Kidz Pediatrics
285 W. Dora Street
Angier, NC 27501-9134
Ph (919) 639-9995 Fax (919) 639-3518

PATIENT PROFILE Registration

Patient Name _____ Today's Date _____

Address _____ Patient D.O.B. _____

City/Zip _____ Social Security _____

County _____

Email address _____ Sex: M / F Adopted: Yes / No

Tel 1 _____ home cell work other

Tel 2 _____ home cell work other

Tel 3 _____ home cell work other

HEALTH INSURANCE INFO:
Primary **Subscriber** Policy Holder **(include middle initial for patient & subscriber):**

Name _____ Social Security _____

Address _____ Subscriber D.O.B. _____

_____ Policy Number _____

Insurance _____ Policy Group # _____

Employer _____ Policy Effective Date _____

Please provide a COPY of Insurance Card
also keep the office informed of ALL NEW CHANGES (phone/address/new insurance cards)

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PATIENT PROFILE Registration

Acceptance of Privacy Policies

Patient Name: _____ Date of Birth _____

PATIENT PRIVACY PRACTICES

By signing below, I am acknowledging that I have received a copy of the "Kidz Pediatrics' Privacy Policy". * I understand it is my responsibility to read, understand and abide by the policies presented to me.

PATIENT BILL OF RIGHTS

By signing below, I am acknowledging that I have received a copy of "Kidz Pediatrics' Patient Bill Of Rights". * I understand it is my responsibility to read, understand and abide by the policies presented to me.

PATIENT RESPONSIBILITIES

By signing below, I am acknowledging that I have received a copy of "Kidz Pediatrics' Patient Responsibilities". * I understand that it is my responsibility to read, understand and abide by the policies presented to me.

FINANCIAL RESPONSIBILITY

I understand that I am responsible for payment of this account and hereby assume and guarantee prompt payment of all expenses incurred. I am also aware that certain services may not be covered by my insurance carrier and Kidz Pediatrics will make every effort to inform me of these services, in the event these services are not covered. I will be solely responsible for payment of these services. I further understand that payment and copayment is due at the time of service. I give permission to Kidz Pediatrics to bill my insurance company on my behalf, and understand that any outstanding balance, after the insurance company has paid, will be my responsibility. In the event that my account becomes past due, there may be penalty charges and my account can be turned over to a collection agency and I will be responsible for any additional fees and penalties for such service.

CONSENT TO TREAT AND RECEIVE VACCINATION(S)

By signing below, I am consenting to treatment of myself, or dependent, by Kidz Pediatrics and receive vaccinations. I understand that my/their medical information may be viewed or shared amongst the staff of Kidz Pediatrics and their business associates. Every effort will be made to protect my privacy in accordance with the HIPPA regulations.

PERMISSION TO RELEASE MEDICAL INFORMATION

By signing below, I authorize Kidz Pediatrics to release information from my child's medical record, to my/their insurance company, third party payers or their reviewing agencies. This information will be limited to that which is necessary to expedite claim processing. This authorization is valid for every visit to Kidz Pediatrics until written notice revoking this authorization is provided.

* These policies are available for review at the office and furnished upon request.

_____ _____

Legal Guardian or Patient Signature Date signed

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PATIENT PROFILE Registration

Authorization When Parent/Guardian Is Not Present

I, THE PARENT/LEGAL GUARDIAN HEREBY GIVE PERMISSION TO:
(Family/friends must be over 18 years of age and ID will be required at time of service):

	Full name	Relationship	Driver's License or ID#
1.			
2.			
3.			

TO BRING MY CHILD/CHILDREN TO KIDZ PEDIATRICS, P.A. AND TO RECEIVE MEDICAL TREATMENT AND ADVICE DURING MY ABSENCE.

	Child/Children's Name	Date of birth
1.		
2.		
3.		

I am also providing my current insurance information along with my copayment or full payment for the services rendered. I also understand if Kidz Pediatrics is unable to obtain payment from my insurance, I am responsible for payment in full for services rendered to my child/children while under the care of above named person.

I also give permission for Kidz Pediatrics, P.A., to obtain any medical records from any previous physician/facility pertaining to the above named child/children.

Parent/Legal Guardian's Signature Print Name (first/middle/last) Date signed

Witness Signature (Kidz Pediatrics staff) Date signed

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PATIENT PROFILE Medical History

Patient Name: _____ Date of birth _____

PREGNANCY AND DELIVERY INFORMATION

How many pregnancies has patient's mother had _____ Live births _____ Stillborn _____ Miscarriages _____
Were there any complications or infections during the pregnancy or at the time of delivery:

_____

Smoking _____ cigarettes per day Alcoholic drinks per week _____ Any Drugs/Medicine _____
Where was patient born? _____ Cesarea / Natural / Forceps(Vacuum)
Medication to mother during labor _____ Group B Strep: + / -
Birth weight _____ Length _____ APGARs _____ / _____ Days in hospital _____
Born at _____ weeks Hearing test: Passed / Failed R / L
Newborn issues Jaundice Feeding Problems Vomiting Blueness Needed oxygen Fever
Seizures Breathing problems Blood transfusions Other:_____

PATIENT'S PAST MEDICAL HISTORY

Previous medical clinic/physician: _____
Date of last physical: _____
Has patient been hospitalized Yes / No If yes, for what and when _____

_____

Previous surgeries _____

Has patient ever been or is currently being treated for the following illnesses

Mumps Hepatitis Measles Whooping cough (Pertussis) Chicken Pox (Date) _____ Broken bones
Ear infections Pneumonia Head Injury Urine infection Allergies Skin problems Headaches Asthma
Lead poisoning Behavior problems Learning problems Developmental problems Vision problems
Reflux Seizures Heart murmur Depression/anxiety Diabetes Speech problems Cancer
Hearing problems Other _____

Medications (including over-the-counter, natural (herbal), etc.): _____
Medication allergies: _____ Type of reaction: _____
Food/Fruit allergies: _____ Type of reaction: _____
Is patient being seen by any specialist? (if yes, please explain) _____
Where _____

SOCIAL HISTORY

Mother: Age: _____ Occupation: _____
Father: Age: _____ Occupation: _____
Who lives in the home (list first name & age)_____

_____

Pets (inside/outside) _____ Does anyone smoke Inside/outside _____
Primary language _____ Daycare Y / N Religious preference _____
If there is a history of patient smoking, do you need a referral to stop Y / N

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PATIENT PROFILE Medical History

Patient Name: _____ Date of birth: _____

FAMILY HISTORY (Please indicate the relationship to the child, Maternal/Paternal side)

Diabetes	_____	Kidney/Urinary Disease	_____
Cancer	_____	Mental Illness	_____
Seizures	_____	Developmental Delay	_____
Allergies/Asthma	_____	Heart Disease/Stroke	_____
Bleeding problems	_____	High Blood Pressure	_____
Lung Disease	_____	Lead Poisoning	_____
Learning Problems	_____	Sickle Cell Disease	_____
Behavior Problems	_____	Immune/Autoimmune Disease	_____

Other: _____

SAFETY INFORMATION

Seat belt/car seat used	Yes / No	Cigarette smoking	Yes / No
Firearms at home	Yes / No Locked? Yes/No	Domestic violence	Yes / No
Working smoke detectors	Yes /No	Wears a helmet when riding a bike	Yes / No
Where are the medicines kept	_____	**Where are cleaning solutions kept**	_____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship _____

Phone Number _____

May we leave test results on your home voicemail or answering machine/fax Yes / No

May we leave test results on your cell phone voicemail Yes / No

Any restrictions to where we may leave lab results _____

How did you hear about Kidz Pediatrics _____

Do you have any concerns or questions for the doctor today _____

_____

_____

By signing below, I hereby certify that the information furnished on this form is complete, true and accurate to the best of my knowledge.

Sign & Print _____ Relationship _____

Revised by Staff _____ Date Signed _____