CAPE FEAR VALLEY HEALTH | HARNETT HEALTH

Pediatric Patient Registration

Patient's Name_____ **Date of birth**_____-_____-_____ **Sex** M/F
(First) (Middle) (Last)

Address: _____
(Street) (City) (State) (Zip) (County)

Home Phone: (_____) -- _____ **Patient's Social Security Number:** _____

Preferred Language: [ ] English [ ] Spanish [ ] Other
Race: [ ]American Indian [ ]Asian [ ]African American [ ]Caucasian [ ]Native Hawaiian/Pacific Islander [ ]Other
Ethnicity: [ ] Non-Hispanic [ ] Hispanic [ ] Patient Declined
Religious Preference: [ ] Christianity [ ] Jehovah Witness [ ] Buddhism [ ] Islam [ ] Scientology [ ] Hindu [ ] Other

Mother/Guardian: _____ **Date of birth** _____ **SS#:** _____

Home Phone (____) _____ **Cell Phone** (_____) _____

Address: _____
(Street) (City) (State) (Zip) (County)
Email: _____

Employer: _____ **Work Phone:** _____

Father/Guardian: _____ **Date of birth** _____ **SS#:** _____

Home Phone (____) _____ **Cell Phone** (_____) _____

Address: _____
(Street) (City) (State) (Zip) (County)

Employer: _____ **Work Phone:** _____

In case of emergency contact:_____ **Relationship**_____ **Phone:** _____

INSURANCE INFORMATION: We cannot file your insurance without complete information and a copy of your insurance card(s). *Please bring your insurance cards with you to the front desk when you have completed this form and also to each visit.*

PRIMARY INSURANCE

Insurance Name_____ **Policy Holder's Name** _____

Policy Holder's DOB _____-_____-_____ **Policy Holder's SS#**____-____-_____ Policy **Holder's Employer** _____

Subscriber ID # _____ **Group #** _____

SECONDARY INSURANCE

Insurance Name _____ **Policy Holder's Name** _____

Policy Holder's DOB _____-_____-_____ **Policy Holder's SS#**____-____-_____ **Policy Holder's Employer** _____

Subscriber ID # _____ **Group #** _____

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Pediatric Patient Registration
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Patient Name _____

Financial Agreements and Authorization for Treatment: I hereby authorize Premiere Pediatrics and its physicians and such assistants as a physician may designate to furnish and perform on me or the patient stated above ("Patient") such medical care, examination, and treatment as may be ordered by a Premiere Pediatrics physician in his or her medical judgment and such medical care, examination, or treatment as is reasonable incident thereto. I hereby authorize direct payment to Premiere Pediatrics of all medical insurance benefits (including without limitation Medicare and Medicaid benefits) to which the Patient is entitled in consideration of services to be rendered by Premiere Pediatrics to the Patient. I understand that, to the extent permitted by applicable law, I am and I agree hereby to be, financially responsible to Premiere Pediatrics for charges not covered by this agreement, and I hereby guarantee payment to Premiere Pediatrics on demand for all such charges. I understand that all co-pays and self pay monies are collected up front before services are rendered.

Parent / Guardian Signature _____ _____ Date _____

Authorization to Release Information: I hereby authorize Premiere Pediatrics to furnish, to the extent permitted by applicable law, any medical information acquired in the course of the Patient's examination and /or treatment to any insurance company, government agencies and their agents, and professional review organizations with which I or the Patient stated above may have insurance coverage or which may be assisting in payment of the medical care provided by Premiere Pediatrics to me or the Patient stated above. I also hereby authorize Premiere Pediatrics to release any medical information to any licensed physician, health care provider, or medical facility to which I or the Patient stated above may be referred, admitted, or transferred for further medical care or to a school nurse when requested. I understand that I may revoke this authorization by written notice at any time except to the extent that action already has been taken.

Parent / Guardian Signature _____ Date _____

Receipt of Notice of Privacy Practices: I understand and have been provided with a Premiere Pediatrics Notice of Privacy Practices, which provides a more complete description of how Patient health information may be used or disclosed. I understand that Premiere Pediatrics reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by requesting a copy from any employee of Premiere Pediatrics.

Parent / Guardian Signature _____ Date _____

CAPE FEAR VALLEY HEALTH | HARNETT HEALTH

Pediatric Medical History

Patient's Name _____Date of birth _____/_____/_____
(First) (Middle) (Last)

Person completing this Form: _____Relationship_____

Please list any medical problems, past and present, that your child has been treated for by a medical provider (asthma, allergies, congenital malformations, diabetes, etc.)

_____

_____

_____

_____

BIRTH HISTORY:
List any pregnancy complications (pre-eclampsia, maternal diabetes, premature delivery, etc):

_____

Was child delivered term (40 weeks) _____ If not, how many weeks old when born? _____

Birth weight _____ lbs _____ ounces

List any complications after child was born, up to about 2 weeks of age :

_____

MEDICAL CARE:
Please list any SURGERIES and approximate dates:

_____

_____

Please list any HOSPITALIZATIONS and approximate dates:

_____

_____

Please list any CURRENT MEDICATIONS and approximate dates:

_____ _____

_____ _____

Immunizations: ☐ Up to date ☐ Not up to date ☐ Not immunized ☐ Unsure

List the medical office(s) who have administered your child's vaccines:

_____ _____

_____ _____

Pediatric Medical History

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Drug Allergies:

_____ _____

_____ _____

HOME/SOCIAL ENVIRONMENT:
Who lives in the home with your child?

Name_____ Relationship_____ Age_____

Name_____ Relationship_____ Age_____

Name_____ Relationship_____ Age_____

Name_____ Relationship_____ Age_____

Name_____ Relationship_____ Age_____

Name_____ Relationship_____ Age_____

Marital status of parents:

☐ Married ☐ Divorced ☐ Separated ☐ Never Married

Does anyone smoke around the child? _____ If yes, who? _____

Are there any guns in the home? _____ If yes, are they locked up? _____

SCHOOL:

☐ Public ☐ Private ☐ Home Schooled

For public or private school, please provide name of school: _____

Grade level: _____

School performance: ☐ Above Average ☐ Average ☐ Below Average

Discipline Problems? ☐ YES ☐ NO

NUTRITION:
Please list any food allergies or diet restrictions your child has:

_____ _____

_____ _____

Do you feel your child eats healthy? _____ If no, what are your concerns? _____

Do you feel your child is overweight? _____

CAPE FEAR VALLEY HEALTH | HARNETT HEALTH

Pediatric Medical History

ACTIVITY:
List school and non-school related sports and physical activities in which your child actively participates:

_____ _____

_____ _____

Please list the number of hours per day your child spends doing the following activities:

Playing sports/Physical activity _____ Doing Homework _____

Sleeping _____ Watching TV: _____

Playing video games: _____ Computer/Internet: _____

FAMILY HISTORY:
Please list illnesses, if known, pertaining to relatives listed below.
If child is adopted or family medical history is unknown, please check here: ☐

Mother: ☐ Alive ☐ Deceased: please list age when she died: _____

Medical problems, if any:

_____

Father: ☐ Alive ☐ Deceased: please list age when he died: _____

Medical problems, if any:

_____

Brothers: How many? _____ Current ages? _____
Medical problems, if any:

_____

Sisters: How many? _____ Current ages? _____
Medical problems, if any:

_____

List any major medical problems that grandparents or aunts/uncles have, especially relating to heart disease, diabetes, stroke, cancers, etc.)

_____

_____

_____

CAPE FEAR VALLEY HEALTH | HARNETT HEALTH

Parental Consent For Care

PLEASE READ CAREFULLY:

Under law, the providers of Premiere Pediatrics of Harnett Health need your permission to treat your child in your absence. If there should ever be the possibility of someone other than yourself, the custodial parent, bringing your child in for treatment, whether it is for a well visit or when he/she is sick, please complete the information below so that we may treat your child. This form authorizes these persons to sign the consent for vaccine administration, and to agree to any health care the child should need.

Payment of any co pays, coinsurance, or charges for services rendered in the case of no insurance are due at the time of treatment and will be the responsibility of the adult bringing the patient in for medical treatment.

I, _____, am the custodial parent having legal custody

of _____, a minor child, born on_____. I authorize the people listed below to do any acts which may be necessary or proper for the health care of the minor child, including, but not limited to, the power to provide for such health care at Premiere Pediatrics of Harnett Health by the medical providers, nurses, or laboratory personnel, or other persons whose services may be needed for such health care, and to consent to and authorize any health care, including administration of vaccines, medications, and other procedures, except the withholding or withdrawal of life-sustaining procedures.

This consent shall be effective from the date it is executed until the date I terminate it in writing that is witnessed by this healthcare provider. By signing here, I indicate that I have the understanding and capacity to recognize the importance of, to communicate, and to assign the health care decisions covered by this document, I am fully informed as to the contents of this document, and I understand the full scope and importance of powers to the agent(s) named herein.

_____

(Custodial Parent's Signature) (Date)

_____Witnessed by Staff Member of Premiere Pediatrics

Name of Persons Authorized to Bring Child for medical treatment	Relationship to Child

HIPAA Privacy Information

HIPAA PRIVACY INFORMATION

HIPAA Privacy

Premiere Pediatrics of Harnett Health would like to inform you about the protection for the privacy of your or your child's medical records. Our practice is, and has always been dedicated to providing quality health care and maintaining the confidentiality of your health care information. We understand that your medical information is personal and we are committed to protecting it. A new federal regulation is the Health Insurance Portability and Accountability Act of 1996 or HIPAA. We are required by law to protect the privacy of health information about you and that can be identified with you, which we call "protected health information" or PHI for short. We are required by law to furnish you a Notice of Privacy Practices. Our Notice of Privacy Practices describes the policies we have put in place to insure privacy of your or your child's protected health information. This Notice informs you how we will use or disclose health information within our practice, as well as use or disclose health information within our practice, as well as use and disclose to other offices that may need information, like other health care providers who are involved in your care or the care of your child. We will ask that you provide us with written Acknowledgment that you have received this notice. Under the HIPAA rules, we are required to request this acknowledgment.

We will be glad to answer any questions or respond to any concerns you may have about our Privacy Practices at your next appointment or you may contact our office at (910)892-4248.

We consider it a privilege and honor that you have chosen Premiere Pediatrics of Harnett Health to assist with you or your child's health care. We want you to feel assured that we have taken the appropriate measures of maintaining the privacy of your health care information.

Premiere Pediatrics
802 Tilghman Drive
Dunn, NC 28834
(910)892-4248 Fax: (910)892-4461

CAPE FEAR VALLEY HEALTH | HARNETT HEALTH

Effective April 2018

It is our responsibility to make sure that all medical information pertaining to your child is protected according to HIPPA. We will now only be allowed to release or discuss any information regarding your child to the people that you allow our office to speak with. If at any time you do not wish for us to discuss any medical information to the people that you have listed below you will need to fill out another form to keep your child's medical records up to date. We will release information to both legal guardians listed on the patient information form unless specifically told not to do so.

For security reasons we ask that you choose a password that will be used when someone calls our office so we can be sure that we are speaking to an authorized person. The password that you choose should be given to only those that you have listed below and should be remembered at all times. If at any time you forget the password it will only be given to legal guardian (one who filled out the form) in person only.

At any time you or someone else calls our office you will be asked for the password that you have set for your child's account and if you do not have it, we will not be able to release any information.

Child's Name: _____

Password: _____ ***(please print; this can be a word or a number).***

Security Question: _____
(If the password is ever forgotten we will ask the legal guardian these questions)

Security Answer: _____
(This should answer your security question above, when you give us this answer; we will give you the password that you have forgotten)

Please provide the names of those that you give our office permission to release medical information to regarding your child. Please include patent's name as well.

Name	**Phone Number**	**Relationship to Patient**

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

CAPE FEAR VALLEY HEALTH | HARNETT HEALTH

PREMIERE PEDIATRICS of Harnett Health
802 Tilghman Drive
Dunn, North Carolina 28334
Telephone number 910-892-4248

AUTHORIZATION TO SECURE INFORMATION

Patient Name _____ DOB___/___/___
Last First MI/Maiden Name

Treatment Dates_____ SSN _XXX / XX /_____

I hereby consent to and authorize:

_____
Name of Facility/Individual to RELEASE Information

_____
Address

_____

to release to Premiere Pediatrics of Harnett Health information concerning the history, treatment, examination and/or hospitalization of the above patient. I understand that the specific type of information to be released includes:

- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Labs, X-Rays, EKGs
- ☐ Operative/Procedure
- ☐ Emergency Dept Record
- ☐ Consultation Reports
- ☐ Other (Specify): _____

I DO _____ DO NOT _____ (PLEASE INITIAL) authorize the release of portions of the record relating to substance abuse, psychological/psychiatric conditions and/or communicable disease, including Acquired Immunodeficiency Syndrome (AIDS), or tests for infection with Human Immunodeficiency Virus (HIV), if present.

I understand that this consent is revocable except to the extent that action has already been taken. **This consent will automatically expire 90 days from date of signature, unless another date is specified below (*).** NOTE: UNLESS OTHERWISE PERMITTED BY LAW, FURTHER RELEASE OF THIS INFORMATION IS PROHIBITED WITHOUT MY PRIOR WRITTEN CONSENT.

_____ _____
Signature of Patient or Legal Representative Date

_____
State Relationship to Patient

_____ _____
Signature of Witness **Date**

***Authorization not valid beyond**_____
(Date cannot exceed one year from date of signature)

CAPE FEAR VALLEY HEALTH | HARNETT HEALTH

NO SHOW POLICY

Please kindly give our office 24 hours notice if you will be unable to make your scheduled appointment time.

A pattern of repeated "no shows" for appointments will result in dismissal from this practice. A "no show" is defined as a missed appointment in which the individual does not call to cancel or reschedule the appointment.

Your signature below indicates you are aware and understand this policy. Should you have any questions, please direct them to the front office staff or Practice Manager.

Thank you!

PLEASE RETURN INFORMATION
TO: Office Fax: 910-892-4461
OR
Electronically through Allscripts:
FAX NUMBER: (910) 694-0100