



## PATIENT REGISTRATION (REGISTRO DE PACIENTE)

Name \_\_\_\_\_  
 Nombre \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Male/ Hombre Social Security # \_\_\_\_\_ Phone \_\_\_\_\_  
 Fecha de Nacimiento \_\_\_\_\_ Female/Mujer # Seguro Social \_\_\_\_\_ Telefono \_\_\_\_\_  
 Address: \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_  
 Domicilio \_\_\_\_\_ Ciudad \_\_\_\_\_ Estado/Codigo Postal \_\_\_\_\_  
 School \_\_\_\_\_ Referred By \_\_\_\_\_  
 Escuela \_\_\_\_\_ Referido Por \_\_\_\_\_  
 Father/Guardian \_\_\_\_\_ D.O.B. \_\_\_\_\_ SS# \_\_\_\_\_  
 Padre/Guardian \_\_\_\_\_ Fecha de Nacimiento \_\_\_\_\_ # de SS \_\_\_\_\_  
 Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_ Employment \_\_\_\_\_  
 Telefono \_\_\_\_\_ Tel. Celular \_\_\_\_\_ Empleo \_\_\_\_\_  
 Mother/Guardian \_\_\_\_\_ D.O.B. \_\_\_\_\_ SS# \_\_\_\_\_  
 Madre/Guardian \_\_\_\_\_ Fecha de Nacimiento \_\_\_\_\_ # de SS \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_  
 Contacto de Emergencia \_\_\_\_\_ Telefono \_\_\_\_\_  
 Closet Relative \_\_\_\_\_ Phone \_\_\_\_\_  
 Pariente mas Cercano \_\_\_\_\_ Telefono \_\_\_\_\_  
 Person Responsible \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Persona Responsable \_\_\_\_\_ Parentesco al Paciente \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_  
 Domicilio: \_\_\_\_\_ Telefono \_\_\_\_\_

Payment required at time of service unless prior arrangements have been made.  
 El pago se cobra al momento que rinde el servicio a menos que haya hecho un arreglo previo

1.- Insurance \_\_\_\_\_ Effective Date \_\_\_\_\_ Address \_\_\_\_\_  
 Aseguranza \_\_\_\_\_ Fecha Efectiva \_\_\_\_\_ Domicilio \_\_\_\_\_  
 City \_\_\_\_\_ State/Zip \_\_\_\_\_ Phone \_\_\_\_\_  
 Ciudad \_\_\_\_\_ Estado/Codigo Postal \_\_\_\_\_ Telefono \_\_\_\_\_  
 Subscriber's Name \_\_\_\_\_ I.D. # \_\_\_\_\_ Group # \_\_\_\_\_  
 Nombre del Asegurado \_\_\_\_\_ # de Identificacion \_\_\_\_\_ # de Grupo \_\_\_\_\_

2.- Insurance \_\_\_\_\_ Effective Date \_\_\_\_\_ Address \_\_\_\_\_  
 Aseguranza \_\_\_\_\_ Fecha Efectiva \_\_\_\_\_ Domicilio \_\_\_\_\_  
 City \_\_\_\_\_ State/Zip \_\_\_\_\_ Phone \_\_\_\_\_  
 Ciudad \_\_\_\_\_ Estado/Codigo Postal \_\_\_\_\_ Telefono \_\_\_\_\_  
 Subscriber's Name \_\_\_\_\_ I.D. # \_\_\_\_\_ Group # \_\_\_\_\_  
 Nombre del Asegurado \_\_\_\_\_ # de Identificacion \_\_\_\_\_ # de Grupo \_\_\_\_\_

3.-Additional Coverage \_\_\_\_\_  
 Covertura Adicional \_\_\_\_\_

E-Mail \_\_\_\_\_

**Authorization to pay benefits to Physician:** I hereby authorize direct Payment to be made to the above name corporation. I understand That Healthy Kidz Pediatrics will file an insurance claim on my behalf As a courtesy nevertheless. I'm financially responsible for the charges Not covered by my insurance company. I also understand that if my Account is not paid by myself or the insurance company after 90 Days of date of service. It will be turned over to an independent Collection agency and \$ 25.00 fee will be added for returned checks.  
**Authorization to release information:** I hereby authorize the above Pediatrics to release any information required Pediatrics el derecho de enviar informacion de el examen cuando sea necesario para mandar cobrar a las aseguranzas medicas. Se otorga el derecho de presentar documentos y fotocopias , como si fueran Originales cuando sea necesario.

**Autorizacion para pago al medico por servicios :** Doy autorizacion de pago directo a la corporacion arriba mencionada, entiendo que Healthy Kidz Pediatrics va a mandar cobrar a mi nombre a la aseguranza por servicios medicos. Reconozco mi responsabilidad personal en caso de que dichos servicios no sean pagados por la aseguranza dentro de 90 dias se contratara una agencia de coleccion y se agregara un cobro de proceso \$ 25.00 a la cuenta .y en caso que su cheke sea regresado por no tener suficientes fondos,se agregara un cobro adicional de \$ 25.00  
**Se otorga el derecho de enviar informacion:** Se le otorga a Healthy to Healthy Kidz el derecho de enviar informacion de el examen cuando sea necesario para mandar cobrar a las aseguranzas medicas. Se otorga el derecho de presentar documentos y fotocopias , como si fueran Originales cuando sea necesario.

Parent/Guardian \_\_\_\_\_  
 Padres/Guardian \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Firma \_\_\_\_\_ Fecha \_\_\_\_\_

# Health History

Name of Patient		Name of Person Completing Form	
Date / /	Relationship to Patient		
Sex <input type="radio"/> Male <input type="radio"/> Female	Race	Social Security #	DOB / /

## ... PLEASE LIST ALL PEOPLE IN HOUSEHOLD ...

	Name	DOB	Occupation	Education
Father:				
Mother:				
Other:				
Other:				
Other:				
Other:				

Have there recently been any major changes or stresses in the child's life? ☐ Yes ☐ No

If YES, please explain: \_\_\_\_\_

Does the child regularly go to a baby-sitter, pre-school or day care? ☐ Yes ☐ No

Is your child exposed to cigarette smoke? ☐ Yes ☐ No

## ... BIRTH HISTORY ...

Birth weight: \_\_\_\_\_ Length: \_\_\_\_\_ Place: \_\_\_\_\_

During the pregnancy did the mother: (If Yes, please explain.)

- |   |  |       |
|---|--|-------|
| <input type="checkbox"/> Have any Medical Problems?         | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| <input type="checkbox"/> Smoke or Drink?                    | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| <input type="checkbox"/> Use any Medication?                | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| <input type="checkbox"/> Use Alcohol or Drugs?              | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| <input type="checkbox"/> Have Problems with Labor/Delivery? | <input type="radio"/> Yes <input type="radio"/> No | _____ |

How long did the baby stay in the hospital after birth? \_\_\_\_\_

## ... PAST MEDICAL HISTORY ...

Is the child's general health: ☐ Good ☐ Fair ☐ Poor

- |  |  |       |
|--|--|-------|
| <input type="checkbox"/> Does the child have any allergies?  | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| <input type="checkbox"/> Is the child taking any medication? | <input type="radio"/> Yes <input type="radio"/> No | _____ |

Please list any hospitalizations, operations, serious illnesses or accidents. (with dates)

_____	Date: _____
_____	Date: _____

Has the child had any problems with the following? If YES, please explain.

- |                     |  |       |                     |  |       |
|---------------------|--|-------|---------------------|--|-------|
| Eyes/Vision         | <input type="radio"/> Yes <input type="radio"/> No | _____ | Skin                | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| Feet                | <input type="radio"/> Yes <input type="radio"/> No | _____ | Lungs               | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| Digestion/Nutrition | <input type="radio"/> Yes <input type="radio"/> No | _____ | Teeth               | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| Ears/Hearing        | <input type="radio"/> Yes <input type="radio"/> No | _____ | Heart               | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| Urine/Kidney        | <input type="radio"/> Yes <input type="radio"/> No | _____ | Seizures            | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| Joints              | <input type="radio"/> Yes <input type="radio"/> No | _____ | Repeated Infections | <input type="radio"/> Yes <input type="radio"/> No | _____ |

**... FAMILY HISTORY ...**

Have any of the child's brothers or sisters died? If YES, give age and cause. ☐ Yes ☐ No

Have any of the child's blood relatives had the following diseases? If YES, please list family member.

- |  |  |       |
|--|--|-------|
| <input type="checkbox"/> Heart disease             | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| <input type="checkbox"/> Tuberculosis              | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| <input type="checkbox"/> High Blood Pressure       | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| <input type="checkbox"/> Kidney Disease            | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| <input type="checkbox"/> Allergies/Asthma          | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| <input type="checkbox"/> Cancer                    | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| <input type="checkbox"/> Diabetes                  | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| <input type="checkbox"/> Mental/Emotional Problems | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| <input type="checkbox"/> Sickle Cell               | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| <input type="checkbox"/> Seizures                  | <input type="radio"/> Yes <input type="radio"/> No | _____ |

**... DEVELOPEMENT ...**

Do you have any concerns about the following? If YES, please explain.

- |   |  |       |
|---|--|-------|
| <input type="checkbox"/> Development            | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| <input type="checkbox"/> Behavior               | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| <input type="checkbox"/> Eating Habits          | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| <input type="checkbox"/> Sleeping Habits        | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| <input type="checkbox"/> School Experience      | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| <input type="checkbox"/> Bathroom/Toilet Habits | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| <input type="checkbox"/> Discipline             | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| <input type="checkbox"/> Other (explain)        | <input type="radio"/> Yes <input type="radio"/> No | _____ |

..... IMMUNIZATIONS WILL BE COPIED ON IMMUNIZATION RECORD BY OFFICE STAFF .....

**... This Section Is for Teenagers and is to Completed by the Teenager ...**

Do you:

- |  |  |
|--|--|
| Use Tobacco?                             | <input type="radio"/> Yes <input type="radio"/> No |
| Drink Beer or other Alcoholic Beverages? | <input type="radio"/> Yes <input type="radio"/> No |
| Use any kind of drugs?                   | <input type="radio"/> Yes <input type="radio"/> No |

(For Females) How old were you when you had your first period? \_\_\_\_\_

- |  |  |
|--|--|
| Are you sexually active?                         | <input type="radio"/> Yes <input type="radio"/> No |
| If YES, do you use birth control?                | <input type="radio"/> Yes <input type="radio"/> No |
| Have you ever been pregnant or fathered a child? | <input type="radio"/> Yes <input type="radio"/> No |

Do you have any concerns about the following? If YES, please explain.

- |   |  |       |
|---|--|-------|
| Safety Issues                           | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| Substance Use (drugs, alcohol, tobacco) | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| Sexually transmitted Diseases           | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| Family Planning                         | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| Other (explain)                         | <input type="radio"/> Yes <input type="radio"/> No | _____ |

☐ Yes ☐ No

Reviewed By

Date

Notes:

## Vaccines for Children (VFC) Program Patient Eligibility Screening Record

A record of all children 18 years of age or younger who receive immunizations must be kept in the health care provider's office for 6 years. The record may be completed by the parent, guardian, individual of record, or by the health care provider. VFC eligibility screening and documentation of eligibility status must take place with each immunization visit to ensure the child's eligibility status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine. Providers using a similar form (paper-based or electronic) must capture all reporting elements included in this form.

1. Child's Name : \_\_\_\_\_  

Last Name
First Name
MI
2. Child's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_
3. Parent/Guardian/Individual of Record: \_\_\_\_\_  

Last Name
First Name
MI
4. Primary Provider's Name: \_\_\_\_\_  

Last Name
First Name
MI
5. To determine if a child (0 through 18 years of age) is eligible to receive federal vaccine through the VFC and state programs, at each immunization encounter/visit enter the date and mark the appropriate eligibility category. *If Column A-D is marked, the child is eligible for the VFC program. If column E, F or G is marked the child is not eligible for federal VFC vaccine.*

	Eligible for VFC Vaccine				Not eligible for VFC Vaccine		
	A	B	C	D	E	F	G
Date	Medicaid Enrolled	No Health Insurance	American Indian or Alaskan Native	*Underinsured served by FQHC, RHC or deputized provider	Has health insurance that covers vaccines	**Other underinsured	***Enrolled in KidsCare

\*Underinsured includes children with health insurance that does not include vaccines or only covers specific vaccine types. Children are only eligible for vaccines that are not covered by insurance. In addition, to receive VFC vaccine, underinsured children must be vaccinated through a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) or under an approved deputized provider. The deputized provider must have a written agreement with an FQHC/RHC and the state/local/territorial immunization program in order to vaccinate underinsured children.

\*\* Other underinsured are children that are underinsured but are not eligible to receive federal vaccine through the VFC program because the provider or facility is not a FQHC/RHC or a deputized provider. However, these children may be served if vaccines are provided by the state program to cover these non-VFC eligible children.

\*\*\*Children enrolled in separate state Children's Health Insurance Program (CHIP). These children are considered insured and are not eligible for vaccines through the VFC program. Each state provides specific guidance on how CHIP vaccine is purchased and administered through participating providers.

Please be advised:

If your insurance company does not cover immunizations and you do not let us know at the time of the visit, it is your responsibility to pay the cost involved. We cannot make the Vaccines for Children Program retroactive and you are only eligible for the Vaccines for Children Program at the time of the visit. If you are unsure if immunizations and well check-ups are covered, please contact your insurance company.

Thank You.

Please sign below indicating that you understand and agree with the above statement.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_