Patient Registration Form

PATIENT INFORMATION:

NAME: ____ Preferred Name: ______________________

SEX: M / F   DATE OF BIRTH: _____ / _____ / _____ Social Security Number: ____________________

NAME: ____ Preferred Name: ______________________

SEX: M / F   DATE OF BIRTH: _____ / _____ / _____ Social Security Number: ____________________

NAME: ____ Preferred Name: ______________________

SEX: M / F   DATE OF BIRTH: _____ / _____ / _____ Social Security Number: ____________________

CONTACT INFORMATION:

MOBILE PHONE: _____________________________ USA: ___Yes ___ No

HOME PHONE: ______________________________ WORK PHONE: ___________________________

Guardian EMAIL: ______________________________________

PATIENTS ADDRESS: ____

City: ____________________________ State: _____________ Zip Code: ________________

Preferred Method of Communication: __ Mobile # __ Home # __ Work # __ Email __ Mail

INSURANCE INFORMATION:

ACTIVE PLAN NAME AND TYPE: ____________________________________ or ___________Self

Insurance ID: ____________________________ Group ID: __________________________

GUARANTOR NAME: ___________________________________ RELATIONSHIP: _________________

ADDRESS: ______Same as Patient or: ____

City: _________________ State: ___ Zip Code _____ DATE OF BIRTH (*Guarantor*): __ / __ / __ SEX: M / F

DEMOGRAPHICS:

Preferred Language: ________________________

ETHNICITY: _____: Hispanic or Latino ______: Not Hispanic or Latino

RACE:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White

How or where did you hear about SuperKids Pediatrics?
____

Guardian (F or M)
Name: ___________________________
Date of Birth: ___________________________
Address: ________________________________
____
Cell #: __________________________________
Occupation: _____________________________
Work Phone: ____________________________
Driver's License #: ________________________

Guardian (F or M)
Name: ______________________________
Date of Birth: ____________________________
Address: ________________________________
____
Cell #: __________________________________
Occupation: _____________________________
Work Phone: ____________________________
Driver's License #: ________________________

Previous Primary Care Provider: ____
Phone: ____
Address: ____

Siblings:
Name: ____ Date of Birth: ____/_____/_____ Sex: M/F
Name: ____ Date of Birth: ____/_____/_____ Sex: M/F
Name: ____ Date of Birth: ____/_____/_____ Sex: M/F

PREFERED PHARMACY USED: _________________________ PHONE: _________________________

LOCATION/ADDRESS: ____

The undersigned hereby authorizes the release of any information relating to treatment, healthcare options and all claims or benefits, submitted on behalf of myself and / or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits and for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I hereby authorize my insurance company (ies) to pay and hereby assign directly to SuperKids Pediatrics all benefits, if any, otherwise payable to me for his/her services. I understand that even though SuperKids Pediatrics has agreed to participate with my insurance company, I am ultimately responsible for all charges related to my children's care.

Parent / Guardian

Print: ____

Sign: ____

Date: ____

PEDIATRIC HEALTH QUESTIONNAIRE

Todays Date: __________________

Patients Name:_______________________________ Age: ___ Birth Date:______________

PARENTS:

Name: ______________________________________ Age: ____ Relationship: Father / Mother

Name: ______________________________________ Age: ____ Relationship: Father / Mother

Sibling Name: ____________________ Age: _______

Sibling Name: ____________________ Age: _______

Sibling Name: ____________________ Age: _______

Who does the child live with? ______________________________ Pets at home? _________________

Birth History:

Complications during pregnancy? Yes No

Was the baby Premature? Yes No

Any complications after birth? Yes No (jaundice, breathing, feeding problems, infections)

Hospitalizations/Illnesses:

Please, list below any hospitalizations, surgeries and/or serious injuries. Age

____ _____

____ _____

Present Medications: Please, list below any medication (prescription medication, over the counter medication, herbs) your child is now taking or takes often.

