Caldwell Pediatrics does NOT operate as a walk-in clinic.

2. Patients arriving 15 minutes AFTER their appointment will be RESCHEDULED.

3. Insurance cards, payment, and photo ID are required AT THE TIME OF VISIT.

4. Patients/parents/guardians are required to be OFF of cell phones while at the registration window.
REGISTRATION FORM  

PATIENT INFORMATION

Date: ______________________

Patient Name: _________________________________________________________

Address: ______________________________________________________________

Suite/Apt. #: ________________

City: __________________________ State: ______________ Zip Code: ______________

Home #: __________________ Work #: __________________ Cell #: __________________

May leave message at: □ Home □ Work □ Cell Email address (age 18 and up): ______________

Gender: □ F □ M DOB: ___/___/_____ Preferred Language: _______________ Hospital Born: _______________

Race/Ethnicity: □ American Indian □ Black/African American □ Hispanic/Latino □ Native Hawaiian □ White □ Asian

□ Other _______________________

Pharmacy Name and Address: _____________________________________________ Phone #: ______________

Siblings & DOB: __________________________________________________________

RESPONSIBLE PARTY INFORMATION

Mother’s Name or Guardian: ___________________________________________ Social Security or DL#: ______________

DOB: ___/___/_____ Address: ____________________________________________ City/State: _______________/____ Zip: ______________

Home #: __________________ Work #: __________________ Cell #: __________________

Mother’s Employer: ____________________________________________________ Employer’s Address: ______________

Father’s Name or Guardian: ____________________________________________ Social Security or DL#: ______________

DOB: ___/___/_____ Address: ____________________________________________ City/State: _______________/____ Zip: ______________

Home #: __________________ Work #: __________________ Cell #: __________________

Father’s Employer: ____________________________________________________ Employer’s Address: ______________

Email Address for Electronic Communications- Mother: __________________ Father: __________________

EMERGENCY CONTACT (other than parent)

Name: __________________________ Relationship to Patient: __________________

Address: __________________________________ City/State: _______________/____ Zip: ______________

Home #: __________________ Work #: __________________ Cell #: __________________
INSURANCE INFORMATION

Insurance Company: ____________________________ Policy #: ____________________________
Group #: ____________________________ Insured’s Name: ____________________________ DOB: ____________
Secondary Insurance: ____________________________ Policy #: ____________________________
Group #: ____________________________ Insured’s Name: ____________________________ DOB: ____________

NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT

Our Notice of Privacy Practices (available upon arrival to our office) provides information about how we may use and disclose protected health information (PHI) about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy.

I have received a copy of Caldwell Pediatrics and Wellness Center’ Notice of Privacy Practices. I understand that I may ask questions to the Medical Practice if I do not understand any information contained in the Notice of Privacy Practices.

_____________________________________________ ________________________________
Patient or Parent/ Legal Guardian Signature Date

DISCLOSURES OF PROTECTED HEALTH INFORMATION TO FAMILY MEMBERS AND FRIENDS

Disclosures may be made to family and friends related to the patient’s health or as needed for payment of health care services. We will only disclose information relevant to current treatment.

I authorize Caldwell Pediatrics and Wellness Center to disclose my health care information to:

____________________________________________________________________________
Name Phone Number Relationship

____________________________________________________________________________
Name Phone Number Relationship

_____________________________________________ ________________________________
Patient or Parent/ Legal Guardian Signature Date
FINANCIAL POLICY AND RELEASE

Regarding Insurance: You are responsible for checking with your carrier to see if services at our office will be covered. All copayments must be made at the time of service. It is your responsibility to notify us of any changes in your policy information. Your insurance policy is a contract between you and your insurance company; we are not a party to that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered and not considered reasonable and necessary under your medical plan. You will be responsible for these balances. Additionally, it is your responsibility to obtain and track referrals for your visits.

Release: I hereby authorize direct payment of insurance benefits that are otherwise payable to me. I hereby authorize the release of my medical records to third party insurers or other persons to whom disclosure is necessary to establish or collect a fee for services provided.

