Patient Registration Form

CUMBERLAND PEDIATRICS

Today's Date: _____

PATIENT INFORMATION

Name: _____

Date of Birth: _____ Sex: ☐ M ☐ F

Home Address: _____

City: _____ State: _____ Zip: _____

Sibling Names and Ages *(ex: Jack, 9)*: _____

_____

PARENT/GUARDIAN INFORMATION

PRIMARY FAMILY EMAIL: _____

PRIMARY FAMILY PHONE: (____) _____ (*OFFICE USE: LABEL AS "MAIN")*

Mother's Name: _____ Date of Birth: _____

Mobile Phone: (____) _____ **Work Phone:** (____) _____

Home Address (*if different from child*): _____

City: _____ State: _____ Zip: _____

Employer: _____

Father's Name: _____ Date of Birth: _____

Mobile Phone: (____) _____ **Work Phone:** (____) _____

Home Address (*if different from child*): _____

City: _____ State: _____ Zip: _____

Employer: _____

Alternate Contact (relative or friend): _____

Alternate Contact Phone: (_) _____

Relationship to patient: _____

We are required to collect the following information for each patient.

Please complete this section before returning the form. Thank you.

Preferred Doctor/ARNP:

_____

Your Preferred Language:

_____

Your Child's Race/Ethnicity
(select one primary)

- ☐ American Indian
- ☐ Asian
- ☐ Black/African American
- ☐ Caucasian
- ☐ Hispanic
- ☐ Multiracial
- ☐ Unknown
- ☐ Other _____
- ☐ Decline to answer

Insurance Information

Name of Insurance Company: *(if more than one plan please list both and provide copies Of insurance cards*

_____ _____ (Ins Co)

Member ID#: _____ _____ (Member ID)

Group #_____ Contact# _____ _____ _____ (Group #/Contact#)

FORM COMPLETED BY:

_____ _____ _____

Name *(print)* **Signature** **Date**

CUMBERLAND PEDIATRICS

PEDIATRIC HEALTH HISTORY

Child's Name _____ Date of Birth _____Age _____ Male _____ Female _____

Mother's Name _____ Father's name _____

Prior Physician _____ Prior Physician Phone: _____

Child's Past Medical History

Pregnancy/Neonatal Period

Where was your child born? _____
Is the child yours by ☐birth ☐adoption ☐stepchild ☐other
Pregnancy complications _____
Delivery by ☐vaginal ☐c-section
Reason for c-section _____
Complications _____
Was your child premature ☐No ☐Yes, born at _____ weeks
Complications _____
Apgar scores 1 minute _____ 5 minutes _____
Birth weight _____ Length _____
Other problems in the newborn period _____
_____

Infancy/Childhood/Adolescence

Has your child ever been treated for or diagnosed with: (explain)

☐ Asthma or reactive airway disease _____
☐Wheezing or bronchiolitis _____
☐ Seasonal allergies or eczema _____
☐ Food allergy _____
☐ Recurrent ear infections _____
☐ Pneumonia _____
☐ Urinary tract infections _____
☐ Genetic syndrome _____
☐ Seizures _____
☐ Anemia _____
☐ Broken bone _____
☐ Mental retardation or learning disability _____
☐ Depression/anxiety _____

Other chronic medical conditions _____
_____
Has your child ever been hospitalized ☐No ☐ Yes (explain)
_____
_____
Previous surgeries and dates _____
_____
Previous pediatrician _____
Please list any specialist your child is currently seeing and reason:
_____
_____

Medications

ALLERGIES to medicine/vaccines (list and describe reaction)
_____
_____
Current medications and dose: _____
_____
_____
Vitamins _____
Herbal supplements _____
Over-the-counter meds _____

Development/Nutrition

At what age did your child:
Walk alone _____ Sit alone _____
Toilet train(day) _____ Say words _____
1st period (females) _____
Was your child breastfed ☐ No ☐Yes, how long? _____
Has your child had any unusual feeding/dietary problems? Explain.
_____
_____

