



Child Patient Registration

Child Patient Name (First, MI, Last): Gender: Male Female
Date of Birth: Marital Status: Single Married Social Security #:
Mailing Address: City/State: Zip Code:
Street Address: City/State: Zip Code:
Phone (Home): Phone (Cell): Phone (Work):
Email:

Parent/Guardian

1) Name: Gender: Male Female
Relationship to Patient: Date of Birth:
Mailing Address: Social Security #:
City: Phone: (Primary)
State, Zip code: (Secondary)
2) Name: Gender: Male Female
Relationship to Patient: Date of Birth:
Mailing Address: Social Security #:
City: Phone: (Primary)
State, Zip code: (Secondary)

Emergency Contact:
Relationship: Phone:

- Can the above listed contacts (with photo identification) pick up prescriptions if you are unavailable?
Yes No

If you would like to give us permission to release/discuss personal information in your medical record with someone other than yourself, please fill out the Authorization Form: PHI Release Authorization.

We may need to communicate upcoming appointment information, test results and/or other information regarding your medical care. What is the best phone number for contact where we may also leave messages?

Home Cell Work

Race

- White
Black or African American
Asian
Other:
American Indian or Alaska Native
Native Hawaiian or Other Pacific Islander

Preferred Language

- English
Other:

Ethnicity

- Non-Hispanic or Latino
Hispanic or Latino
Other

The above information is thorough and accurate to the best of my knowledge. For any changes to the above information, I will notify the office.

PATIENT/Authorized Person SIGNATURE: Date:

Authorized Person NAME (print): Relationship:

CPS Update/Staff Initial

Consents and Terms

Patient Name (First, MI, Last): _____ **Date of Birth:** ____/____/____

Insurance Information* (fill out completely)

Primary Insurance: _____

Insurer ID#: _____

Group #: _____

Claims Address: _____

Subscriber: _____

Subscriber's Date of Birth: _____

Relationship to patient:

Self Spouse Other

Secondary Insurance: _____

Insurer ID#: _____

Group #: _____

Claims Address: _____

Subscriber: _____

Subscriber's Date of Birth: _____

Relationship to patient:

Self Spouse Other

Workers Compensation

Company _____ Address _____

Claim # _____ Date of Injury _____ Body Part Covered _____

Case Manager _____ Phone Number _____ Ext _____

Employer at time of injury _____ Contact Name/Phone _____

Attorney Name _____ Phone _____

Please let us know if you have any questions.

Payment Policy: Payment is due at time of service; Co-pays are due; Full payment is due for self-pay patients. Cash or credit cards (Visa, MasterCard and Discover) are accepted. On a limited basis checks may be accepted. There is a service charge on any returned check; full payment required within 10 days of notice.

Insurance: The office will kindly bill your insurance company. We participate with a number of medical insurance plans that we will contact to verify eligibility and benefits. You have the **ultimate responsibility of verifying the coverage with your insurance.** You acknowledge that we may be an out of network provider with your insurance. If your insurer sends payment directly to you, you agree to endorse the insurance check and forward funds to the appropriate entity above within 30 days of receipt. Patients who do not supply accurate and/or updated insurance information are Self-Pay.

Insurance Referrals: If your plan requires a referral from your Primary Care provider, it is your responsibility to obtain it before seeking treatment from us. If a claim is denied due to a lack of referral you are responsible for charges.

Missed Appointments: If you are unable to keep an appointment you must notify the office at least 24 hours prior to your scheduled appointment. If you "no-show" or cancel without sufficient notice, you may be subject to a 'no show' cash fee, payable by you, not your insurance company.

The above information is thorough and accurate to the best of my knowledge. I will notify the office of any changes within 30 days. If I do not notify the office of insurance changes, I am fully financially responsible.

I understand that rude or disrespectful treatment of staff is not tolerated and may result in my discharge. (e.g. using profanity, raising my voice, making vulgar or inappropriate comments).

I understand that my health is my own, not my families' or spouse's. Therefore, I need to be the person to communicate with the provider and his/her staff if at all possible

I consent to evaluation and treatment by any Salmon Falls Family Healthcare provider. I authorize my Provider to communicate with other providers regarding my treatment and care.

I acknowledge that I have a copy and/or access to the Notice of Privacy Practices.

I authorize release of records and information for treatment, payment and healthcare operations.

I authorize my insurance carrier to pay benefits for services rendered, directly to PMC Medical Group, LLC or any of its affiliates. I am financially responsible for claims denied or not covered by my insurance carrier.

I have read and agree to the terms of the above information.

CPS Update/Staff Initial

PATIENT/Authorized Person SIGNATURE: _____ **Date:** _____

Authorized Person NAME (print): _____ **Relationship:** _____

Child Health History Form

Child Name: _____ **DOB:** ____/____/____ **Gender:** Male Female

Reason for today's visit: _____

BIRTH HISTORY

Age of mother at birth: _____ Birth Weight: _____ Type of delivery: _____

Problems/medications during pregnancy: _____

Condition of baby at birth: _____

MEDICAL HISTORY (Please list any medical history and if possible the age for each)

Chronic illnesses: _____

Daily Medication: _____

Hospitalizations: _____

Surgeries: _____

Additional Injuries requiring medical treatment: _____

ALLERGY HISTORY

No Known Allergies Medication Allergies Environmental/Seasonal Allergies Latex Allergies

Allergen (ex. Food, Dust, Animals, Pollen, Medication)	Reaction (ex. Rash, nausea, respiratory, shock, etc.)

FAMILY HISTORY (Please check any medical conditions that are present in your family members. If applicable, please list family member beside condition (Mom, Dad, Sibling, Maternal grandparent, Paternal grandparent, Great grandparent, etc.)

Asthma: _____

Diabetes: _____

Heart Disease: _____

Seizures: _____

Thyroid problems: _____

High blood pressure: _____

Obesity: _____

Mental illness: _____

High cholesterol: _____

Cancer (specify): _____

Genetic disorders: _____

Kidney/disorders: _____

Bowel problems: _____

ADHD: _____

Learning Disability: _____

Other (please list): _____



SOCIAL HISTORY

Siblings: Yes No

Siblings Names & Date of Birth: _____

If parents live separately, where is the child's primary residence?: _____

Who lives at home?: _____

- Does your child use a car seat? Yes No
- Does your child use seatbelts? Yes No
- Do you wear a seatbelt? Yes No
- Does your child wear a helmet? Yes No
- Are there any guns in the house? Yes No
- If yes, are they locked up? Yes No
- Do you smoke cigarettes? Yes No
- Do you put sunscreen on your child? Yes No
- Do you use sunscreen? Yes No

Check all activities that apply for child, and how many hours per day?

- Watch TV: _____ Play Video Games: _____
- Use Computer: _____ Exercise/Sports/Outside Play: _____

How often do you eat at fast food restaurants? _____

Name & Relationship of Person Completing Form: _____

Signature: _____

Date: _____

Witness: _____

Date: _____