Pinecone Pediatrics Patient Registration
(PLEASE PRINT CLEARLY)

Patient's Legal Name: _____
Last First Middle

Address: _____
Street Apt. #

_____
City State Zip

Date of Birth (Mo./Day/Year): _____ Age: _____ Sex (circle): M F

Best contact #: (_____)_____ Cell #: (_____)_____ Home #: (____)_____

Email: _____ Referred by: _____

Parent/Legal Guardian: _____	Parent/Legal Guardian: _____
Relationship to patient: _____	Relationship to patient: _____
Address (if different): _____	Address (if different): _____
Birthdate: _____	Birthdate: _____
Employer: _____ SS#:_____	Employer: _____ SS#:_____
Preferred Contact #: _____	Preferred Contact #: _____
Consent to leave message: YES/NO	Consent to leave message: YES/NO

Parents Marital Status: Married/Divorced/Single/Widowed/Other _____

Insurance Information

Primary Insurance Carrier: _____

Member ID #: _____ Group #: _____

Policy Holder Name: _____ DOB: _____ Relationship to Patient : _____

Secondary Insurance Carrier: _____

Member ID #: _____ Group #: _____

Policy Holder Name: _____ DOB: _____ Relationship to Patient : _____

- Insurance Disclaimer: I understand that it is my responsibility to provide all insurance information to Pinecone Pediatrics for proper billing. If any insurance information is withheld including any other insurance for the patient, I understand that I will be financially responsible for charges incurred during this time. _____
Initials
- Secondary Coverage: I understand that is it my responsibility to disclose any other coverage that may be in addition to the primary coverage. I agree that I have completed coordination of benefits with both coverages to determine which coverage is designated as primary and secondary based on the insurance rules. Failure to do so may result in claim denials and/or rejections and incurred charges will be my responsibility to pay. _____
Initials

I agree that the above is true and correct to the best of my knowledge. I understand that the office policy is that the parent who requests treatment for the child is responsible for the costs associated with services rendered. I acknowledge that I have read and agree to the Pinecone Pediatrics Statement of Financial Responsibility.

Print Name (Parent): _____ Relationship to Above Patient: _____

Signature of Parent: _____ Date: _____

Initial History Questionnaire

Patient Name:_____

Form Completed By: Date:

Birth Date:_____ Age:_____

Household

Please list all those living in the child's home.

Name	Relationship to child	Birthdate	Health problems

Are there siblings not listed? If so, please list their names, ages, and where they live. _____

_____

What is the child's living situation if not with both biological parents?

◯ Lives with adoptive parents ◯ Joint custody ◯ Single custody

◯ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

_____

Birth History ◯ Don't know birth history

Birth weight _____ Born at term?_____ or _____weeks. Was the delivery: ◯ Vaginal ◯ Cesarean

If cesarean, why? _____

Was initial feeding ◯Formula ◯Breast milk How long breastfed? _____

Did your baby go home with mother from hospital? _____

Were there any prenatal or neonatal complications? ◯Yes ◯No

Explain:_____

Was NICU stay required? ◯Yes ◯No

Explain:_____

During pregnancy, did mother

Use tobacco? ◯Yes ◯No Drink Alcohol? ◯Yes ◯No Use drugs or medications? ◯Yes ◯No Prenatal vitamins? ◯Yes ◯No

What_____When_____

General

Do you consider your child to be in good health? ◯Yes ◯No

Explain:_____

Does your child have any serious illnesses or medical conditions? ◯Yes ◯No

Explain:_____

Has your child had any surgery? ◯Yes ◯No

Explain:_____

Has your child ever been hospitalized ◯Yes ◯No

Explain:_____

Is your child allergic to medicine or drugs? ◯Yes ◯No

Explain:_____

Do you feel your family has enough to eat? ◯Yes ◯No

Explain:_____

Are there any guns in the home? ◯Yes ◯No If yes, are they locked safely away from your child's reach? ◯Yes ◯No

Biological Family History

Have any family members had the following?

