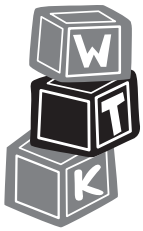

Springs Pediatrics
A Division of One Pediatrics

ONE pediatrics℠

PATIENT REGISTRATION

Patient Name (First, MI, Last) _____ DOB _____

Preferred Name (Ex: Christopher "Chris") _____ Patient Social Security # _____

Address _____

City, State, Zip _____ Gender: MALE FEMALE

Race _____ Ethnicity: NON-HISPANIC HISPANIC DECLINE TO ANSWER

Primary Language Spoken in the Home _____

Pharmacy _____ Address _____

How Did You Hear About Our Practice? _____

Emergency Contact (Outside of the Home) _____ Phone _____

Other Children in the Home That Are Patients of This Practice _____

GUARANTOR / RESPONSIBLE PARTY INFORMATION

Name _____

Relationship to Child _____

DOB _____ SSN _____

☐ Same as Patient

Address _____

_____

Primary Phone _____

Cell _____ Daytime _____

Employer _____

Name _____

Relationship to Child _____

DOB _____ SSN _____

☐ Same as Patient

Address _____

_____

Primary Phone _____

Cell _____ Daytime _____

Employer _____

Email (For Patient Portal) _____

If Parents Are Divorced Or Separated, Please Complete The Following Section.

Who Has Primary Custody? _____

Are there any legal restrictions that would keep the non-custodial parent from consenting to medical treatment for the child, or from obtaining information about the child's medical treatment? YES NO

If yes, please explain, and provide our office a copy of any legal paperwork that supports this restriction. _____

_____

_____

CONTINUE TO BACK →

INSURANCE INFORMATION

Primary Insurance _____ Employer _____

Member / Subscriber ID# _____ Group# _____

Subscriber's Name _____ DOB _____

Subscriber's SSN _____ Relationship to Patient _____

Secondary Insurance _____ Employer _____

Member / Subscriber ID# _____ Group# _____

Subscriber's Name _____ DOB _____

Subscriber's SSN _____ Relationship to Patient _____

CONTACT PREFERENCES

☐ Cell Phone (text)

☐ Email Address

☐ Postal Mail

☐ Appointment Reminders

☐ Statements

☐ Telephone: Is it ok to leave message? YES NO

I authorize the release of any medical information needed to determine medical benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I hereby consent to routine diagnostic procedures and medical treatment provided through Springs Pediatrics and understand that no guarantee of results has been made.

Signature _____ Date _____

ONE Pediatrics, PLLC: All Star Pediatrics, Pediatrics of Bullitt County, East Louisville Pediatrics, Prospect Pediatrics, South Louisville Pediatrics, Springs Pediatrics, Kaplan Barron Pediatric Group, Oldham County Pediatrics, and Growing Kids Pediatrics.

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PEDIATRIC HEALTH HISTORY QUESTIONNAIRE

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Child's Name _____ Date of Birth _____

Mother's Name _____ Father's Name _____

Address _____

Pregnancy and Birth History

Mother's age at birth	Father's age at birth
Did mother have any of the following during pregnancy	
☐ Fever or rash	☐ Tobacco use (how much)
☐ Group B strep	☐ Alcohol use (how much)
☐ Sugar in urine / diabetes	☐ Street drug use (what type)
☐ High blood pressure	☐ Medication use (prescription or over-the-counter - list below)
☐ Anemia	
☐ Infections (if yes what type and how were they treated)	

Newborn History

Birth Weight:	Birth length:	Head Circumference:
Born on time? ☐ Early ☐ Late	How much:	
Type of delivery ☐ Vaginal ☐ C-section (why):		
How old was baby when she/he left the hospital?		
During the first week of life did the patient have any of the following		
☐ Feeding trouble	☐ Seizures	☐ Fever
☐ Excess vomiting	☐ Breathing trouble	☐ Receive antibiotics
☐ Jaundice (yellow skin)	☐ Need of oxygen	☐ Diarrhea
☐ Cyanosis (blueness)	☐ Blood transfusion	☐ In intensive care unit

Family History

Relationship	Name	Living Y / N	Age	Major Medical Problems and/or Cause of Death
Father				
Mother				
Siblings				

Specifically have any of the child's relatives had the following conditions

Condition	Relative	Condition	Relative
☐ Diabetes		☐ Kidney problems	
☐ Cancer		☐ Heart Disease	
☐ Seizures		☐ Stroke	
☐ Allergies/asthma		☐ Anemia	
☐ Bleeding problems		☐ HIV	
☐ High blood pressure		☐ Skin problems	
☐ Lung disease		☐ Chemical dependency	
☐ Mental illness		☐ Other:	

Are there any religious or cultural factors that you would like us to take into account when planning your child's healthcare?