Returned Checks and Collection Fees: There will be a $25 returned check fee on all returned checks. In the event that a check is returned for insufficient funds, we reserve the right to call your bank to verify funds for any future checks that are presented for payment. In the event that your account is turned over to a collection agency, you will be responsible for all collection costs including reasonable attorney’s fees whether or not the attorney files suit. Additionally, you will be assessed a finance charge of 1.5% per month on balances over thirty (30) days past due, which is an APR of 18%.

Missed Appointments: Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the minimum rate of $25 per missed appointment. Please help us serve you better by keeping your scheduled appointments.

I have read, understand and agree to this Financial Policy:

___________________________________
Patient Name (print)

___________________________________       ______________________
Patient or Parent/ Legal Guardian Signature   Print Name   Date
Permission to Treat

I________________________________________ authorize Caldwell Pediatrics and Wellness Center and its personnel to deliver medical services to my child(ren):

______________________   ______________
______________________   ______________
______________________   ______________

Print child’s and date of birth

I/We authorize the following people to bring my child in for treatment:

Name: ____________________________ Relationship: _________________________
Name: ____________________________ Relationship: _________________________
Name: ____________________________ Relationship: _________________________

____________________________________      ______________________________
Signature of Legal Guardian                      Date
Patient History

Name: ____________________________________
Acc. Number: ______________________________
Birth date: ___________ Age ___________
Form completed by: _______________________
Date completed: _________________________

HOUSEHOLD:
Please list all those living in the child’s home:

<table>
<thead>
<tr>
<th>NAME</th>
<th>RELATIONSHIP TO CHILD</th>
<th>BIRTHDATE</th>
<th>HEALTH PROBLEMS</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

Are there any siblings not listed? If so, please list their names and ages and where they live: ______________
____________________________________________________________________________________

If mother and father are not living together or if child does not live with parents, what is the child’s custody status?
____________________________________________________________________________________

If one or both parents are not living in the home, how often does he/she see the parent/s not in the home?
____________________________________________________________________________________

BIRTH HISTORY:
Birth weight: _____________ Method of delivery: _______vaginal _______cesarean
If by cesarean section, why: __________________________________________________________.
Was the baby born term: _____________ early: ___________ if early, how many weeks: __________.
Did your baby have any problems right after birth? _______Yes _______No
If yes, explain problems: ____________________________________________________________.
Did mother have any illness or problems with her pregnancy: _______Yes _______ No
If yes, explain: _________________________________________________________________.
How was baby fed initially? breast _______bottle________________
During pregnancy, did mother smoke: _______Yes _______ No
Drink alcohol _______ Yes _______ No / Use drugs or medications: _______Yes _______ No
If yes, what medications or drugs were used:
________________________________________________

Was the baby discharged home with the mother: ______ Yes ______ No 
If no, explain ____________________________________________________________

GENERAL:
Do you consider your child to be in good health? _____Yes _____No Explain ____________________________
Does your child have any serious illness or medical conditions?: _____Yes _____No Explain ______________________
Has your child had serious injuries or accidents? _____Yes _____No Explain ______________________________
Has your child had any surgery? _____Yes _____No Explain _______________________________
Has your child ever been hospitalized? _____Yes _____No Explain ____________________________
Is your child allergic to any medicines or drugs? _____Yes _____No Explain ________________________

DEVELOPMENT:
Are you concerned about your child’s physical development? _____Yes _____No Explain _______________
Are you concerned about your child’s mental or emotional development? _____Yes _____No Explain __________
Are you concerned about your child’s attention span? _____Yes _____No Explain ______________________
If your child is in school:
How is his/her behavior in school? _______________________________________________________________
Has he/she failed or repeated a grade in school? ___________________________________________________
How is he/she doing in academic subjects? _______________________________________________________
Is he/she in special or resource classes? ________________________________________________________