Name Dosage

____

____

Previous Medications: Please, list below any previous medication (prescription medication, over the counter medication, herbs) your child used to take on a regular basis.

Name Dosage

____

____

Is your child allergic to any medication, food or things from the environment? ___ Yes ___ No If Yes, please list: ____ .

What kind of reaction does it provokes? Runny nose, rash, anaphylaxis, GI symptoms, difficulty breathing, other: ____

Family History:

Is there a family history of: *(please circle Yes or No)*

Asthma	___ Yes	Heart Disease	___ Yes
Allergies	___ Yes	Tuberculosis	___ Yes
Seizures	___ Yes	Diabetes	___ Yes
Deafness	___ Yes	Mental Retardation	___ Yes
Cancer	___ Yes	Slow Learner	___ Yes
High Cholesterol	___ Yes	Mental Illness	___ Yes
Thyroid	___ Yes	Substance Abuse	___ Yes

Immunizations: Is your child up to date for her/his age? ___ Yes ___ No

Developmental/Social:

Have you ever feel your child is slow in: development? ___ Yes ___ No
Does your child get along well with other children? ___ Yes ___ No
Speech/language? ___ Yes ___ No
Social skills? ___ Yes ___ No
Motor skills? ___ Yes ___ No

Name of child's school: ________________________________ Grade: ________________

Are there any school problems or concerns? *If yes, please explain*

____

____

Teen concerns:

Smoking: ___ Yes

Alcohol: ___ Yes

Social/Recreational Drug use: ___ Yes ___ No

Sexual Issues: ___ Yes ___ No

Filled out by: _______________________________ Relationship:____________________________

Signature:______________________________ Date: _______________ Phone #:________________

Clinician Signature: _______________________________________ Date: ______________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

SuperKids Pediatrics
9121 N Military Trail Ste 102, Palm Beach Gardens, FL 33410
Phone: 561-619-2460 – Fax 844-886-3192

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

____
Please print your name here

____
Signature

____
Date

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below names(s) of the individual(s) you authorize our office to discuss care. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

____ ____
____ ____

FOR OFFICE USE ONLY
We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

☐ The patient refused to sign.
☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
☐ We weren't able to communicate with the patient.
☐ Other (Please provide specific details)
____
____

____
Employee signature

SuperKids Pediatrics Office Policies

9121 N Military Trail Suit 102, Palm Beach Gardens, FL 33410 Phone 561-619-2460

Office Policy

Thank you for choosing SuperKids Pediatrics! We are excited to partner with you and provide your family with the highest primary care possible. It is within this context that we ask you to take a few moments to review our office policies. We will be glad to answer any questions or discuss any concern with you.

• **No show or late arrivals** (considered >10 minutes after scheduled appointment). I understand that a no-show charge for the lost appointment will apply and that the first-available appointment may or may not be on the same day the appointment was missed. I understand that patients who have arrived on time will be seen ahead of those who arrive late. Please call ahead if you are late or unable to make your appointment time. I UNDERSTAND THAT A $25 DOLLAR FEE WILL BE ASSESSED FOR ALL MISSED APPOINTMENTS NOT CANCELLED AT LEAST WITH 24-HOURS ADVANCED NOTICE.

• **Appointments for additional siblings**. I understand that if I schedule an appointment with one child but no for my other(s) child, the practice might not be able to accommodate an encounter with a provider at the same time for my additional child. I understand that I need to schedule appointments ahead of time for all children.

• **Insurance & Demographic Information**. Please update your records with practice prior to each encounter. I understand that it is my responsibility to update any demographic or insurance information and any consequence arising while billing my insurance. I understand that I need to have my insurance information with insurance card and active policy at each appointment. It is my responsibility to provide SuperKids Pediatrics and my insurance company with all information needed to process my claim for services in a timely manner.

