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
Escuela_____ **E-mail address** _____
Father/Guardian **D.O.B.** **SS#**
Padre/Guardian_____ **Fecha de Nacimiento** _____ **# de SS**_____
Phone **Mobile Phone** **Employment**
Telepfono_____ **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 Responsible_____ **Parentesco al Paciente**_____
Address **Phone**
Domicilio: _____ **Telefono** _____

Payment required at time of service unless prior arrangenments 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**_____
Suscriber'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**_____
Suscriber's Name **I.D. #** **Group #**
Nombre del Asegurado_____ **# de Identificacion**_____ **# de Grupo**_____
3.-Additional Coverage
Covertura Adicional_____

Refered by _____

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 Pediatircs to release any information required In the course of my examination or treatment to insurance companies For payment. I hereby authorize any photocopies of this form to be Valid as the original.

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 Pediatrics el derecho de enviar informacion de el examen cuando sea necesario para mandar cobrar a las aseguranzas medicas. Se otorga el derecho de presenter documentos y fotocopias , como si fueran Originales cuando sea necesario. to Healthy Kidz

Parent/Guardian
Padres/Guardian_____ Signature
Firma _____ Date
Fecha_____

Health History

Name of Patient		Name of Person Completing Form	
Date / /	Relationship to Patient		
Sex ○ Male ○ 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.)

□ Have any Medical Problems? ○ Yes□ ○ No _____

□ Smoke or Drink? ○ Yes□ ○ No _____

□ Use any Medication? ○ Yes□ ○ No _____

□ Use Alcohol or Drugs? ○ Yes□ ○ No _____

□ Have Problems with Labor/Delivery? ○ Yes□ ○ No _____

How long did the baby stay in the hospital after birth? _____

• • • PAST MEDICAL HISTORY • • •

Is the child's general health: □ ○ Good□ □ ○ Fair□ □ ○ Poor

□ Does the child have any allergies? ○ Yes□ ○ No _____

□ Is the child taking any medication? ○ Yes□ ○ 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	○ Yes□ ○ No _____	Skin	○ Yes□ ○ No _____
Feet	○ Yes□ ○ No _____	Lungs	○ Yes□ ○ No _____
Digestion/Nutrition	○ Yes□ ○ No _____	Teeth	○ Yes□ ○ No _____
Ears/Hearing	○ Yes□ ○ No _____	Heart	○ Yes□ ○ No _____
Urine/Kidney	○ Yes□ ○ No _____	Seizures	○ Yes□ ○ No _____
Joints	○ Yes□ ○ No _____	Repeated Infections	○ Yes□ ○ 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.

□	Heart disease	○ Yes□ ○ No	
□	Tuberculosis	○ Yes□ ○ No	
□	High Blood Pressure	○ Yes□ ○ No	
□	Kidney Disease	○ Yes□ ○ No	
□	Allergies/Asthma	○ Yes□ ○ No	
□	Cancer	○ Yes□ ○ No	
□	Diabetes	○ Yes□ ○ No	
□	Mental/Emotional Problems	○ Yes□ ○ No	
□	Sickle Cell	○ Yes□ ○ No	
□	Seizures	○ Yes□ ○ No	

• • • DEVELOPEMENT • • •

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

□	Developement	○ Yes□ ○ No	
□	Behavior	○ Yes□ ○ No	
□	Eating Habits	○ Yes□ ○ No	
□	Sleeping Habitts	○ Yes□ ○ No	
□	School Experience	○ Yes□ ○ No	
□	Bathroom/Toilet Habits	○ Yes□ ○ No	
□	Discipline	○ Yes□ ○ No	
□	Other (explain)	○ Yes□ ○ 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 Tabacco?	○ Yes□ ○ No
Drink Beer or other Alcoholic Beverages?	○ Yes□ ○ No
Use any kind of drugs?	○ Yes□ ○ No

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

Are you sexually active?	○ Yes□ ○ No
If YES, do you use birth control?	○ Yes□ ○ No
Have you ever been pregnant or fathered a child?	○ Yes□ ○ No

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

Safety Issues	○ Yes□ ○ No	
Substance Use (drugs, alcohol, tabacco)	○ Yes□ ○ No	
Sexually transmitted Diseases	○ Yes□ ○ No	
Family Planning	○ Yes□ ○ No	
Other (explain)	○ Yes□ ○ No	

Reviewed By ○ Yes□ ○ No 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:**_____

MEDICAL RECORD RELEASE AUTHORIZATION

Previous Medical Provider or Facility Name: _____

Address: _____

_____

Phone: _____

From: HEALTHY KIDZ PEDIATRICS
215 SOUTH POWER RD STE #106
MESA, AZ 85206 Phone (214-0051) Fax (480) 214-0055

I authorize you to release photocopies of confidential medical records to possession or control of Healthy Kidz Pediatrics it's employee or agents. FOR THE PURPOSES HEREOF, "MEDICAL RECORDS" SHALL INCLUDE ALL CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661) CONFIDENTIAL COMMUNICABLE DISEASE RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661), CONFIDENTIAL ALCOHOL OR DRUG ABUSE-RELATED INFORMATION (AS DEFINED IN 42 CFE SECTION 2.1 ET SEQ.), AND CONFIDENTIAL MENTAL HEALTH DIAGNOSIS AND TREATMENT INFORAMTION

_____ _____
Patient's Full Name Date of Birth

This authorization may include items protected by Code of Federal Regulations, 42 CFR Part 2, and other provisions set forth in A.R.S. Sections 36-661, they may include items related to communicable diseases (as defined in A.R.S. Section 36-661). This request is in compliance with the health insurance portability and accountability act of 1996 (HIPAA).

The information requested is to be used for the purpose of: _____
_____

I specifically request the following type of information be released: _____
_____

This authorization is subject to revocation at any time, except to the extent that action has been taken in reliance of this consent prior to revocation. In any event, this authorization expires twelve (12) months from the date of signature.

Parent/Legal Guardian: _____ Date: _____
Relationship to Patient: _____
Signature of Witness: _____