Social History

Who lives in the child's household? ☐ Mom ☐ Dad ☐ Step_____
☐ Siblings (# _____) ☐ Grandparents ☐ Other _____
Mother's occupation _____
Father's occupation _____
Child's parents are ☐ married ☐ unmarried ☐ divorced ☐ other
Childcare ☐ parents ☐ relatives ☐ daycare ☐ babysitter/nanny
Days per week in childcare (not with parents) _____
School's name _____ Grade _____
Any concerns about school performance? ☐ No ☐ Yes, explain
_____
Do any household members smoke ☐ Yes ☐ No
How many hours per day does your child spend:
Watching TV _____Computer _____Video games _____
Sports/exercise: Type _____
How often? _____ How long _____min

Family History

Do any family members have any of the following conditions:

Condition	Mother	Father	Sibling	Grandparent
Asthma	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Blood disorder	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Heart attack/disease	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Depression/anxiety	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐
_____	☐	☐	☐	☐

Please explain all positives. _____
_____
_____
_____

Child's Health History (*Check all that apply*)

☐ Rheumatic Fever
☐ Birth Defects
☐ Genetic Defects
☐ Mental Retardation
☐ Asthma
☐ Chicken Pox
☐ Congenital Heart Defect
☐ Frequent runny nose
☐ Cough, short of breath
☐ Chest tightness, wheeze
☐ Hemophilia
☐ Bone/Joint pain, swelling
☐ Meningitis
☐ Cancer
☐ Speech problems
☐ Eye Problems
☐ Itchy eyes
☐ Rashes
☐ Abnormal moles
☐ Abnormal bruising, bleeding
☐ Nausea, vomiting, diarrhea
☐ Constipation, blood in stool
☐ Abdominal pain
☐ Heart Murmur
☐ Tires easily with exertion
☐ Fainting
☐ Frequent or painful urination
☐ Bedwetting, frequent accidents
☐ Vaginal or penile discharge
☐ Headaches
☐ Seizures
☐ Clumsiness
☐ Milestone delay
☐ Anxiety/stress
☐Depression
☐ Sleep problems
☐ Anger concern
☐ Concerns with attention, impulsivity

Patient Name _____ Date of Birth _____
(Last, First, Middle)

ACKNOWLEDGEMENT RECEIPT OF NOTICE OF PRIVACY PRACTICES (NOPP)

The undersigned acknowledges he/she has received a copy of the Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information (PHI). You may also obtain a copy on our website at cumberlandpediatrics.com or contacting our office at 770.951.5400.

_____ _____
Patient/Legal Representative Signature Date

Staff Use Only *(check box):* ☐ NOPP Offered Pt Declined to Sign ☐ Emergency Situation NOPP Not Offered

---

ASSIGNMENTS OF BENEFITS

Financial Waiver/Policy

I hereby assign medical and/or surgical payments to include major medical benefits to which I am entitled, private insurance and any other health plan to Cumberland Pediatrics, PC for services provided by Cumberland Pediatrics, PC

By signing this document (below), I understand if claims are denied due to eligibility status, invalid medical group or invalid Primary Care Physician (PCP), I will assume full responsibility for all charges incurred by me and all dependents. Additionally, I will be held financially responsible for any non-covered benefits, deductibles or any co-payments for services, which have been provided to me. We always recommend that you check with your health plan prior to receiving any medical services to assess your benefits and eligibility for coverage. We typically submit our office specimens to Quest Lab unless specifically requested at the time of service of every visit.
It is my responsibility to understand my insurance benefits and plan coverage.
This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

OTHER FINANCIAL POLICIES

Release of Information for Reimbursement

To the extent necessary to obtain reimbursement, the physician's office may disclose any portion of the patient's record, including his/her medical records, to any party the patient has identified as liable for any portion of the physicians charges, including but not limited to, insurance companies, healthcare service plans, workers' compensation carriers, social security administration and peer review organizations. You agree, in order for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

Late / Cancellations / Appointment No Shows

If you cancel your appointment with less than 8 business hours (8 business hours – 1 business day), or miss your appointment, you will be charged a fee. It is within the physician's discretion to dismiss you from the practice if you've had repeated cancellations or no-show appointments.

Charges for Completion of Forms and Photo Copying Medical Records:

There is a charge for completion of forms and photo copying of medical records.

Payment Method:

For your convenience, we accept VISA, MasterCard, Discover Card, and cash. Personal checks will only be accepted for insurance co-payments. Please make your check payable to Cumberland Pediatrics, PC. There may be a charge for returned checks.

By signing this document, I understand and agree with the Assignments of Benefits and Other Financial Policies listed above.

_____ _____
Patient /Legal Representative Signature Date