HT Family Physicians

Date:_____

Pediatric Patient Registration Form

✓ *By completing this questionnaire you provide us with important, basic information for our records.*

Patient's Name:_____ Patient's Date of Birth:__/____/____

Patient's Home Address: _____

_____

Home Phone Number: (_____)_____ Email:_____

Patient lives with: ☐ Both parents ☐ Mother ☐ Father ☐ Other:_____

Mother's Information	***Father's Information***
Last Name, First Name:	Last Name, First Name:
Date of Birth:	Date of Birth:
Home Address:	Home Address:
City: State: Zip:	City: State: Zip:
Daytime Phone N^{o}: ( )	Daytime Phone N^{o}: ( )
Cellular Phone N^{o}: ( )	Cellular Phone N^{o}: ( )

Insurance billing statement mailed to: Mother Father

In the case of an emergency, in which a parent/legal guardian cannot be reached, we may need to call someone on your child's behalf. Please list below the name of someone we have your permission to contact if necessary:

Emergency Contact: _____
(Name of person NOT living with child) *(Relationship to child?)*

Emergency Contact's Phone Number: (_____)

I have been given a copy of HT Family Physicians' Notice of Privacy Practices.

Signature: _____ **Date:**_____

CONSENT FOR CONTINUING TREATMENT OF MINOR CHILD

I, the parent /guardian of _____ , a minor child, do hereby consent to any
(child's full name)
diagnosis or treatment rendered under the general or specific instructions of physicians at HT Family Physicians.

This consent is given in advance of any specific diagnosis or treatment being required, and it is given to encourage those persons who have temporary custody of my child, and said physician(s), to exercise their best judgment as to the requirements of such diagnosis or medical treatment.

This consent shall remain effective until revoked in writing and delivered to said physician or to said persons entrusted with the custody, care and control of said minor child.

Legal Guardian:_____
(print name) *(signature)* *(date)*

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Insurance Information

Primary Insurance

Insurance Subscriber Name: _____DOB ___/____/___ (Name of person who carries the insurance)

Health Plan:_____ Group No: _____ ID No: _____

Secondary Insurance

Insurance Subscriber Name: _____DOB ___/____/___ (Name of person who carries the insurance)

Health Plan:_____ Group No: _____ ID No: _____

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Financial Responsibility for Services Rendered by HT Family Physicians

I acknowledge that acceptance of my insurance information is not a guarantee of payment by my health plan until the claim has been processed and paid. I further understand that if my claim is not accepted for payment I am personally responsible for payment of medical services rendered to myself or a member of my family.

I acknowledge that medical billing statements for services rendered by HT Family Physicians will be sent to the person who carries the insurance for the patient/family member.

Signature: _____ **Date**: _____

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LATE TO APPOINTMENT POLICY

We value your time and strive to see you as close to your appointment time as possible. Recognizing unanticipated things happen, we will hold your appointment for a 10 minute grace period after the scheduled start time of your appointment. In consideration of every patient, all appointments will be automatically canceled thereafter. If you arrive after your appointment has been cancelled, you will be asked to reschedule the appointment.

MISSED APPOINTMENT OR "NO-SHOW" POLICY

It is your responsibility to remember your scheduled appointment. After three (3) missed appointments, we may choose to discontinue your care.

_____ _____

Your Signature Acknowledges Receipt Date

HT Family Physicians

Child's Name: _____

Date Of Birth: _____ Age: _____ ☐ M ☐ F

Name of Person Completing the Questionnaire: _____

Pediatric Initial History Questionnaire

Birth Weight:	Was the delivery Vaginal? Cesarean?
Was the baby born at term? Early? Late?	If Cesarean, why?
If early, how many weeks gestation?	Did your baby have any problems right after birth?
Did mother have any illness or problem with her pregnancy?	Yes No Explain
Yes No Explain:	
	Was initial feeding Breast? Bottle?
During pregnancy, did mother	Did your baby go home with mother from the hospital?
Smoke Yes No Drink alcohol Yes No	Yes No Explain:
Use drugs or medications Yes No	
What? When?	

General

Do you consider your child to be in good health		Yes		No	Explain:
Does your child have any serious illness or medical condition?		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 medications 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 emotional development?		Yes		No	Explain:
Are you concerned about your child's attention span?		Yes		No	Explain:
Is your child in school?		Yes		No	Explain:
Has your child ever been hospitalized?		Yes		No	Explain:
Is your child allergic to any medications or drugs?		Yes		No	Explain:
How is his/her behavior in school?					