PEDIATRIC UROLOGY ASSOCIATES P.C.
PATIENT REGISTRATION FORM

Please take a few minutes to complete this form, this will allow us to provide you the best possible care. Please answer **all questions.** **If** you do not know an answer please indicate that by writing "do not know", if a question does not apply to your situation please write "not applicable or N/A". All responses will be held in confidence as part of your medical record.

Patient's Legal Name (Last, Middle Initial, First): _____ _____

Patient's Social Security #: _____-_____-_____ Birth date: _____ Age: _____ M or F ____ Weight:_____

Patient's Address: _____ _____ _____
CITY STATE ZIP

Home phone: (___) ___-_____ Cell phone: (___) ___-_____ Work phone: (____) ____-_____

Parent Legal Guardian Name (Last, Middle Initial, First): _____ _____

Who lives with the patient: _____ # of household members: _____

Responsible Party: _____ Relationship: _____
(Adult accompanying child to office)

Complete Address: _____, _____, _____, _____
ADDRESS CITY STATE ZIP

Primary Care Physician Name: _____ Phone number: (____) ____-_____

Local Pharmacy Name and Phone Number: _____

May we contact the above physician to share information regarding the course of patient's treatment? _____ Yes _____ No

Is there medical treatment, including a blood transfusion, that you would refuse based on personal or religious beliefs? _____ Yes _____ No

Primary Insurance: _____ Subscriber's Name: _____

Subscriber's Date of Birth: _____ Subscriber's Social Security Number: _____-____-_____ Sex M or F

Relationship to patient: _____ Policy #: _____ Group #: _____

Subscriber's Employer and Occupation: _____ Work Phone #: (____) ____-_____

Secondary Insurance: _____ Subscriber's name: _____

Sex of Subscriber: M or F Birthdate of Subscriber: _____ Social Security Number: _____ -_____-_____

Relationship to patient: _____ Policy #: _____ Group #: _____

Subscriber's Employer and Occupation: _____ Work Phone #: (____) ____-_____

Emergency Contact: Name: _____ Phone #: (_____) _____-_____

PLEASE READ. ALL CHARGES ARE DUE AT THE TIME OF SERVICES. ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE RESPONSIBLE PARTY OF THE PATIENT. NECESSARY FORMS MAY BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE AS APPLICABLE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR PRACTICE MANAGER. IF YOUR ACCOUNT FALLS TO COLLECTION, THE RESPONSIBLE PARTY WILL BE HELD ACCOUNTABLE FOR ALL COLLECTIONS FEES ASSESSED. MEDICAL INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE WILL NOT BECOME INVOLVED IN DISPUTES BETWEEN YOU AND YOUR INSURNACE COMPANY REGARDING DEDUCTIBLES, WPAYMENTS, "USUAL AND CUSTOMARY" CHARGES, ETC., OTHER THAN TO SUPPLY FACTUAL INFORMATION IF NECESSARY.

INSURANCE AUTHORIZATION AND ASSIGNMENT: I request that payment of authorized insurance company benefits be made either to me or on my behalf to Pediatric Urology Associates for any services furnished to me by that party who accepts assignment. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers of any other insurance company any information needed for this or a related insurance company claim. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In insurance company assigned cases, the physician or supplier agrees to accept the charge determination of the insurance company as the full charge as determined by the insurance contract, and the patient is responsible only for the deductible, coinsurance and non-covered services as applicable. Coinsurance and the deductible are based upon the charge determination of the insurance company involved

Patient Guardian Signature: _____ Date: _____

Patient Name: _____

What condition is your child here to have evaluated and treated? _____

_____

_____

_____

Has your child received any treatment for this condition in the past? _____

_____

Has your child been treated by another Urologist in the past for this condition? _____No _____Yes

If "yes" please specify _____

_____

PREGNANCY & BIRTH:

Where was your child born? _____

Is your child yours by: ☐ Birth ☐ Adoption ☐ Stepchild ☐ Other: _____

_____

Please indicate any medical problems during the pregnancy ☐None ☐ Specify

_____

_____

Delivered by ☐Vaginal birth ☐ Caesarean If Caesarean Why _____

_____

Please indicate any medical problems during your child's newborn period ☐None If premature, how early? _____

_____

Were there any abnormalities noted on prenatal ultrasound examinations? ☐ None If so what? _____

_____

GENERAL HEALTH ISSUES:

Any problems with feeding? ☐None If so what _____

Any problems sleeping? ☐None If so what _____

Any developmental problems? ☐None ☐Speech ☐ Fine motor skills ☐ Gross motor skills ☐ Other: _____

