Pediatric Registration Pack

Patient Information

Patient Name:_____Date of Birth:_____Today's Date:_____

Age:____ Female_____ Male_____ Email:_____

Address_____City_____

State____ Zip_____ Home Phone:_____ Alternate phone _____

Alternate Contact Name and Phone Number:_____

Who do you give permission to bring your child to our office for treatment?_____

Child's Previous Doctor(s):_____

Referred by: _____

Health Insurance Information

Primary Insurance_____Policy Number_____Group Number_____

Policy Holder's Name:_____Policy Holder's Date of Birth:_____

Policy Holder's Name of Employer:_____Employer: _____
Phone:_____ Insurance Phone#: _____

Insurance Billing Address_____City_____Zip_____

Payment Policy: If you have current insurance coverage Sacred Circle Health Care Clinic will be happy to bill your primary insurance for you. If you do not have current insurance then 100% of all doctor visits, other treatments, pharmacy and dental fees are due at the time of services. We accept cash and/or credit cards as payment.
Cancellation Policy: Last minute cancellations of scheduled appointments are challenging to fill, wasteful of an opportunity for another patient and costly to the clinic. We therefore require changes or cancellations to be made at least 48 hours prior to your schedule appointment.
I understand that I am financially responsible for all charges regardless of insurance coverage and/or treatment outcome. I further understand that 100% of fees are due at the time of services are rendered and that all sales are final.

Parent/Guardian Signature:_____ Print Name:_____

Date:_____

CONCERNS: What are the Top Three Health Concerns for your Child today?

1)_____

2)_____

3)_____

Current Medications:_____

Allergies to Medications:_____ **Other Known Allergies**_____

BIRTH HISTORY

Where was your child born:_____ **Hospital Name:**_____ **Other Place:**_____

Any problems with pregnancy or birth? Yes No Describe_____

Birth Weight_____ **Was your child breastfed? Yes No How long?**_____

HEALTH HISTORY **Has your child had any of the following conditions in the past or currently?**

- ◯ Allergies
- ◯ Asthma
- ◯ Bladder or Urinary infections
- ◯ Chickenpox
- ◯ Ear Infection
- ◯ Eczema
- ◯ Rashes
- ◯ Heart Problems
- ◯ Colic
- ◯ Seizures
- ◯ Headaches
- ◯ Bronchitis
- ◯ Strep Throat
- ◯ Constipation
- ◯ RSV
- ◯ Pneumonia
- ◯ Abdominal pain
- ◯ Bed Wetting
- ◯ Bladder/stool control
- ◯ Weight gain or loss
- ◯ Anemia

VACCINATION HISTORY **Which of the following immunizations has your child had?**

- ◯ DTaP
- ◯ DT
- ◯ Tetanus Only
- ◯ Hepatitis A
- ◯ Chickenpox
- ◯ MMR (Measles, Mumps and Rubella)
- ◯ Polio
- ◯ Hepatitis B
- ◯ HPV
- ◯ Pneumococcal conjugate
- ◯ Meningococcal
- ◯ HIB

HOSPITAL HISTORY

Has your child ever had to be admitted to a hospital?

Hospital:_____ **Age:**_____ **Reason:**_____

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Development and Behavior

Is your child developing as you expect: Yes No Explain:_____

Is your child's language skills as you expect: Yes No Explain:_____

Does your child have special limitations: Yes No Explain:_____

Does your child wear a seat belt or car restraint? ◯ **Always** ◯ **Frequently** ◯ **Occasionally** ◯ **Rarely**

FAMILY HISTORY

Please identify the race of your family:

◯ Asian or Pacific Islander ◯ Black/African American ◯ Hispanic ◯ American Indian ◯ White

DO YOU FEEL LIKE YOU LIVE IN A SAFE PLACE ◯ Yes ◯ No

Do you feel that you have enough food supplies for you and your children ◯ Enough ◯ Less than enough

In the past year have you ever felt threatened in your home? ◯ Yes ◯ No

In the past year has your partner or other family member pushed, punched, kicked or hurt you? ◯ Yes ◯ No

What kinds of guns do you have in your home? _____

Are the guns in your home locked up? ◯ Yes ◯ No

Does anyone in your home smoke? ◯ Yes ◯ No Do any relatives/friends smoke? ◯ Yes ◯ No

In the house? ◯ Yes ◯ No In the Car ◯ Yes ◯ No

How strong are your family's religious beliefs or practices? ◯ Strong ◯ Moderate ◯ Minimal

Do you read to or with your children on a regular basis? ◯ Yes ◯ No

How often does your family eat meals together? ◯ Often ◯ Occasionally ◯ Rarely ◯ Never

Does your family have a medical history of any of the following?

◯ High blood pressure	**◯ Learning Problems**	**◯ Drug Problems**
◯ Diabetes	**◯ Nerve Problems**	**◯ Seizures**
◯ Lung Problems (Asthma)	**◯ Mental Illness**	**◯ Cancer**
◯Heart Problems	**◯ Drinking Problems**	**◯ Other _____**

PARENT HISTORY

The child's Parents are: ◯ Married ◯ Single ◯ Divorced ◯ Other_____

Do you use babysitting? ◯ Yes ◯ No Does your child attend day care? ◯ Yes ◯ No

SCHOOL NAME: _____ Grade _____ Teacher _____

Any concerns about school performance? ◯ Yes ◯ No

Describe: _____

The information I have provided is accurate and true to the best of my knowledge.

Parent/Guardian Signature:_____Date:_____

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability and Accountability Act of 1996, HIPAA), I have certain rights to privacy regarding my children's protected health care information. I understand that the information can and will be used to:

- Conduct, plan and direct my treatment and follow-up amount the multiple health care providers who may be involved in the treatment of my children directly and indirectly
- Obtain payment from third party payers
- Conduct normal health care operations such as quality assessments and physician certifications

I have received, read and understand the Sacred Circle Health Care Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to changes its Notice of privacy Practices from time to time and that I may contact the organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my children's private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree that you are bound to abide by such restrictions.

Patient Name:_____ **Birthdate:**_____

Relationship to Patient: _____

Signature:_____ **Date:**_____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:
Date:_____**Signature:**_____

Reasons:_____

_____

Medical Minor Consent Form

Dear Parent or Legal Guardian,

Since your child(ren)_____ is/are a minor(s),
(Patient name)

it becomes necessary that a signed permission is obtained from a parent or legal guardian before any medical services can be started and accomplished by any Doctors or Medical Assistants associated with Sacred Circle HealthCare. Authorization is hereby granted to do an examination, and provide medical care instructions as deemed necessary. Following a consultation, authorization is hereby granted to administer any applicable treatment, and perform such operations or otherwise treat my child as it may be deemed necessary and or advisable. I also give permission to provide my child with emergency care if needed. I further understand that this consent will remain in effect until such time that I choose to terminate it. I understand that I accept responsibility for payment of services rendered. I certify the truth of the information given. I also authorize the release of pertinent information to those persons requiring it for treatment of my child or for the purpose of payment of the account or credit references.

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Signed: _____ Date: _____

Printed Name: _____

Additional Children:

1._____ **5._____**

2._____ **6._____**

3._____ **7._____**

4._____ **8._____**

PARENTAL PREAUTHORIZATION FOR MEDICAL CARE TO CHILDREN

For families who are ongoing patients of the Sacred Circle Health Care, it may be more convenient to have prior authorization for medical care delivered to minors without a parent having to be present during treatment. Please review the following authorization for treatment and complete the information if you want to authorize such treatment in advance.

AUTHORIZATION

I (we) request and authorize the Practice and its personnel to deliver medical care to my (our) child listed below:

Name: _____ Date of birth: _____

Please try to contact me (us) regarding the healthcare of my (our) child at the following number(s):

Parent's name: _____

Phone (office/home): _____

Parent's name: _____

Phone (office/home): _____

Other (relationship): _____

Phone (office/home): _____

Signature: _____

Date: _____

Print name and relationship: _____

NOTE: *If any special parental or custodial relationship (such as custody with one parent only, legal custody/guardians with no parent, etc.) is in place, please explain in the space below with your signature, printed name, and a phone number at which you can be contacted.*

_____

_____

_____

Signature: _____

Printed name: _____

Phone: _____