• **Billing**. I understand that it is my responsibility to understand my insurance policy coverage and limitations. I understand that SuperKids Pediatrics will collect all patient responsibility and balance at the time of service. I understand that any charge not covered by my insurance policy regardless of the reason, is my responsibility. I understand that if my account is not paid in full within 90 days of a statement date, a 25% collection agency processing fee will be added to the outstanding balance, and it will be turned to collection for further processing. I understand that no additional services will be provided for delinquent accounts until they are brought current. I understand that I am ultimately responsible for all professional fees incurred for services and consults performed.

• **No electronics, food, or smoking**. I understand that the use of cell phone, recording devices, radios, electronic devices, headphones, or ear plugs is not permitted in the examination rooms. I further understand that no food, drinking, smoking (cigarette or vaping) is allowed in the office.

• **After-hours Call Service**. Please limit after-hour calls to urgent issues only. For emergencies call 911. I understand that for refills, appointment requests, and other no urgent matters, I may leave a message or call the office during regular hours so that they can be appropriately managed by the appropriate care team. I UNDERSTAND THAT AN AFTER HOUR FEE OF $35.00 MAY BE ACCESSED FOR THE CONVINIENCE OF THE AFTER HOURS SERVICE.

• **Well Child Care (WCC) requirement**. I understand that SuperKids Pediatrics require full commitment with all recommended WCC visits. These visits include encounters at 1,2,4,6,9,12,15,18 and 24 months of life. One yearly visit thereafter. WCC visits are a condition for primary care provider-patient relationship with SuperKids Pediatric office. I further acknowledge that it is standard procedure for physicians to submit claims for “illness” related evaluations addressed during a scheduled well child examination visit.

• **Vaccine Policy Statement**. SuperKids Pediatrics recommends and firmly believes in the effectiveness of vaccines to prevent serious illness and to save lives, and in their safety. I understand that SuperKids Pediatrics is not accepting new families who choose not to vaccinate their child. In an effort to increase immunity within SuperKids Pediatircs patients and community, SuperKids Pediatrics will continue helping families who are delaying or choosing an “alternate” vaccine schedule. However, I understand that SuperKids Pediatrics require a limit of 24 months of life for vaccine compliance based on the AAP vaccine schedule recommendations at 24 months. I further understand the consequences if my child does not receive the vaccine(s). I understand that SuperKids Pediatrics could require further compliance for overseas travelers and/or with additional high-risk conditions. I understand that my provider at SuperKids Pediatrics will spend time with me in discussing available science behind each intervention, concerns, myth busting, and how vaccines relate to diseases and preventive care. I am aware that my insurance company may not reimburse me for vaccination or administration fees not completed while the appropriate well child encounter. In addition, I may be charge a copay or co-insurance for returning for an office visit to receive vaccines.

I have read and agree to all the provisions of the above Office Policies and statements.

Name of Guarantor or Responsible Party: ____

Signature of Responsible Party: ____ Date: _____________

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

(TO REQUEST RELEASE OF MEDICAL INFORMATION PLEASE COMPLETE AND SIGN BELOW.)

I, ________________, hereby voluntarily authorize the disclosure of information from my health record.
(Name of Patient)

Patient Name:______________________________ Patient's Date of Birth:_________________________

Purpose of Release
- ☐ Change in insurance or Physician
- ☐ Continuation of Care
- ☐ Referral
- ☐ Other

Type of Information
- ☐ 2 years prior from last seen
- ☐ Complete Medical Record
- ☐ Dates Other: ____________________
- ☐ Specific Information Request

The Information is to be provided to:

Name Organization/Facility: **SuperKids Pediatrics**

Address: 9121 N. Military Trail Ste. 102, Palm Beach Gardens, FL 33410

Phone Number: 561-619-2460

Fax Number: **844-886-3192**

____ __________________________
Patient's Signature or Patient's Guardian Date

____ __________________________
Printed Name of Patient's Guardian Relationship to Patient

HIPAA Authorization for Release of Information

Under HIPAA with patients' written request, records must be provided within 30 days of a request. Under House Bill 300 Texas Law with patient's written request, records must be provided within 15 days of a request.