_____

Any concerns about exposure to environmental agents? ☐ No ☐ Yes If so what agents

☐Lead ☐ Mold ☐ Tobacco ☐ Other: _____

IMMUNIZATIONS:

Has your child had:

☐ Chickenpox	☐ Measles	☐ Mumps	☐ Rubella
☐Meningitis	☐ Tuberculosis (TB)	☐ Flu	☐ Hepatitis A
☐Hepatitis B	☐ Tetanus	☐ Varicella (chicken pox)	

MEDICATIONS:

Please list **ALL** medications (prescription as well as over-the counter), vitamins, herbs and supplements your child takes:

Medication	**Dose**	**Frequency**	**Start Date**

Patient Name: _____

ALLERGIES / ADVERSE REACTIONS TO:

IF NONE PLEASE INDICATE □

		Side-effects
Medications:	_____	_____
	_____	_____
	_____	_____
	_____	_____
Chemicals:	_____	_____
	_____	_____
Foods:	_____	_____
	_____	_____

PAST MEDICAL HISTORY: Has your child had (or does your child have) problems with:

Vision/eyes	□none	□Glaucoma	□Near or far-sighted	□Glasses	□Cataracts	□Blurred vision
	□Other please specify: _____					
Ears, Nose,	□none	□Hearing loss	□frequent ear infections	□Injury to ears	□Discharge from ears	□Head colds
Throat	□Sinus infections	□Post nasal drip	□Nose bleeds	□Sore throat	□Difficulty swallowing	
	□Loss or change of smell or taste					
	□Other please specify: _____					
Respiratory	□none	□Asthma	□Pneumonia	□Sinus infections	□Chronic cough	
/Breathing	□Other please specify: _____					
Heart/	□none	□Heart murmur	□High Blood Pressure	□Mitral valve lesion	□Aortic valve lesion	□Rapid Heart rate
Circulation	□Rheumatic Fever, Rheumatic Heart Disease		□Fainting/dizziness	□High Cholesterol	□Shortness of Breath	
	Other please specify: _____					
Digestive system	□none	□Food intolerance	□Vomiting	□Diarrhea	□Nausea	□Jaundice
	□Colitis	□Crohn's disease	□Ulcers	□Constipation		
	□Other please specify: _____					
Orthopedic	□none	□Problems walking	□Problems running	□Arthritis	□Bone fractures	□Spine injury
	□Scoliosis	□Joint swelling	□Muscle spasms	□Numbness of feet or hands		
	□Other please specify: _____					
Endocrine	□none	□Diabetes	□Hypothyroid	□Growth Hormone deficiency		□Fevers
	□Chills	□Excessive sweating				
	□Other please specify: _____					
Hematologic	□none	□Anemia	□Easy bruising	□Prior transfusions	□Sickle cell disease	□Hemophilia
	□Von Willebrand's	□Bleeding after dental extractions		□HIV/AIDS		
	□Other please specify: _____					
Neurological	□none	□Seizures	□Fainting/blackouts	□Tremors	□Paralysis	□Spina Bifida
	□Headaches					
	□Other please specify: _____					

Skin	□none	□Rashes	□Eruptions	□Birth marks	□Café-au-lait spots
	□Wounds that do not heal		□Changes in skin	□Changes in nails	□Changes in hair
	□Other please specify:				

Cancer □none If "yes", type of cancer _____

Date diagnosed _____ Treatment: _____

Physician in charge of treatment _____

Patient Name: _____

PAST SURGICAL HISTORY:

□none □Tonsillectomy □Adenoidectomy □Appendectomy □Hernia repair

□Cardiac Surgery □Spine surgery □Eye surgery □Intestinal surgery □Previous Urologic Surgery

□Other please specify: _____

Has your child been exposed to a local anesthetic? □ No □ Yes

If "yes" was there any problem or adverse reaction to the local anesthetic? _____

Has your child been exposed to a general anesthetic? □ No □ Yes

If "yes" was there any problem or adverse reaction to the general anesthetic? _____

Has any family member had any problem or adverse reaction with either local or general anesthetic? □ No □ Yes

If "yes" please specify: _____

Does your child bleed or bruise easily? □ No □ Yes

If "yes" please specify _____

PRIOR HOSPITALIZATIONS OR SERIOUS ILLNESSES:

Year/Reason: _____ _____

Year/Reason _____ _____

Year/Reason _____ _____

I HEREBY CERTIFY THAT THE INFORMATION GIVEN ON THIS FORM IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE.

_____ _____ _____

(Signature of parent/legal guardian) **Relationship to patient** **DATE**