REGISTRATION FORM – PEDIATRICS

**Please complete all boxes** **PT #****Acct\_Account -** **PP\_LastName**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PEDIATRIC PATIENT** | | | | | | | | | | | |
| CHILD’S – Last Name | | | | First Name (Full legal name) | | | | | Middle Name | | |
| CHILD’S – Mailing Address City State Zip | | | | | | | | | CHILD’S - Home Phone | | |
| Date of Birth | | Sex | | Social Security # (if applicable) | | | | | Race (for statistical use only) | | |
| Child’s Pediatrician (First and Last Name)  Dr. | | | | Did this doctor refer you?  🞏 Yes 🞏 No | | | | | | | |
| **INSURANCE** | | | | | | | | | | | |
| Primary Insurance Company | | | | | Patient’s Contract Number / Group Number | | | | | | |
| Subscriber’s Full Name + Date of Birth | | | | | Employer’s Name | | | | | Subscriber Number/Group | |
| Secondary Insurance Company - Copay | | | | | Patient’s Contract Number / Group Number | | | | | | |
| Subscriber’s Full Name + Date of Birth | | | | | Employer’s Name | | | | | Subscriber Number/Group | |
| Tertiary Insurance Company | | | | | Patient’s Contract Number / Group Number | | | | | | |
| Subscriber’s Full Name + Date of Birth | | | | | Employer’s Name | | | | | Subscriber Number/Group | |
| **Automobile Claim:** *Please ask to speak with our billing department before your appointment.* | | | | | | | | | | | |
| **RESPONSIBLE PARTY** | | | | | | | | | | | |
| MOTHER’S – First and Last Name Email | | | | | | | | | | | |
| Home Address 🞏 Same as child? | | | City | | | | | State | | | Zip |
| Home Phone | Work Phone | | Cell Phone | | | | Date of Birth | Social Security# *(required)* | | | |
| Occupation | Employer Name and Address | | | | | | | | | | |
| father’s– First and Last Name Email | | | | | | | | | | | |
| Home Address 🞏 *Same as child?* | | | City | | | | | State | | | Zip |
| Home Phone | Work Phone | | Cell Phone | | | | Date of Birth | | Social Security# *(required)* | | |
| Occupation | Employer Name and Address | | | | | | | | | | |
| marital status of parents:  🞏 Married 🞏 Separated 🞏 Divorced □ Other | | | | | | IF DIVORCED/SEPARATED, CHILD LIVES PRIMARILY WITH:  🞏 Mother 🞏 Father 🞏 Other *(please explain)* | | | | | |
| Please use the following space to explain any “other” information we may need to know: | | | | | | | | | | | |

Pt # Acct\_Account

**Patient Financial Policy**

In order to promote understanding between our patients and the practice, we have implemented the following financial policy. If you have questions about the policy, please ask to speak with someone in the billing department. We are committed to providing the best possible care and service to you and your complete understanding of your financial responsibilities are a key element in providing that service. If you have questions about whether or not we participate with your insurance, please contact our office prior to your appointment. For questions about your insurance coverage, please contact your insurance company prior to your appointment. It is always best to ask questions about your insurance coverage prior to having services performed.

For all services rendered to minor patients, we will hold the parent or guardian responsible for expenses incurred.

*Often we will perform surgical procedures and lab work that will require an outside laboratory for processing. We will bill your insurance company for the interpretation of this and a separate statement will be sent to you for any amount not paid by your insurance company.*

Patients With Insurances We Participate with:

* Insurance companies require us to collect your co-pay at the time of service.  Please be prepared to meet your insurance co-pay requirements at the time of service, or we will need to reschedule your appointment.  We accept Cash, Check, Money Order, Care Credit, Visa, MasterCard, Discover and American Express.
* A copy of your current insurance card must be provided at each visit in order to file a claim to your insurance company.
* You will be responsible for any coinsurance or deductibles that your insurance requires.
* Your insurance policy is a contract between you and your insurance company in which the doctor is not involved.
* We will file an insurance claim with your insurance company if you provide us with your current insurance card at your visit.
* Please note: Because a service “is covered” by insurance, does not necessarily mean that your insurance company will pay for the service. Many insurance policies have deductibles that need to be met before they will pay for services. If you are unsure if you have such a policy, please contact your insurance company prior to your visit.
* If you fail to notify us of an insurance change, you will be fully responsible for any amount not paid by your insurance company.
* 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.

Patients With Insurances We Do Not Participate with:

* If you have received out-of-network authorization for services at our practice, it is your responsibility to obtain any out-of-network authorization that is needed from your insurance company.  If authorization is not received prior to services, you will be required to reschedule your appointment.
* A copy of your current Insurance card must be provided at each visit in order to file a claim to your insurance company.