Childhood hearing loss	◯Yes ◯No	Who: _____	Comments:_____
Nasal allergies	◯Yes ◯No	Who: _____	Comments:_____
Asthma	◯Yes ◯No	Who: _____	Comments:_____
Tuberculosis	◯Yes ◯No	Who: _____	Comments:_____
Heart disease (before 55 years old)	◯Yes ◯No	Who: _____	Comments:_____
High cholesterol/needs medication	◯Yes ◯No	Who: _____	Comments:_____
Anemia	◯Yes ◯No	Who: _____	Comments:_____
Bleeding disorder	◯Yes ◯No	Who: _____	Comments:_____
Cancer (before 55 years old)	◯Yes ◯No	Who: _____	Comments:_____
Liver disease	◯Yes ◯No	Who: _____	Comments:_____
Kidney disease	◯Yes ◯No	Who: _____	Comments:_____

Biological Family History (continued from previous page)

Diabetes (before 55 years old)	◯Yes ◯No	Who: _____	Comments:_____
Bed-wetting (after 10 years old)	◯Yes ◯No	Who: _____	Comments:_____
Obesity	◯Yes ◯No	Who: _____	Comments:_____
Epilepsy or convulsions	◯Yes ◯No	Who: _____	Comments:_____
Alcohol abuse	◯Yes ◯No	Who: _____	Comments:_____
Drug abuse	◯Yes ◯No	Who: _____	Comments:_____
Mental illness/depression	◯Yes ◯No	Who: _____	Comments:_____
Developmental disability	◯Yes ◯No	Who: _____	Comments:_____
Immune problems, HIV, or AIDS	◯Yes ◯No	Who: _____	Comments:_____
Tobacco use	◯Yes ◯No	Who: _____	Comments:_____

Additional family history: _____

_____

Past History

Does your child have, or has your child ever had,

Chickenpox	◯Yes ◯No	When: _____
Frequent ear infections	◯Yes ◯No	Explain: _____
Problems with ears or hearing	◯Yes ◯No	Explain: _____
Nasal allergies	◯Yes ◯No	Explain: _____
Problems with eyes or vision	◯Yes ◯No	Explain: _____
Asthma, bronchitis, bronchiolitis, or pneumonia	◯Yes ◯No	Explain: _____
Any heart problem or heart murmur	◯Yes ◯No	Explain: _____
Anemia or bleeding problem	◯Yes ◯No	Explain: _____
Blood transfusion	◯Yes ◯No	Explain: _____
HIV	◯Yes ◯No	Explain: _____
Organ transplant	◯Yes ◯No	Explain: _____
Malignancy/bone marrow transplant	◯Yes ◯No	Explain: _____
Chemotherapy	◯Yes ◯No	Explain: _____
Frequent abdominal pain	◯Yes ◯No	Explain: _____
Constipation requiring doctor visits	◯Yes ◯No	Explain: _____
Recurrent urinary tract infections and problems	◯Yes ◯No	Explain: _____
Congenital cataracts/retinoblastoma	◯Yes ◯No	Explain: _____
Metabolic/Genetic disorders	◯Yes ◯No	Explain: _____
Cancer	◯Yes ◯No	Explain: _____
Kidney disease or urologic malformations	◯Yes ◯No	Explain: _____
Bed-wetting (after 5 years old)	◯Yes ◯No	Explain: _____
Sleep problems; snoring	◯Yes ◯No	Explain: _____
Chronic skin problems (eg. acne, eczema)	◯Yes ◯No	Explain: _____
Frequent headaches	◯Yes ◯No	Explain: _____
Convulsions or other neurologic problems	◯Yes ◯No	Explain: _____
Obesity	◯Yes ◯No	Explain: _____
Diabetes	◯Yes ◯No	Explain: _____
Thyroid or other endocrine problems	◯Yes ◯No	Explain: _____
High blood pressure	◯Yes ◯No	Explain: _____
History of serious injuries/fractures/concussions	◯Yes ◯No	Explain: _____
Use of alcohol or drugs	◯Yes ◯No	Explain: _____
Tobacco use	◯Yes ◯No	Explain: _____
ADHD/anxiety/mood problems/depression	◯Yes ◯No	Explain: _____
Developmental delay	◯Yes ◯No	Explain: _____
History of family violence	◯Yes ◯No	Explain: _____
Sexually transmitted infections	◯Yes ◯No	Explain: _____

Any other significant problem_____

_____

Pinecone Pediatrics
Statement of Patient Financial Responsibility and Office Policies

Patient Name: _____ DOB: _____

Pinecone Pediatrics appreciates the confidence you have shown in choosing us to provide for your health care needs. The service(s) you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full. We DO NOT bill Medicaid or Veterans Affairs policies as a secondary insurance.

I have read the above policy regarding my financial responsibility to Pinecone Pediatrics, for providing services to me or the above-named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Pinecone Pediatrics, the full and entire amount of bill incurred by me or the above-named patient; or, if applicable, any amount due after payment has been made by my insurance carrier.