FAMILY HISTORY:
Have any members of the family had the following:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Who</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deafness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nasal allergies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Tuberculosis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart disease (before 50 years old)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High blood pressure (before 50 y.o.)</td>
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<td></td>
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<tr>
<td>High cholesterol</td>
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<tr>
<td>Anemia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bleeding disorder</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liver disease</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
Kidney disease  Yes
  ___No___ Who________________________

Diabetes (before 50 y.o.)  Yes ___No___ Who________________________

Bed-wetting (after 10 y.o.)  Yes ___No___ Who________________________

Epilepsy or convulsions  Yes ___No___ Who________________________

Alcohol abuse?  Yes ___No___ Who________________________

Drug abuse?  Yes ___No___ Who________________________

Mental illness?  Yes ___No___ Who________________________

Mental retardation?  Yes ___No___ Who________________________

Immune problems, HIV or AIDS?  Yes ___No___ Who________________________

Additional family history or comments: ____________________________________________________
  ____________________________________________________
  ____________________________________________________

PATIENT HISTORY:

Does your child have, or has he/she ever had:

Chickenpox:  Yes__ No____ When______________________________

Frequent ear infections:  Yes__ No____ Explain______________________________

Problems with ears or hearing:  Yes__ No____ Explain______________________________

Nasal allergies:  Yes__ No____ Explain______________________________

Problems with eyes or vision:  Yes__ No____ Explain______________________________

Asthma, bronchitis, bronchiolitis, pneumonia:  Yes__ No____ Explain______________________________

Any heart problem or heart murmur:  Yes__ No____ Explain______________________________

Anemia or bleeding problems:  Yes__ No____ Explain______________________________

Blood transfusions:  Yes__ No____ Explain______________________________

Frequent abdominal pain:  Yes__ No____ Explain______________________________

Constipation requiring doctor visits:  Yes__ No____ Explain______________________________

Bladder or kidney infections:  Yes__ No____ Explain______________________________

Bed-wetting (after 5 y.o.):  Yes__ No____ Explain______________________________

(For girls) has she started menstrual period?  Yes__ No____ When______________________________

(For girls) are there problems with period?  Yes__ No____ Explain______________________________

Any chronic or recurrent skin problems (Acne, eczema, etc)?  Yes__ No____ Explain______________________________

Frequent headaches:  Yes__ No____ Explain______________________________
Convulsions or other neurologic problems: Yes___ No____ Explain_____________________

Diabetes: Yes___ No____ Explain_________________________________

Thyroid or other endocrine problems: Yes___ No____ Explain_________________________________

Any other significant problem: Yes___ No____ Explain_________________________________

Use of alcohol or drugs: Yes___ No____ Explain_________________________________
Records Release

I Hereby Authorize You to Release My Child’s Records to the Following:

TO: [All fields required]
Dr. __________________________________________________________

(Street Address) (City) (State) (Zip Code)

(Telephone Number) (Fax Number)

FROM: [All fields required]
Dr. __________________________________________________________

(Street Address) (City) (State) (Zip Code)

(Telephone Number) (Fax Number)

Extent of information to be released:
Complete Health Records ______
Office Notes ______ from ____________ to ______________
Immunizations Only ______
Lab Only ______
X-Ray Only ______
Other __________________________________________________________

Please include any Medical information concerning diagnosis and records of treatment or examination rendered.

Please note there may be a per page charge.

Child’s Name: ______________________________________ Date of Birth: ________________
Child’s Name: ______________________________________ Date of Birth: ________________
Child’s Name: ______________________________________ Date of Birth: ________________
Name of Legal Guardian: ____________________________________________

(Street Address) (City) (State) (Zip Code)

☐ I would like to pay an additional cost to have my child’s medical records mailed certified mail which includes a tracking number. This cost will be determined by the weight of the package being mailed.
☐ I would not like to pay the additional cost to have my child’s medical records mailed certified mail, and I understand Caldwell Pediatrics and Wellness Center is not responsible for any medical records that the USPS fails to deliver timely or loses.

Parent’s Signature: __________________________________ Date: ______________
Telephone Number: ______________________________

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