Self-Pay Patients:

* I understand that payment is due, in full at the time of my appointment.  We accept Cash, Check, Money Order, Care Credit, Visa, MasterCard, Discover and American Express.
* Urologic Consultants participates with a medical credit card plan called, “Care Credit”.  Please ask to speak with our billing department for more information about the payment plan options through Care Credit.

Other:

* 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.
* I understand that there will be a $25.00 fee for all returned checks.
* I also 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, an HIV and Hepatitis-B (BBV blood test) will be performed.

PATIENT’S SIGNATURE: DATE:

**SIGNATURE OF GUARDIAN: DATE:**

**Pt #****Acct\_Account**

**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)

# Pt #Acct\_Account

# UROLOGIC CONSULTANTS, P.C.

# REVIEW OF SYSTEMS

## *Constitutional Symptoms Integumentary*

Poor growth ❑ Yes ❑ No Skin rash ❑ Yes ❑ No

Other Other

## *Eyes Musculoskeletal*

Poor vision ❑ Yes ❑ No Joint pain or swelling ❑ Yes ❑ No

Other Other

## *Allergic/Immunologic Respiratory*

Hay fever ❑ Yes ❑ No Wheezing or asthma ❑ Yes ❑ No

Drug allergies ❑ Yes ❑ No Chronic cough ❑ Yes ❑ No

Other Other

## *Psychologic Hematologic/Lymphatic*

Attention deficit ❑ Yes ❑ No Swollen glands ❑ Yes ❑ No

Hyperactivity ❑ Yes ❑ No Blood clotting problem ❑ Yes ❑ No

Other Other

## *Endocrine Cardiovascular*

Excessive thirst ❑ Yes ❑ No Heart murmurs ❑ Yes ❑ No

Diabetes ❑ Yes ❑ No Congenital heart disease ❑ Yes ❑ No

Other Other

## *Neurological Gastrointestinal*

Seizures ❑ Yes ❑ No Abdominal pain ❑ Yes ❑ No

Other Nausea/vomiting ❑ Yes ❑ No

Constipation ❑ Yes ❑ No

Other

### FAMILY HISTORY/SOCIAL HISTORY

How many brothers and sisters? Birth Order

Grade in school? Sports?

Current weight 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

**UROLOGIC CONSULTANTS, P.C.**

#### Patient Acknowledgement

I hereby acknowledge that I have reviewed **Urologic Consultants Notice of Privacy Practices**. I further understand that a copy of the Notice of Privacy Practices is available to me upon my request.

Patient’s Name: Acct\_FullName #Acct\_Account

Signature (Parent if Minor): **X**

##### RELEASE OF INFORMATION

🞎 Check box if we may leave messages on your answering machine.

I hereby grant permission to Urologic Consultants, P.C. to release my protected health information to the following family members and/or friends who may be involved in my care:

**🗦 PLEASE PRINT 🗧**

* Spouse (Name)
* Other (Name/Relation)
* Other (Name/Relation)

***NOTE: Information will automatically be released to parents of patients who are under the age of 18 unless otherwise indicated. Please list names below of parent(s) who should NOT receive protected information. You must also present legal documentation of non-rights for any persons listed.***

Name(s)/Relation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recorded by:

**(FOR OFFICE USE ONLY)**

# Accounting of Disclosures: *(for purposes other than treatment, payment and health care operations)*

## Date Requesting Party Information Provided Purpose

Appt\_Date / Appt\_Resource

**PATIENT HISTORY SHEET DOS:** **Appt\_Date**

**UC Dr: Appt\_Resource**

**pcp: dr. PC\_FullName Primary Referring: Dr.** **PR\_FullName**

**INS:** **PI\_Name SUBSCRIBER:** **PI\_Subscriber**

**PI2\_Name PI2\_Subscriber**

**PT Name:** **Acct\_FullName** Patient#: Acct\_Account

SEX: Acct\_Sex

ADDRESS: Acct\_Address1 Acct\_Address2

Acct\_CityStateZip

DOB: Acct\_DOB

HOME PH: Acct\_HPhone WORK PH: Acct\_WPhone

MOM: DAD:

**CHIEF COMPLAINT:**

Location Quality Mod Factors Duration Context

Severity Timing Assoc signs/symptoms

**PRESENT ILLNESS:**

**PAST HISTORY:**

* ALLERGIES:
* OPERATIONS:
* HOSPITALIZATIONS:
* MEDICATIONS:
* MEDICAL PROBLEMS: