FAMILY Health Source

PEDIATRIC PATIENT REGISTRATION FORM

PATIENTINFORMATION

Last, Middle, First	**Social Security #**	**Gender Preference** ☐ M ☐ F ☐ Transgender (M to F) ☐ Transgender (F to M)	**Date of Birth (MM/DD/YY)**
Preferred Language		**Interpreter Needed?** ☐ Yes ☐ No	**U.S. Citizen?** ☐ Yes ☐ No
Patient Race/Ethnicity – Select all that apply. ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White/Caucasian ☐ Other **Is the patient Hispanic?** ☐ Yes ☐ No		**Type of Housing** ☐ Own ☐ Subsidized ☐ Other Shelter ☐ Rent ☐ Public Housing ☐ Homeless ☐ Staying with Friends/Family	
Emergency Contact Name	**Relationship to Patient**	**Emergency Contact Phone**	

PARENT/GUARDIAN INFORMATION

Mother/Guardian Name		**Mother/Guardian Email Address**	
Mother/Guardian Address	**City**	**State**	**ZIP**
Mother/Guardian Primary Phone	**Secondary Phone**	**Preferred Contact Method** ☐ Mail ☐ Cell Phone ☐ Secondary Phone ☐ Portal	
Father/Guardian Name		**Father/Guardian Email Address**	
Father/Guardian Address	**City**	**State**	**ZIP**
Father/Guardian Primary Phone	**Secondary Phone**	**Preferred Contact Method** ☐ Mail ☐ Cell Phone ☐ Secondary Phone ☐ Portal	

INSURANCE&GUARANTOR INFORMATION

Primary Insurance	**Policy #**	**Group #**
Subscriber Name	**Relationship to Patient**	
Secondary Insurance (if applicable)	**Policy #**	**Group #**
Subscriber Name	**Relationship to Patient**	
Guarantor/Name of Person Responsible for Payment (if different from Subscriber)		
Address	**City**	**State**	**ZIP**
Phone	**Relationship to Patient**		

Parent/Guardian Signature	**Relationship to Patient**	**Date**

FAMILY Health Source

PEDIATRIC MEDICAL HISTORY

Patient Name	Date of Birth (MM/DD/YY)

MEDICAL HISTORY

Patient (Child)		Family	
Strep Throat	☐ Yes ☐ No	Thyroid	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Chicken Pox	☐ Yes ☐ No	Heart	☐ Yes ☐ No
Measles	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Ear Infections	☐ Yes ☐ No	Kidney	☐ Yes ☐ No
RSV	☐ Yes ☐ No	Liver	☐ Yes ☐ No
Croup	☐ Yes ☐ No	Mental Illness	☐ Yes ☐ No
Stomach Problems	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No
Mental Illness	☐ Yes ☐ No	Cataracts	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Headaches	☐ Yes ☐ No	Headaches/Migraines	☐ Yes ☐ No
Cancer (Type: _____)	☐ Yes ☐ No	Cancer (Type: _____)	☐ Yes ☐ No
Other: _____	☐ Yes ☐ No	Other: _____	☐ Yes ☐ No

PREVENTIVE CARE

Date of last doctor visit: _____

Date of last dental visit: _____

Dentist's Name: _____

FAMILY HISTORY

Father: ☐ Living ☐ Deceased Age: _____
Cause of Death _____

Mother: ☐ Living ☐ Deceased Age: _____ Cause of Death _____

Siblings, How Many: ☐ Living ____ ☐ Deceased ____ Cause of Death _____

BIRTH HISTORY

☐ Vaginal Birth ☐ C-Section

Birth Weight _____ Birth Length _____

Place of Birth? _____

Pregnancy History: _____

Problems at Birth: _____

MEDICATIONS

Name of Medicine	Dosage	Times per Day

ALLERGIES

NUTRITION

Breast Fed?	☐ Yes ☐ No
Formula?	☐ Yes ☐ No Type: _____
Take Vitamins?	☐ Yes ☐ No
Taking Iron?	☐ Yes ☐ No

SURGERIES

Parent/Guardian Signature	Relationship to Patient	Date

List of Authorized Persons for Medical Purposes

I, _____, the parent or legal guardian of
Parent/Legal Guardian Name

_____, hereby authorize the individual(s)
Child's Name and Date of Birth

listed below to act as temporary guardian(s) for the purpose of bringing my child to Family Health Source. These individuals have permission to bring my child into the clinic and consent to healthcare treatments and examinations in my absence. This authorization is valid for one year from the effective date unless otherwise specified in writing.

Name of Authorized Person	Relationship to Child

Parent/Guardian Signature	Relationship to Patient	Date

For Health Center Use Only		
Employee Signature	**Employee Title**	**Date**

Sliding Fee Scale Agreement

Patient Name	Date of Birth (MM/DD/YY)

Uninsured patients may qualify for the sliding fee scale discount program at Family Health Source. Eligibility for the sliding fee scale discount program is based on household income and family size. We require documentation to determine eligibility.

Family Health Source reserves the right to review your tax return and/or wage statements upon request. Eligibility will be updated periodically depending on the type of documentation provided. If there are any changes in your income status or insurance eligibility prior to your scheduled update, please notify Family Health Source immediately.

Please initial each statement in the space provided.

_____ I certify that the income and family information supplied on this form is true and correct to the best of my *(initials)* knowledge. I understand that if any of the information provided in this form has been falsified, this agreement will be canceled, and I will be responsible for the **FULL** cost of services. I understand this document will be maintained in my permanent medical record and that falsification of information may constitute a federal offense.

_____ I understand that the sliding fee scale is subject to change.
(initials)

_____ I understand that payment is expected upon receipt of services.
(initials)

_____ (If applicable) I have been informed and understand that if I do not supply proof of my income at my next visit, my *(initials)* category will be changed to a higher fee scale.

Patient/Guardian Signature	Relationship to Patient	Date

For Health Center Use Only

Income Verification	Income Source	Amount – Self	Amount – Spouse	Frequency
	☐ Paycheck Stubs – 4 Most Recent			☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually
	☐ Social Security Benefits Determination			☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually
	☐ Last Year's Income Tax Return			☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually
	☐ Unemployment Compensation Statement			☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually
	☐ Notarized Letter of Support			☐ Monthly ☐ Quarterly ☐ Semiannually ☐ Annually
	☐ Other Income			☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually

Total Members in Household*: _____ **For 4 or more household members, please produce last year's tax return.*

☐ Your documented annual income is $_____. Your documented family size is _____.

Therefore, you qualify for the Sliding Fee Schedule noted below until _____.

☐ No proof of income presented – <u>One-time exemption used</u>. Indicate appropriate Sliding Fee Schedule below.

☐ SLIDE A	☐ SLIDE B	☐ SLIDE C	☐ SLIDE D	☐ SLIDE E	☐ SLIDE F

Employee Signature	Employee Title	Date

Authorization and Agreement for Treatment

Patient Name	Date of Birth (MM/DD/YY)

The undersigned hereby makes the acknowledgements and agreements regarding the treatment to be provided to the patient whose name appears on the Registration Form. The patient, guardian, or patient representative must initial all applicable items.

Consent for Treatment

_____ *(initials)* I certify that I am requesting examination and medical treatment of the patient by the physicians and employees of Family Health Source. I give permission for evaluation and treatment and certify that no guarantee or assurance has been made as to the results that may be obtained. If the patient is a minor, I understand that a parent, legal guardian, or responsible adult must accompany the patient to the health center and stay with the patient throughout the entire examination.

Financial Agreement and Assignment of Benefits

_____ *(initials)* I acknowledge that I have received a copy of the Family Health Source Financial Policy and that I agree to abide by its terms.

Patient's Bill of Rights and Responsibilities

_____ *(initials)* I acknowledge that I have received a copy of the Family Health Source Patient's Bill of Rights and Responsibilities and that I agree to abide by its terms.

Notice of Privacy Practices

_____ *(initials)* I acknowledge that I have received a copy of Family Health Source's Notice of Privacy Practices.

Release of Medical Information

_____ *(initials)* (If applicable) In addition to the use and/or disclosure of my PHI as stated above, I authorize my information to be released to the following individual(s). Please provide full name(s) of authorized individual(s) below. I understand that this request will not restrict the normal use or disclosure of PHI as stated above.

Name of Authorized Person	Relationship to Patient

_____ *(initials)* I understand that I may amend or revoke my consent to use and/or disclosure of PHI at any time, if submitted in writing. Use or disclosure that occurs prior to the date on which the revocation of consent is received will not be affected.

I have read and fully understand the above acknowledgments and agreements.

Patient/Guardian Signature	Relationship to Patient	Date

For Health Center Use Only		
Employee Signature	**Employee Title**	**Date**