Providence Pediatrics

PATIENT REGISTRATION

PATIENT'S NAME ______________________________
LAST FIRST MIDDLE

ADDRESS ______________________________
STREET CITY STATE ZIP

HOME PHONE (________) ______________________ E-MAIL ADDRESS ____________

DATE OF BIRTH_____/_____/_____ SS#_______-_______-_______ SEX: MALE FEMALE

HAVE WE SEEN OTHER CHILDREN FOR YOU? Please list names: ____________

PRIMARY INSURANCE CARRIER

INSURANCE CO. ______________________ ADDRESS ______________

INSURED'S NAME ______________________ EMPLOYER ______________

INSURED'S SS#_______-_______-_______ POLICY # ___________ GROUP# ________

SECONDARY INSURANCE CARRIER

INSURANCE CO. ______________________ ADDRESS ______________

INSURED'S NAME ______________________ EMPLOYER ______________

INSURED'S SS#_______-_______-_______ POLICY # ___________ GROUP# ________

RESPONSIBLE PARTY TO PAY BILL

(Mr./Mrs./Ms.)______________________ DATE OF BIRTH _____/_____/_____

ADDRESS (if different from patient) ______________________

HOME PHONE (____)______________ BUSINESS PHONE (____)______________ ext.____

SS#_______-_______-_______ EMPLOYER______________ TITLE ____________

SPOUSE INFORMATION

(Mr./Mrs./Ms.)______________________ DATE OF BIRTH _____/_____/_____

ADDRESS (if different from patient) ______________________

HOME PHONE (____)______________ BUSINESS PHONE (____)______________ ext.____

SS#_______-_______-_______ EMPLOYER______________ TITLE ____________

EMERGENCY CONTACT (other than responsible party or spouse)

RELATIONSHIP______________________ PHONE (____)______________

I hereby consent to the treatment of ______________________ at Providence Pediatrics including diagnostic and other medical care that is deemed necessary. I authorize the release of any information regarding this treatment to my insurance company regarding a claim for benefits, and I assign such benefits to be paid directly to this office. I understand that I am fully responsible for the charges incurred for the above named patient. If this contract is referred for collection activity, I also understand that I am additionally responsible for any collection fees, totalling 25% of any outstanding balance, and all court costs incurred.

Signed:______________________________ DATE _____/_____/_____

Referred by: ______________________________

Date ________________

Pediatric Patient History

Chart # ______________________
MRN # _______________________

Name: ____________________________________ Age: _________ **Date of Birth** _______________ Sex: M F

What is the reason for your visit today? ____

FAMILY HEALTH HISTORY:
Check (✓) under the relationship of the blood relative if they have or have had any of the following:

CONDITION	MOTHER	FATHER	MOTHER'S MOTHER	FATHER'S MOTHER	MOTHER'S FATHER	FATHER'S FATHER	BROTHER	SISTER
Asthma								
Allergies/ Hayfever								
Arthritis								
Alcohol Abuse								
Blood disorders (Anemia etc….)								
Cancer (breast, lung, liver, prostate, skin etc….)								
Diabetes: Type I or Type II_______________								
Downs Syndrome								
Drug Abuse								
Eczema								
HIV								
Hepatitis								
High Blood Pressure								
High Cholesterol								
Heart Murmurs								
Heart Disease-describe____________________								
Kidney stones/ disorders								
Liver disease								
Lead Exposure								
Mental illness/ Retardation								
Muscular Dystrophy								
Mulitple Sclerosis								
Stomach disorders/ IBS _________________								
Thyroid Disease:describe_______________								
Tuberculosis								
Other:								
Other:								

Current medications - Prescription and Over-The-Counter Meds. (including vitamins, herbs, aspirin, antacids, injectables, hormones, and birth control)	**Is child allergic to any medicine? ☐Yes ☐ No Please list all medications and reactions**

Does Your Child:	**Yes**	**No**	**Type**	**Amt./Day**	**Date Quit**
Use Tobacco products	☐	☐			
Consume Alcohol	☐	☐			
Drink caffeine	☐	☐			
Use or used illegal drugs	☐	☐			
Exercise regularly	☐	☐			
Have diet restrictions	☐	☐			
Travel outside US	☐	☐			

Past hospitalizations/surgeries/serious injuries (including blood transfusions)

Carolinas Physicians Network
Carolinas HealthCare System

ACKNOWLEDGEMENT FORM

Medical Records # ________________

Patient's Name: ________________________________ Date of Birth _____/______/______
Day Month Year

We are required by law to provide you with our Notice of Privacy Practices which explain how we use and disclose your health information. We are also required to obtain your signature acknowledging that this notice has been made available to you.

Signature:____ Date: ____________________
(Patient or Authorized Representative)

Relationship to Patient: _________ Self ___________ Spouse __________ Other ___________

Reason Patient Unable/Unwilling to Sign: ____

____

ACKNOWLEDGEMENT FORM
DOCUMENTO DE RECONOCIMIENTO DE CAROLINAS PHYSICANS NETWORK

Numero de Registro Medico ________________

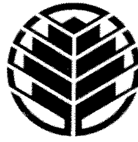
Nombre del Paciente ___________________________ Fecha de Nacimiento _____/_____/_____
Dia Mes Ano

La ley nos requiere que nosotros le proveamos a usted con nuestro Aviso de Practicas de Privacidad las cuales explican como podemos usar y divulgar su informacion medica. La ley tambien nos requiere que obtengamos su firma, reconociendo que este aviso lo hemos hecho disponible para usted.

