, MasterCard and Discover.
2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor; in other words, if you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurance, we will refund any overpayment to you.
3. We have made prior arrangement with many insurance companies and other health plans to accept any assignment of benefits. We will bill them, but you are required to pay a co-payment and/or deductible at the time of your visit.
4. If you are insured by a plan that requires services to be authorized by your Primary Care Provider, you will be responsible for obtaining the authorization prior to your appointment. Should you request medical treatment from our practice without authorization from your Primary Care Provider, you will be responsible for payment at the time of service.
5. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you on an unassigned basis. This means the insurer will send the payment directly to you. Therefore, our charges for your care are due at the time of service.
6. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
7. We will bill your insurance company for all services provided in the hospital. You are responsible for any balance due.
8. I understand according to the State of Michigan, Department of Health, Act 488 of 1988 that if a health care professional in this practice sustains a cutaneous, mucous membrane or open wound exposure to blood or other body fluids from myself that a HIV and Hepatitis-B (BBV blood test will be performed).
9. I authorize payment of medical benefits by the insured directly to Urologic Consultants, P.C. I also request payment of government benefits directly to the party who accepts assignment.

PATIENT'S NAME: _____

DATE: _____

SIGNATURE OF GUARDIAN: _____

DATE: _____

UROLOGIC CONSULTANTS, P.C.
PRELIMINARY PATIENT QUESTIONNAIRE FOR CHILDREN

PATIENT'S NAME: _____ BIRTHDATE: _____ TODAY'S DATE _____

REFERRING PHYSICIAN:

First and Last Name: _____

Address: _____

Have any other family members been seen at Urologic Consultants? Yes No

If yes, please list name and relationship _____

What is the reason for your visit? Include appropriate dates: _____

Was your child born at full term? Yes No
If no, how many weeks early _____

What was your child's birth weight? _____

Did your child spend any time in neonatal? Yes No

Has your child ever had a urinary tract infection? Yes No

Has your child ever had any blood in the urine? Yes No

Has your child ever had urinary tract stones? Yes No

Has your child had any prior kidney x-rays or ultrasounds? Yes No

Does your child have any daytime wetting? Yes No In diapers

Does your child have any nighttime wetting? Yes No In diapers

Immunizations up to date? Yes No

What medications does your child take? _____

What allergies to medications does your child have? _____

What operations has your child had? _____

What hospitalizations has your child had? _____

What medical problems does your child have? _____

Is there anything else we should know? _____

(OVER)

UROLOGIC CONSULTANTS, P.C.
REVIEW OF SYSTEMS

Constitutional Symptoms

Poor growth Yes No
Other _____

Eyes

Poor vision Yes No
Other _____

Allergic/Immunologic

Hay fever Yes No
Drug allergies Yes No
Other _____

Psychologic

Attention deficit Yes No
Hyperactivity Yes No
Other _____

Endocrine

Excessive thirst Yes No
Diabetes Yes No
Other _____

Neurological

Seizures Yes No
Other _____

Integumentary

Skin rash Yes No
Other _____

Musculoskeletal

Joint pain or swelling Yes No
Other _____

Respiratory

Wheezing or asthma Yes No
Chronic cough Yes No
Other _____

Hematologic/Lymphatic

Swollen glands Yes No
Blood clotting problem Yes No
Other _____

Cardiovascular

Heart murmurs Yes No
Congenital heart disease Yes No
Other _____

Gastrointestinal

Abdominal pain Yes No
Nausea/vomiting Yes No
Constipation Yes No
Other _____

FAMILY HISTORY/SOCIAL HISTORY

How many brothers and sisters? _____
Grade in school? _____
Current weight _____

Birth Order _____
Sports? _____
Current height _____

Is there a family history of cancer? Yes No
Is there a family history of kidney disease? Yes No
Is there a family history of kidney stones? Yes No
Is there a family history of bleeding problems? Yes No

Who does the child live with? Mother Father Both Grandparents Other _____

I give Urologic Consultants permission to give medical treatment to _____
Name of patient

Signature of Parent or Legal Guardian _____ Date _____