PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient's Name (Last, First, MI): _____

Patient's Cell Phone Number: _____ Alternate Phone Number (☐ Home or ☐ Work): _____

E-Mail Address: _____

Mailing Address: _____ Apt. # _____

City:_____ State: _____ Zip: _____ County: _____

Date of Birth: _____ Age: _____ Sex: M F Social Security Number: _____

INSURANCE INFORMATION

Primary Insurance: _____

Primary Insured Name: _____

Policy: _____

Phone Number: _____

Date of Birth: _____

Group: _____

Patient is Subscriber/Policy Holder: Y N

Secondary Insurance: _____

Secondary Insured Name: _____

Policy: _____

Phone Number: _____

Date of Birth: _____

Group: _____

Patient is Subscriber/Policy Holder: Y N

RELEASE OF INFORMATION

I hereby give permission to the person(s) listed below to receive information about the care of the above named patient.

Name(s): _____ Relationship to Patient: _____

APPOINTMENT CANCELLATION/NO-SHOW POLICY

If you wish to cancel your appointment, it must be done 24 hours in advanced of the scheduled time. If you fail to make your appointment and do not call to cancel it, you will be charged $25. If you No Show the second visit, you will be charged $25. If after no-showing a third visit, you will be dismissed from the practice. This will not be paid by your insurance, and you will be fully responsible to pay it. If you no-show your first new patient visit, you will NOT be rescheduled.

Parent or Guardian Signature: _____ Date: _____

DINOSAUR JUNCTION PEDIATRICS
HEALTH HISTORY

Race:
[ ] American Indian/ Alaska Native
[ ] Asian
[ ] Black/African American
[ ] Hawaiian/Pacific Islander
[ ] White/Caucasian
[ ] Decline
[ ] Other: _____

Ethnicity:
[ ] Non-Hispanic/Latino
[ ] Hispanic/Latino
[ ] Decline
[ ] Other: _____

MEDICAL INFORMATION

Please note that Dino-Peds does not refill any prescriptions that are considered to be controlled substances after business hours.

Please list any **MEDICATIONS** patient currently takes, prescribed or over the counter.

Medication	Dosage	Route	Frequency

Any **Allergies** to Medication or Food (list reactions): _____

Preferred **Pharmacy**: _____

Is your child up to date on immunizations? Y N (Please circle one)

Did your child receive all their immunizations in Colorado? Y N (Please circle one)

Birth Weight: _____ Pregnancy lasted to [ ] full-term or [ ] pre-term (How many weeks? _____)

Any problems at birth? Y N (Please circle) If yes, please describe: _____

Ever had bladder/kidney infection? Y N (Please circle one) If yes, what age? _____

Ever had wheezing? Y N (Please circle one) If yes, what age? _____

Any medical problems? Y N (Please circle one) If yes, please specify: _____

Fractures, concussion, other serious injury? Y N (Please circle one) If yes, please specify: _____

Please list any **SURGERIES** or **HOSPITALIZATIONS** patient has had where the patient was admitted to the hospital. Please include age and reason for admission.

_____

_____

_____

FAMILY INFORMATION

Mother's Name (Last, First, MI): _____

Mother's Cell Phone Number: _____ Alternate Phone Number (☐ Home or ☐ Work): _____

E-Mail Address: _____

Mailing Address: _____ Apt. # _____

City:_____ State: _____ Zip: _____ County: _____

Date of Birth: _____ Social Security Number: _____

Place of Employment: _____

Father's Name (Last, First, MI): _____

Father's Cell Phone Number: _____ Alternate Phone Number (☐ Home or ☐ Work): _____

E-Mail Address: _____

Mailing Address (if different): _____ Apt. # _____

City:_____ State: _____ Zip: _____ County: _____

Date of Birth: _____ Social Security Number: _____

Place of Employment: _____

EMERGENCY CONTACT

Name: _____

Relationship to Patient: _____ Phone Number: _____

HOME INFORMATION

Does your family live in a [ ] house, [ ] apartment, [ ] townhouse, [ ] trailer, or [ ] other _____?

Do both of the child's parents live in the home? Y N (Please circle one)

Please list the people living in the household: _____

Name of School or Daycare: _____

Does anyone in your household smoke? Y N (Please circle one) If yes, do they smoke inside or outside? _____

Do you have animals in the home? Y N (Please circle one) If yes, what type of animal? _____

Do you have heat with stove or a fireplace? Y N (Please circle one)

Do you have trouble paying heat, water, or electricity bills? Y N (Please circle one)

Do you have enough food available? Y N (Please circle one)

Are there any drug or alcohol problems at home? Y N (Please circle one)

Are there carbon monoxide and fire detectors in the home? Y N (Please circle one)

Does your child feel safe at home? Y N (Please circle one)

FAMILY MEDICAL HISTORY

Please place a mark or enter the information in the appropriate space regarding your child's relative with the condition in the left-hand column.

CONDITION	PATIENT	MOTHER	FATHER	SIBLING	MATERNAL GRANDPARENT	PATERNAL GRANDPARENT	OTHER
ADHD/ADD							
Alcoholism							
Allergies							
Anemia							
Asthma							
Bleeding Disorder							
Breast Cancer							
Bronchitis							
Cancer (specify)							
Other Cancer (specify)							
Celiac Disease							
Cholesterol							
Chron's Disease							
Depression							
Diabetes (Child)							
Diabetes (Adult)							
Eczema							
Emphysema							
Other lung disease (specify)							
Epilepsy or seizures							
Gastro esophageal reflux							
Heart attack less than age 50							
High blood pressure							
Heart disease (specify)							
Lactose intolerance							
Leukemia or lymphoma							
Lupus							
Melanoma							
Migraines							
Neurological disorder							
Rheumatic fever or rheumatic heart disease							
Rheumatoid arthritis							
Schizophrenia							
Stroke less than age 50							
Sudden death							
Low thyroid (hypothyroidism)							
Other thyroid (specify)							
Other (specify)							

Patient Medical Packet **Certification**

By signing below, you agree that the above information is true and correct. You authorize Dinosaur Junction Pediatrics to leave a voicemail on the phone number(s) above unless otherwise noted. Should there be any missing information, Dino-Peds may refuse service. By signing this, you acknowledge receipt of the clinic's Privacy Act Policy, Financial Agreement, and the CIIS Immunization Notice. This indicates we participate with Colorado prescription Monitoring Program Agreement, and Quality Health Network which is a centralized data base for healthcare professionals and authorize RX prescription history consent. I hereby give a lifetime authorization for payment for insurance benefits to be made directly to Dinosaur Junction Pediatrics. I understand I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collections, and reasonable attorney fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment benefits. I further agree that a photocopy of this agreement shall be valid as the original.

_____

SIGNATURE OF PARENT OR GUARDIAN

_____ _____

PRINTED NAME OF PARENT OR GUARDIAN

_____

DATE

_____ _____

NAME OF PATIENT

_____

DATE OF BIRTH

_____

RELATIONSHIP TO PATIENT