Firma: __________________________________ Fecha: _______________________________
(Paciente o Representante Autorizado)

Relacion al Paciente: ________ Mismo _________ Esposo (a) __________ Otro ___________

Razon Por la Cual El Paciente No Puede/No Desea Firmar:_______________________________



Providence Pediatrics

This consent gives us permission to treat the patient for those items specified below. This consent will remain in effect for one (1) year, or until you notify us otherwise.

As the parent or legal guardian, I ______________________________ (your name),

give permission for ______________________________ (patient's name), to be seen at Providence Pediatrics according to the guidelines below.

- ❑ May come to the Doctor's office alone
- ❑ May come to the Doctor's office with a responsible adult: 1. ________________
  2. ________________
  3. ________________

I give my permission for the following:

- ❑ Well child checks or routine physical examinations
- ❑ Immunizations
  - ❑ Pediatric Immunization information packet given to parent/legal guardian and questions answered ______________________________ (staff signature)
- ❑ Sick visits typically covered under a general consent
- ❑ Other: ______________________________

If additional treatment is needed, I will be contacted to give verbal consent.
I can be reached at: ________________________ (phone or pager number) or
________________________ (phone or pager number).

(Parent or Legal Guardian Signature) ______________________________

(Date) ________________

(Witness Signature) ______________________________

(Date) ________________

Patient Information: I give permission to release the health information of: **(One Patient Per Form)**

Patient Name: ______________________________ Date of Birth: ______________________________

Street Address: ______________________________ Last 4 numbers of SSN:______________________

City, State, Zip: ______________________________ Telephone: (   ) ______________________________

Email address: ____

Release Information From:

____
(List applicable Facility(s) and/or Practice(s)

____

____
(Phone number) (Fax number)

Release Information To:

____
(Name of facility, person, company) (Relationship)

____
(Street Address or PO Box, City, State, Zip Code)

____
(Phone number) (Fax number)

PURPOSE OF RELEASE (check reason): ☐ Request of individual/personal ☐ Continued patient care ☐ Insurance
☐ Legal purpose including discussions & proceedings ☐ Other______________________________

Fill in dates of treatment for records to be released:

Treatment dates: From ______________________________**To** ______________________________

Hospital Summary: May include history & physical, discharge summary, operative notes, consults, diagnostic test results, medication list, allergies.
Office/Clinic Summary: May include most recent office visits, physical exam, consults, diagnostic test results.

Hospital (check all that may apply):
☐ Hospital Summary
☐ Discharge Summary
☐ History and Physical
☐ Consultation reports
☐ Operative Reports
☐ Laboratory reports
☐ Radiology/X-Ray Reports
☐ Pathology reports
☐ Emergency Record
☐ Cardiac Reports/EKG
☐ Other______________
____
____
____
____
☐ Entire record (Not including psychotherapy notes)

Office/Clinic (check all that may apply):
☐ Office/Clinic Summary
☐ Office Visits
☐ Physical Exam
☐ Laboratory Reports
☐ Radiology Reports
☐ Other______________________
____
☐ Entire Record (Not including psychotherapy notes)

Behavioral Health/Sub. Abuse (check all that may apply):
☐ Hospital Summary
☐ Assessments
☐ Discharge Summary
☐ Physician Orders
☐ Progress notes
☐ Medications
☐ Lab reports
☐ Other ______________________________
☐ Entire Record (Not including psychotherapy notes)

FORMAT:
☐ CD (charges may apply)
☐ Email Address noted above, where permitted
☐ Paper copy (charges may apply)
☐ Other______________________________

DELIVERY METHOD:
☐ Reg.US Mail ☐ Pick-up ☐ Fax, where permitted
☐ Overnight/Express Mail Service, where permitted
☐ Secure email
☐ Other: ______________________________

PATIENT'S RIGHTS – I understand that:

- **I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice.**
- **This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases.**
- **Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.**
- **Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in health plan, or eligibility for benefits.**
- **CHS will not share or use my health information without my permission other than by ways listed in CHS's Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at carolinashealthcare.org.**
- **A fee may be charged for providing the protected health information.**
- **I have a right to receive a copy of this form upon request.**

This permission expires one year after the date of my signature unless another date or event is written here: ______________________

Signature: ______________________________ **Print Name:** ______________________________ **Date:**______________

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form.
Note the relationship/authority if signature is not that of the patient (Written Proof May be Requested):
☐ **Healthcare Agent/POA** ☐ **Guardian** ☐ **Executor/Administrator/Attorney in Fact** ☐ **Spouse**
☐ **Parent** ☐ **Adult Child** ☐ **Affidavit Next of Kin** ☐ **Other:** ______________________________

Note: If minor consented for their outpatient treatment for pregnancy, sexually transmitted disease or behavioral/mental health without parental consent, the minor must sign this authorization. When the patient is a minor being treated for substance abuse, the minor must sign this authorization, regardless of who consented for treatment.

Signature of Minor:______________________________ **Print Name:** ______________________________ **Date:** ______________

Authorization given to patient / Date of release:__________________via ☐Mail ☐Fax ☐Other____________☐**ID Verified** ☐**DL/Other ID**____________________
CHS Employee Name & Title: ______________________________**CHS Employee Signature:** ______________________________**Date:**______________

Patient Information or Sticker

Name:
DOB:
Medical Record #:
Account #: