PATIENT REGISTRATION FORM

Andrew M. Matthew M.D., Jessica M. Hochman M.D, Karen Tenenblatt, M.D.

Child's Name: _____ DOB:_____ Sex:_____

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Home Address: _____ City:_____ State:_____ ZIP:_____

Billing Address: _____ City:_____ State:_____ ZIP:_____

Home #:_____ Email address:_____ May we contact you via email? Y / N

Emergency contact:_____ Phone:_____

PARENT #1 Name: _____ DOB_____ SS#_____

Employer:_____ Occupation:_____ Work Phone:_____

Cell Phone:_____ Drivers License Number:_____ State:_____

PARENT #2 Name: _____ DOB_____ SS#_____

Employer:_____ Occupation:_____ Work Phone:_____

Cell Phone:_____ Drivers License Number:_____ State:_____

INSURANCE INFORMATION:

Subscriber Name: _____ Insurance Company_____

ID#_____ Group #_____ Phone#_____

Secondary Insurance Company _____

ID#_____ Group #_____ Phone#_____

Financial Agreement: By signing below, I hereby certify the correctness of the above information and authorize the release of information to my insurance company. I assign benefits to Andrew M. Matthew, MD, Jessica M. Hochman, MD, and/or Dr. Tenenblatt, MD. A photocopy of the assignment may serve as an original. I hereby agree that in consideration for services rendered by the doctor(s), I shall make prompt payment to my account as bills are presented. I also understand that I am ultimately responsible for my bill regardless of my insurance coverage. Also note there is a 24 hour cancellation policy. **There is a $50 fee for walk-in appointments, missed appointments, or appointments cancelled less than 24 hours.**

Permission to Treat: I give permission to Andrew M. Matthew, M.D, Jessica Hochman, M.D. and Dr. Karen Tenenblatt, MD to render treatment for my minor children.

Signature: _____ Relationship:_____ Date:_____

NEWBORN/INFANT HISTORY QUESTIONNAIRE (Please fill out for each child <12 Months)

Child's Name:_____ Nickname:_____ Birthdate:_____

Did mother take any medications, drugs, alcohol or smoke during pregnancy? NO YES

If yes, please explain:_____

Were there any problems with the pregnancy? NO YES

If yes, please explain:_____

Was the delivery_____ vaginal/Cesarean? _____ forceps/ vacuum used?

Were there any problems with the birth? NO YES

If yes, please explain:_____

Baby's birth weight:_____ Length_____

Has your baby had problems since birth? NO YES

If yes, please explain:_____

Mother's blood type (if known): _____ Baby's blood type (if known):_____

If you are breast feeding or formula feeding, how often does your baby eat and how often?_____

Are you having any problems with feeding? NO YES

If yes, please explain:_____

Does your baby have any elimination problems? NO YES

If yes, please explain:_____

Does your baby have any sleeping problems? NO YES

If yes, please explain:_____

Does your baby seem to be developing normally? NO YES

If yes, please explain:_____

Please circle any medical problems that run in the child's family:

anemia	depression	hay fever	mental retardation	cancer
allergies	diabetes	heart problems	seizures	genetic problems
asthma	early deaths	high blood pressure	sickle cell disease	tuberculosis
birth defects	eczema	kidney problems	thyroid disease	liver problems

If any above are circled, please describe: _____

_____

CHILD/ADOLESCENT HEALTH QUESTIONNAIRE (Please fill out for each child over 1 year of age)

Child's Name:_____ Nickname:_____ Birthdate:_____

BIRTH HISTORY:

Hospital where born:_____

Birth Weight:_____ Length_____

Was the delivery_____ vaginal/Cesarean? Full term or premature? _____

Did mother take any medications, drugs, alcohol or smoke during pregnancy? NO YES

If yes, please explain:_____

Any problems or health concerns during pregnancy? YES NO

If yes, please explain:_____

Any issues as a newborn? YES NO

If yes, please explain:_____

EARLY DEVELOPMENT:

Feeding history: Breast milk? _____ Formula name/type?_____

Age when sat? _____ Age when walked?_____ First words?_____

MEDICAL PROBLEMS:

Any problems after birth?	YES	NO
Any reactions to vaccinations?	YES	NO
Reactions/allergies to drugs?	YES	NO
Recurring infections?	YES	NO
Multiple (>3) ear infections by age 2?	YES	NO
Bronchitis or pneumonia?	YES	NO
Kidney or bladder infections?	YES	NO
History of seizures?	YES	NO
Constipation or recurrent diarrhea?	YES	NO
Environmental Allergies? Asthma? Eczema?	YES	NO
Allergies to foods?	YES	NO
Childhood diseases? (e.g. chickenpox?)	YES	NO

BEHAVIOR PROBLEMS: Please circle all that apply:

Temper tantrums Sleep problems Toilet training problems Aggression

Any other concerns? _____

Accidents: (examples: broken bones, loss of consciousness or overdosing?)_____
_____ _____

Hospitalizations? If yes, why?_____

Surgeries?_____

Please circle any medical problems that run in the child's family:

anemia	depression	hay fever	mental retardation	cancer
allergies	diabetes	heart problems	seizures	genetic problems
asthma	early deaths	high blood pressure	sickle cell disease	tuberculosis
birth defects	eczema	kidney problems	thyroid disease	liver problems

If any above are circled, please describe: _____

_____

Dear Patient,

We understand that insurance policies are complicated and constantly changing. As a courtesy, our office will bill your insurance policy. However, our office does not verify benefits, and thus it is your responsibility to call your carrier and ensure our participation in your health insurance network. If, for whatever reason, your insurance company does not pay, you, the parent, ultimately will bear the financial responsibility for your child's medical bill.

Furthermore, co-pays must be paid at the time of service. This is a contractual agreement that you have with your insurance company. After your claim has been reconciled with your insurance, you will receive a billing statement from our office. The amount on this statement will reflect your balance, and that balance is due upon receipt. Any balance remaining on your account for services not covered by your insurance company is your responsibility.

Your signature below will confirm that you understand your financial responsibility.

SIGNATURE: _____ DATE:_____

AUTHORIZATION FOR

SOMEONE OTHER THAN PARENT TO BRING CHILD

To whom it may concern:

I authorize _____

_____

_____

to bring my child/children,

Child's Name _____ DOB_____

Child's Name _____ DOB_____

Child's Name _____ DOB_____

Child's Name _____ DOB_____

to the office of Oak Park Pediatrics, to be seen and treated by Andrew M. Matthew, M.D., Jessica M. Hochman, M.D., or Karen Tenenblatt M.D.

Effective from dates : _____ Until:_____

Parent printed name_____

Parent signature _____ Date_____

Oak Park Pediatrics

358 Kanan Road
Oak Park, CA 91377
818-707-0046

RECEIPT OF NOTICE OF PRIVACY PRACTICES

WRITTEN ACKNOWLEDGMENT FORM.

I, _____, have received a copy of Dr. Matthew's, Dr. Hochman's and Dr. Tenenblatt's Notice of Privacy Practices.

_____ _____
Signature of Parent/Guardian Date

_____
Patient Name

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

_____ _____
Signature of Parent/Guardian Date

Patient Name _____