PATIENT REGISTRATION FORM

Patient Name: Last ________________________ First ________________________ MI ______

D.O.B ________________________Social Security # ______________________ Sex: (M) (F)

Patient lives with: Mother ____ Father ____ Other: ___________________________________

Mother/Guardian: ____

Social Security # ___________________________________ D.O.B. ______________________

Address: ____

City/State/Zip: ____

Home Phone: _____________________________ Cellular Phone: ________________________

Employer: ________________________________ Work Phone: _________________________

Father/Guardian: ____

Social Security # ___________________________________ D.O.B. ______________________

Address: ____

City/State/Zip: ____

Home Phone: _____________________________ Cellular Phone: ________________________

Employer: ________________________________ Work Phone: _________________________

If the need arises, where may we contact you? _____Home _____Cellular ____ Mother's Work ____ Father's Work

Emergency Contact Person (other than parents): _________________________ Phone: _______________

Referring Doctor: _________________________________ Phone: _______________________

Patient's Physician: ______________________________ Phone: ________________________

Medical care or immunizations cannot be given unless my child is accompanied by one of the following:

____

Parent/Guardian signature __________________ Relationship ____________ Date ______________

AUTHORIZATION OF TREATMENT AND ASSIGNMENT OF BENEFITS

I authorize Pediatric Surgical Associates to treat my child. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to Pediatric Surgical Associates for the medical and surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original.

Parent/Guardian signature _______________________ Relationship ___________ Date ______________

Patient Name: ______________________________ DOB: __________________________

****** PLEASE FILL OUT THIS FORM COMPLETELY ******

What current problems is your child having (what are we seeing your child for)?

____

Check if patient has now or has had the following illness or problems:

__ Trauma (broken bones, loss of consciousness, etc)

__ Stomach of intestinal problems

__ Growth problems

__ Seizures

__ Cancer

__ Neurological problems

__ Anemia or blood disorder

__ Diabetes

__ Asthma

__ Heart problems

__ Emotional/behavioral problems

__ Past surgeries

Please explain: ____

____

Are all immunizations up to date? ____

ALLERGIES (list or indicate none if applicable): ____________________________________

____

FAMILY HISTORY

__ Bleeding

__ Cancer or blood disorder

__ Problems with anesthesia

__ Heart disease or liver disease

Please explain: ____

____

BIRTH HISTORY

Type of delivery: __ Vaginal __ C-Section Baby was: __ Full Term __ Premature

Birth weight: ________ Was he/she on a ventilator? __Yes __ No If so, how long ? ___________

Other complications: ____

I understand that if my child's physician, or any person employed by or under the direction and control of my child's physician (s) is directly exposed to my child's body fluids in any manner which may, according to the then current guidelines for the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or Hepatitis B or C viruses, that I am deemed by law to have consented to testing for infection with HIV or Hepatitis B or C viruses. I further understand by law that I will have deemed to have consented to the release of these test results to the person who is exposed to my child's body fluids.

Parent/Guardian signature __________________ Relationship _____________ Date _______________