Salmon Falls
family healthcare

www.SalmonFallsMD.com

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

First parent/guardian listed will be assigned as guarantor responsible for statements and bills.

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 ☐

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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:** _____

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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:_____