Co-Pay and Deductible Policy

Some health insurance carriers require the patient to pay a co-pay or deductible for services rendered. It is expected at the time the service is rendered for the responsible party to pay at EACH VISIT. The responsible party is the person bringing the child in for the visit. Thank you for your cooperation in this matter.

Consent for Treatment

I hereby authorize Pinecone Pediatrics, through its appropriate personnel, to perform or have performed upon me, or the above-named patient, appropriate assessment and treatment procedures.

Cancellation / No Show Policy

To meet the needs of our patients and to ensure we have adequate openings for children needing appointments, our office requires 48-hours advance notice to cancel a scheduled appointment. No shows and short notice cancellations are subject to a $50.00 fee per missed appointment which includes same day scheduled appointments that are cancelled. Patients who arrive later than 10 minutes from their scheduled appointment time will be considered a no show and will be cancelled.

I understand if I no show for three appointments or cancel for a total of three appointments, I may be discharged from care.

The Practice will notify you in writing, via certified mail, if you are discharged from care.

Professionalism Policy

It is our policy at Pinecone Pediatrics to provide all our patients with the best medical care in the most positive environment possible. Respect to the office staff, other patients, and other family members is mandatory. Inappropriate language, rude, or disruptive behavior in the office or non-compliance that negatively impacts the functionality to provide care may be subject for discharge. If there are any questions or concerns, feel free to ask the Office Manager for clarification.

Non-Contracted Insurance Coverage

If Pinecone Pediatrics is not a contracted provider with my health care coverage, I understand that any balance will be my responsibility to pay in full at the time of service. IT IS PATIENT RESPONSIBILITY TO CONFIRM IN-NETWORK STATUS WITH OUR PROVIDERS.

Self-Pay

I do not have health insurance and will be responsible for services rendered here at Pinecone Pediatrics. I agree to pay Pinecone Pediatrics, the full and entire amount of treatment given to me or to the above-named patient at each visit.

Parent/Guardian Signature _____ Date _____

I have read and understand the above information, and I agree to the terms described:

Parent/Guardian Name_____

Parent/Guardian Signature _____ Date _____

PINECONE PEDIATRICS

Acknowledgement of Receipt of Notice of Privacy Practices

The Health Insurance Portability and Accountability Act (HIPAA), requires us to give you a notice of our privacy practices and to acknowledge your receipt of the notice.

The Notice of Privacy Practices explains how your health information may be used and or disclosed by us. In addition, it explains your rights with regard to your protected health information, as well as our legal responsibilities. You can view the Privacy Practices in one of three manners: we can email you a copy, you can view it on our website, or you may request a paper copy.

I have been provided with access to a copy of the Notice of Privacy Practices in electronic or paper format. I understand that as part of this organizations treatment, payment or health care operations, it may become necessary to disclose my protected health care information to another entity. I hereby consent to such a disclosure for these permitted uses. I also consent to such disclosures via fax.

Patient Name: _____

Parent/Legal Guardian Name (Printed): _____

Parent/Legal Guardian Signature: _____ Date: _____

Please list the names of others with whom you would like to give permission to share your healthcare information (these may include family members or other individuals/entities):

- PLEASE NOTE: WE WILL NOT BE ABLE TO SEE YOUR CHILD IN ABSENCE OF YOUR PRESENCE UNLESS ONE OF THE PARTIES LISTED BELOW ACCOMPANIES YOUR CHILD. IDENTIFICATION WILL BE REQURIED UPON ARRIVAL FOR AN OFFICE VISIT FOR YOUR CHILD FOR ANY PERSON LISTED IN THIS SECTION.

NAME: (FIRST AND LAST)_____ RELATIONSHIP: _____

NAME: (FIRST AND LAST)_____ RELATIONSHIP: _____

NAME: (FIRST AND LAST)_____ RELATIONSHIP: _____

NAME: (FIRST AND LAST)_____ RELATIONSHIP: _____

Phone Correspondence (please answer all questions)

Preferred Contact Phone Number: (_____) _____

May we leave detailed medical information on your home voice mail? _____Yes _____No_____ N/A

Work voice mail? _____Yes _____No ____ N/A Cell phone? _____Yes _____No

Would you like to receive email, text and voice reminders and messaging? _____Yes_____No

Mail Correspondence

Please print the address of where you would like any correspondence from our office to be sent if other than your home:

_____