PLEASE TURN OVER

Past Medical History

Where has child gone for check-ups previously:
Date of last medical check-up:
Date of last dental check-up:
Is your child up-to-date on immunizations? Please supply immunization records.

Has your child had any of the following

☐ Chicken pox	☐ Wears glasses	☐ Asthma
☐ Measles	☐ Heart murmur	☐ Allergies
☐ Mumps	☐ Kidney or bladder infection	☐ Broken bones
☐ Frequent ear infections (> 4 year)	☐ Bed wetting (> 5 years old)	☐ Head injury
☐ Frequent throat infections (> 4 year)	☐ Diabetes	☐ Seizures

Has your child ever been hospitalized or had surgery? If yes, list age and reason:
Has your child ever been on medication regularly that is not on their current medication list? If yes, list medication(s) and reason:
Do you have any concerns about your child's development? If yes, please describe:

Child Social Characteristics

School Grade/Preschool:	City Water: Yes / No
Hours of TV/Electronics Each Day:	Exposure to Second Hand Smoke: Yes / No
Special Diet:	Guns in Home: Yes / No
Weekly Hours of Outdoor Activity:	Wears Sunscreen: Yes / No
Pets:	Wears Seatbelt/Car Seat/Booster: Yes / No
Sports:	
Hobbies:	

Allergies

Please list any allergies to medications or foods and environmental allergies

Medications

Please list any medications that your child takes including over the counter medications, herbs, vitamins and supplements. Include dose and frequency

Specialty Providers

In order that we can best coordinate your child's care, please list any medical providers the child sees outside of this practice and list the year that they last saw them

Parent Signature:_____ Date:_____

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New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____ , understand that as part of my healthcare, Springs Pediatrics
(child's name)
originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations.

I understand that Springs Pediatrics is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Springs Pediatrics reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Springs Pediatrics change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

_____ _____

PATIENT'S SIGNATURE **DATE**

PLEASE TURN OVER

Patient's Consent for Provider to Disclose PHI to Authorized Persons

1. **AUTHORIZATION TO DISCLOSE PHI (PROTECTED HEALTH INFORMATION)**
   I hereby authorize you, my healthcare provider ("Provider"), to disclose any and all of my medical and protected health information ("PHI") to the persons indicated below.

2. **PERSONS TO WHOM DISCLOSURE MAY BE MADE**
   Provider may disclose my PHI to the following persons:

NAME	**RELATIONSHIP, IF ANY**
_____	_____
_____	_____
_____	_____

3. **PURPOSE OF DISCLOSURE**
   The purpose of the disclosure is to allow these persons to participate in my care, participate in the payment of my medical bills, and/or to know the status of my health.

4. **EXPIRATION OF AUTHORIZATION**
   This authorization shall continue until I revoke this authorization in writing, which I may do at any time by sending a letter addressed to the Privacy Officer to any office where I am treated by Provider.

5. **CONDITIONING OF TREATMENT**
   Provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this consent.

6. **REDISCLOSURE BY RECIPIENT**
   I understand that once Provider discloses my PHI to the persons listed herein, my Provider has no control as to whether those persons may redisclose my PHI, which may no longer be protected by federal or state law.

7. **ACKNOWLEDGMENT AND RECEIPT OF COPY**
   I have read, understood, and agreed to this authorization and received a copy of same.

_____ _____
PATIENT NAME OR REPRESENTATIVE **DATE**

IF A REPRESENTATIVE SIGNS, STATE THE REPRESENTATIVE'S AUTHORITY

_____

FOR OFFICE USE ONLY

☐ Consent received by _____ on _____ .
☐ Consent refused by patient, and treatment refused as permitted.
☐ Consent added to the patient's medical record on _____ .