NEW PATIENT RECORD

Date_____

ALL CHILDREN'S NAMES SEX OF CHILDREN DATES OF BIRTH

_____ S.S.#_____

_____ S.S.#_____

_____ S.S.#_____

_____ S.S.#_____

_____

Father's Name _____ Soc. Sec. # _____ Home Phone _____

Mother's Name_____ Soc Sec. # _____ Home Phone _____

Mother's Maiden Name_____ Place of Birth _____

Financially Responsible Party's Name _____
(NOT INSURANCE COMPANY)

Address _____ City _____

State _____ Zip Code _____

Bus. Phone _____ Home Phone _____

Responsible Party's Employer _____

Address _____ Zip Code _____

Husband's Occupation _____

Employer's Address _____ Phone _____

Wife's Occupation _____

Employer's Address _____ Phone _____

In Emergency Notify _____ Phone _____
(FRIEND OR RELATIVE)

Referred By _____

Insurance Co. Name _____

Insured's Name _____ ID# _____ Group# _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Scottsdale Pediatric Ctr. P.C. for services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Scottsdale Pediatric Ctr. P.C. to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request the payment of authorized benefits be made on my behalf.

Patients: _____
Please print all children's names

Parent/Guardian: _____ _____ Date: _____
Please print Signature

PATIENT REGISTRATION

NAME	M F DATE OF BIRTH	DATE
STREET ADDRESS	CITY STATE, ZIP	PHONE ( )
SCHOOL	REFERRED BY	

PEDIATRIC - PATIENT QUESTIONNAIRE

Completed by..... Relation .....

Please check [Y] yes or [N] no, circle or explain where required. N/A-Not Applicable

Reason for today's visit •

Previous medical care • Dr. Dental Care [Y] [N] _____ Eye Exam [Y] [N] _____

PREGNANCY & BIRTH

Mother's age at pregnancy? _____

Any illness during pregnancy? [Y] [N] _____

Medications during pregnancy? [Y] [N] _____

(exclude vitamins & iron) _____

Smoking • alcohol • street drugs • during pregnancy? _____

Was baby early • late • on time? _____

Type of delivery? _____ Birth weight _____ Length _____

Complications? [Y] [N] _____ Apgar _____

Problems with baby at birth? Breathing [Y] [N] Jaundice [Y] [N]

Other _____

Problems soon after? Nursery or home? _____

PAST MEDICAL HISTORY

Allergic reactions? Medicine [Y] [N] Food [Y] [N] Animals [Y] [N]

Insect bites [Y] [N] _____

Medications taken on a regular basis? (exclude vitamins) _____

Immunizations • up to date? [Y] [N] Do you have a record? [Y] [N]

Hospitalizations • (when•where•why?) _____

_____

Serious injuries (when•where?) _____

Red Measles	[Y] [N]	Mumps	[Y] [N]	German Measles (3 day)	[Y] [N]
Chicken Pox	[Y] [N]	Whooping Cough	[Y] [N]	Rheumatic Fever	[Y] [N]
Scarlet Fever	[Y] [N]	Recurrent Ear Infect(s) (3 or more)	[Y] [N]	Throat	[Y] [N]
Asthma/Wheezing	[Y] [N]	Eczema/Hives	[Y] [N]	Seizures	[Y] [N]
Anemia	[Y] [N]	Hepatitis	[Y] [N]	Problems with • hearing	[Y] [N]
Bleeding Tendency	[Y] [N]			vision	[Y] [N]
Blood Transfusions	[Y] [N]	Other _____			

FEEDING & NUTRITION

Food Allergies

Appetite usually good? [Y] [N]

Colic or feeding problems during the first 3 months? [Y] [N]

Breast Fed? [Y] [N] Number of month's? [Y] [N]

Formula? [Y] [N] Current brand? _____

Vitamins? [Y] [N] Brand _____ Fluoride? [Y] [N]

Special Diet? [Y] [N] _____

FEEDING & NUTRITION

Parents • Married? ☐ Separated? ☐ Divorced? ☐

Father's age? Highest school grade? _____ Health? _____

Mother's age? Highest school grade? _____ Health? _____

_____

_____

_____

FAMILY MEDICAL HISTORY

List all blood relatives of your child who have had the following problems.

Anemia/Blood Dis _____

Asthma _____

Mental Retardation _____

Drug Problem _____

Alcoholism _____

Cancer _____

Aids _____

Cystic Fibrosis _____

Musc. Dystrophy _____

Tuberculosis _____

Arthritis _____

Epilepsy / Seizures _____

Heart Disease _____

High Blood Pressure _____

_____

Cholesterol Problem _____

_____

Migraine _____

Sudden Infant Death _____

Birth Defects _____

Early Deafness _____

Diabetes _____

DEVELOPMENT & BEHAVIOR

Age at which child •

Sat alone_____ Walked_____ Used sentences _____

Toilet trained_____ Bicycled _____

Development compared to other children?

_____

Grade in school___ Problems in School? [Y] [N]

_____

Learning problems? [Y] [N]

Getting along with other children? [Y] [N]

Behavior problems? [Y] [N]

Bad habits? _____ Bedwetting? [Y] [N]

Nail biting? [Y] [N] Sleeping? [Y] [N] Hobbies • sports • social activities? _____

Use of street or illegal drugs? [Y] [N]

_____

SYNOPSIS

_____

_____

_____

_____

REORDER # 99-07984

10200 N. 92nd St. - Suite 120
Scottsdale, Arizona 85258

TEL (480) 860-1161
FAX (480) 860-4306

SCOTTSDALE PEDIATRIC CENTER, P.C.

Patient Consent for Use and Disclosure of Protected Health Information

With your consent, Scottsdale Pediatric Center, P.C. may use and disclose protected health information (PHI) about you to carry out treatment, payment and health care operations (TPO). Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures. You have the right to review our Notice of Privacy Practices prior to signing this consent. We reserve the right to revise our Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to our Privacy Officer at 10200 N. 92nd St., Suite 120, Scottsdale, Arizona 85258.

With your consent, Scottsdale Pediatric Center, P.C. may call your home or office and leave a message in reference to any items that assist the practice in carrying out TPO such as appointment reminders, insurance items and any call pertaining to your clinical care.

With your consent, Scottsdale Pediatric Center, P.C. may mail to your home or office any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements.

You have the right to request that we restrict how we use or disclose your PHI to carry out treatment, payment and health care operations. However, we are not required to agree to your requested restrictions, but if we do, we are bound by our agreement.

By signing this form, you are consenting to our use and disclosure of your PHI to carry out treatment payment and health care operations. This consent may be revoked in writing except to the extent that we may have already made disclosures in reliance upon your prior consent. <u>If you decline to sign this consent, we may decline to provide treatment for you.</u>

Signature of Patient or Legal Guardian _____

Patient's Name _____ Date _____

Print Name of Patient or Legal Guardian _____

4/14/03

REORDER # 03-09572