Geauga Family Physicians Board Certified Physicians

Pediatric Registration Form (ages birth – age 12)

Welcome! **Please fill out the following information (Please Print) and return to the receptionist. Thank you!**

Today's Date ____/____/_____ **Which Doctor is your child seeing**: (Dr. Moritz_____) (Dr. Urbancic_____) (Dr. Carlson _____)

Patient's Last Name _____ **Patient's First Name** _____ **MI**____

Male(__)Female(__)Birth Date ___/____/_____ Home Phone: (_____)_____-_____Email_____

Address _____City _____ State _____ Zip _____

Race: _____Preferred Language:_____Ethnicity(Not Hispanic/Latino ___) (Hispanic/Latino _____)

Mother's Name _____ **Father's Name**_____

Date of Birth _____/_____/_____ Date of Birth _____/_____/_____

Cell Phone # _____ Cell Phone # _____

Employer_____ Employer _____

Email _____ Email _____

If no insurance check here __ If your child has insurance coverage please show the receptionist your child's insurance card and please complete the below information: Policy Holder: Last Name _____

First Name_____ MI ___ Date of Birth ___/___/____ Address _____ City _____

State ____ Zip _____ Home #(____) _____ Cell # (_____) _____ Work PH#(____) _____ SS# __ __

__ - __ __ - __ __ __ __ Gender: M __ F __ Name of Employer _____Date of Hire _____

***Patient Consent Form of Our Privacy Notice Required by HIPAA*, The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. You have the right to review an explanation of this privacy notice which is located in a folder in our waiting room. I also understand that sometimes my medical information will be sent to specialists, hospitals, or other facilities or pharmacies and I give authorization to Geauga Family Physicians to follow through with my medical care as they deem medically necessary. We participate in one or more Health Information Exchanges. Your healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs. We and other healthcare providers, may allow access to your health information through the Health Information Exchange for treatment, or other healthcare operations. This is a voluntary agreement. You may opt-out at any time from the Health Information Exchange by notifying our office staff. Often our office will call your home and find you not at home. Completing this form allows us to leave a message on your voice mail or answering machine regarding your medical information. I wish to be contacted in the following manner (<u>Please Check All That Apply</u>):**

I wish to be contacted concerning my child in the following manner (Please Check all that apply):

___ Home telephone (_____)_____ ___ Written Communication

___ OK to leave message with detailed message __ OK to mail medical info to my home address

___ Leave message with call back number __ OK to FAX to this number _____ ___

Work Telephone (_____)_____ ___ Cell phone (_____)_____

___ OK to leave detailed message ___ OK to leave detailed message

___ Leave message with call back number only : ___ Leave message with call back number only

___ Patient Portal or SecuReach Message **How did you hear about us?** _____

Print name of person completing this form:: _____

Signature of person completing this form: _____

Relationship to the patient: _____ (Form updated 3/16/2016)

Geauga Family Physicians

Board Certified Physicians

Pediatric Authorization form for children ages birth – 17 years of age

Patient's Name _____ **Birth Date** _____/_____/_____

Parent(s) or Guardian's Name: _____

Please list any relatives to whom you give approval to discuss your child's medical information with and/or bring your child in for appointments, in the case of your absence (authorization will remain indefinitely unless you revoke in writing).

Name: _____Phone # _____ Relationship to patient _____

Name: _____Phone # _____Relationship to patient _____

Name: _____Phone # _____ Relationship to patient _____

Name: _____Phone # _____Relationship to patient _____

Signature of Person Authorizing Information
Release and Payment Authorization

I understand that sometimes my insurance company does not pay for certain medical care which might include lab work, physicals, or certain procedures. If this happens I will be responsible for payment to Geauga Family Physicians. I understand that if there is no payment after two statements, my child's account will be submitted to a collections agency with an additional $15.00 charge. ***Patient Consent Form of Our Privacy Notice Required by HIPAA*, The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. You have the right to review an explanation of this privacy notice which is located in a folder in our waiting room. I also understand that sometimes my medical information will be sent to specialists, hospitals, or other facilities or pharmacies and I give authorization to Geauga Family Physicians to follow through with my medical care as they deem medically necessary. We participate in one or more Health Information Exchanges. Your healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs. We and other healthcare providers, may allow access to your health information through the Health Information Exchange for treatment, or other healthcare operations. This is a voluntary agreement. You may opt-out at any time from the Health Information Exchange by notifying our office staff.**

Print name of person completing this form: _____

Signature: _____ Today's Date _____/_____/_____

Relationship to the patient: _____ (Form updated 3/21/2016)

Geauga Family Physicians

Board Certified Physicians

Pediatric Health History Form for ages birth – 12 years old. Please return completed form to the receptionist. Thank you!

Please Print **Patient's Name** _____ **Date of Birth** ___/_____/_____

Social History:

Please list other siblings and dates of birth: _____

_____

_____

Please list *other household members* and their relationship to the patient _____

_____

_____

Is the patient in the custody of a person other than the parent? If yes, please explain: _____

_____

_____

Are there any pets in the household? Yes _____ No _____If yes, please list: _____

_____

How old is your home (in what year was it built? _____ Do you have any concerns about lead exposure? Yes_____No _____

Are there smokers in the household? Yes_____ No _____If yes, please explain: _____

_____

Family Medical History:

Had any blood relative, have any of the following?

What is mom's current height? Feet_____Inches _____

What is dad's current height? Feet_____Inches _____

Circle (Y for Yes) (N for No			Relationship
Bleeding disorders	Y	N	_____
Cancer	Y	N	_____
Diabetes	Y	N	_____
Epilepsy	Y	N	_____
Heart Disease	Y	N	_____
High Cholesterol	Y	N	_____
Stroke	Y	N	_____
Colon Polyps	Y	N	_____
High Blood Pressure	Y	N	_____

Patient's Medical History:

What was the patient's birth weight? Pounds _____ Ounces _____

Does the child have allergies? If yes please explain below:

Medicine allergies: _____

Food allergies: _____

Environmental allergies: _____

Was the patient born (C-section ____) (Vaginal _____)

Birth History: was the patient full term? (Yes _____) (No _____)

If no, how many weeks early was the patient? _____

Did the patient have any medical problems as a newborn? If yes, please explain: _____

_____

Has the patient ever been hospitalized or have had Surgery? If yes, please explain: _____

_____

_____

Is the patient current with immunizations? (Yes ___) (No___) ***Please bring in a copy of your child's immunization record or on this website print the Immunization form and complete.*** Does the patient take any medications? If yes, please list names and dosages: _____

Does the patient have any chronic medical conditions (asthma, allergies, frequent ear infections, etc)? If yes, please explain:

_____

_____

Name of person completing this form. _____ **Today's date:** ____/_____/_____

Relationship to the patient: _____ **Signature:** _____

(Form updated 3/16/2016)