sgh PEDIATRICS

**PATIENT REGISTRATION**
**(Please print clearly)**

**Patient Information** Date of Birth:_____

First Name: _____ Middle Name:_____ Last Name: _____

Race/Ethnicity: _____ Sex: ☐ Male ☐ Female Primary Phone Number: _____

Address (Street, City, State, and Zip Code): _____

**Parent Information**

Mother's Full Name: _____ Mother's Date of Birth: _____

Mother's Cell Number: _____ Mother's Work Number: _____

Address (if different than Patient's): _____

Mother's Email: _____ Employer: _____ Occupation: _____

Father's Full Name: _____ Father's Date of Birth: _____

Father's Cell Number: _____ Father's Work Number: _____

Address (if different than Patient's): _____

Father's Email: _____ Employer: _____ Occupation: _____

**Sibling Names and Dates of Birth:**

_____

_____

**Who can we thank for referring you to our practice or how did you hear about SGH Pediatrics?**

_____

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Phone 817-375-5755 Fax 817-375-5788

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**Patient Name: _____ Patient DOB: _____**

**Primary Pharmacy Information**

Name: _____ Phone Number: _____

Address: _____

**Birth History**

Hospital of Birth: _____ Number of weeks pregnant: _____ Type of delivery: _____

Problems or complications around birth? _____ Did baby go home with you? ☐ Yes ☐ No

Birth Weight: _____ Discharge Weight: _____

Feeding (please circle one): **Breast** **Bottle** **Both** If bottle, which formula are you using? _____

**Patient's History**

Any known allergies? ☐ Yes ☐ No If yes, please explain: _____

Is your child on any medications? ☐ Yes ☐ No If yes, please list them: _____

_____

Has your child ever had surgery? ☐ Yes ☐ No If yes, please provide age/date and type of surgery: _____

_____

Has your child ever been hospitalized? ☐ Yes ☐ No If yes, please provide age/date and explain: _____

_____

**Family Medical History**

List below any of the **PATIENT'S** immediate relatives (mother, father, siblings, grandparents, aunts, and uncles) who have had any of the following illnesses:

| Condition | No | Yes | Family Member(s) | Explain/Specify/Comments |
|---|---|---|---|---|
| Allergies (Specify) | | | | |
| Anemia | | | | |
| Asthma, Emphysema, TB | | | | |
| Birth Defects (Specify) | | | | |
| Blood Disease | | | | |
| Cancer (Specify) | | | | |
| Drug/Alcohol Use | | | | |
| Ear/Nose/Throat Disorder | | | | |
| Heart Disease | | | | |
| Infections (Frequent/Severe) | | | | |
| Kidney/Liver Disease | | | | |
| Learning Problems | | | | |
| Mental Illness/Retardation | | | | |
| Metabolic/Genetic Disease | | | | |
| Nerve Disorder (Epilepsy, C.P.) | | | | |
| Rheumatic Fever | | | | |
| Sickle Cell Trait | | | | |
| Thyroid Disease | | | | |
| Other | | | | |

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**Patient Name: _____ Patient DOB: _____**

## Consent for treatment and understanding of financial responsibility

The patient agrees to general medical treatment by SGH Pediatrics and understands and consents to the review and use of his/her medical records by SGH Pediatrics. All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. However, it is understood and agreed to, that the patient is responsible for all fees, including remainder of deductibles, regardless of insurance coverage. It is customary to pay for services when rendered, unless other arrangements have been made in advance. *****SGH Pediatrics does not accept Medicaid*****

I hereby authorize SGH Pediatrics to furnish information concerning my medical condition and treatment thereof to insurance carriers. I also assign insurance benefits paid on my behalf by any and all insurance companies that cover the expenses I incur as the result of any diagnostic services or treatment provided to me by SGH Pediatrics. I further agree that this authorization to release information and assignment of benefits shall remain in effect unless and until it is revoked in writing by me.

**Parent/Guardian Name (Printed): _____ Relationship to patient: _____**

**Parent/Guardian Signature: _____ Date: _____**

## Consent for care – Parent Substitute

**(Complete this section for people that you would like to be able to bring your child in without a parent/guardian present)**
**(The below individuals must be 18 years of age or older)**

I, (parent/guardian's name) _____, give permission for:

Name: _____ Relationship to Child: _____

Name: _____ Relationship to Child: _____

Name: _____ Relationship to Child: _____

Name: _____ Relationship to Child: _____

Name: _____ Relationship to Child: _____

to bring my child, (child's name) _____, for his/her appointments.

Please give them any instructions and/or prescriptions that may be needed.

In case of emergency, I can be reached at (Contact Number) _____.

## HIPPA Acknowledgement

1. I hereby acknowledge that I have been presented with a copy of SGH Pediatrics notice of privacy practices.
2. I hereby acknowledge that I have been presented with a copy of the SGH Pediatrics Office Proctocol Handout and understand my responsibilities.

**Parent/Guardian Name (Printed): _____ Relationship to patient: _____**

**Parent/Guardian Signature: _____ Date: _____**

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**Authorization to release protected health information**
**To: SGH Pediatrics**

**Patient Name: _____ Patient DOB: _____**

I, the undersigned, authorize the release of or request access to the information specified below from the medical record(s) of the above named patient(s), which is called "Protected Health Information" under a federal health privacy law, as described below:

**The Protected Health Information will be used for the following purposes:**
**____** Continuation of care ____ Insurance Application _____ billing records
____ History & Physical ____ Transfer of Care ____ Other (description) _____

**Specific Description of the Information to be used or disclosed (including service date(s):**
**____**All Medical records ____Newborn Records (Hospital Name) _____
_____ Shot record only _____Other _____

**Persons or Class of Persons Authorized to Make the Use of Disclosure:** SGH Pediatrics

The above information may be released (FROM) _____
Specify Name of title of individual or the name of the organization from which records are to be released and the appropriate address.

_____
Doctor, Hospital, Insurance Company, Self, etc. Phone Number

_____
Address (Street, City, State, Zip Code)

**I understand that if the person or entity that receives this information is not a health plan or healthcare provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law.**
**I understand that I may revoke this authorization at any time by notifying SGH pediatrics in writing. However, if I chose to do so, I understand that my revocation will not affect any action taken by SGH Pediatrics before receiving my revocation. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in the health plan, or eligibility for benefits.**

Parent/Guardian Signature Relationship to patient Date

Office Representative Initials: _____ Date Completed: _____

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**Patient Agreement**

I acknowledge that I have read and understand the policies and procedures of SGH Pediatrics as outlined in this document. I agree to adhere to the specific policies of SGH Pediatrics. I am aware that if I do not comply with the above stated guidelines, SGH Pediatrics reserves the right to terminate care with the office.

**Parent/Guardian Name (Printed): _____ Relationship to patient(s): _____**

**Parent/Guardian Signature: _____ Date: _____**

**Patient Name(s)/DOB:**

_____

_____

_____

_____

_____

_____

_____

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