Patient Registration

Date: _____ **Reason for this visit:** _____

Is this work related? [ ] YES [ ] NO Is this Auto Accident related? [ ] YES [ ] NO

Last Name: _____ **First Name:** _____ **MI:** _____

SS#: _____-_____-_____ **DOB:** _____ **Sex: [ ] Male [ ] Female**

Address: (If P.O. Box please provide street address also)

Street: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Preferred Email: _____

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

Mother's Cell: _____ Father's Cell: _____

Parents' Address: (If different from child)

Street: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ **Preferred Method of contact:** [ ] Home [ ] Cell [ ] E-mail

Parent's Marital Status: _____

Custody of Child: _____ **Relationship:** _____

Who else may bring child for medical care: _____

_____

Other important information we need to know: _____

_____

_____

_____

Race: [ ] American Indian/Alaskan Native [ ] Asian [ ] Black/African American
[ ] Pacific Islander/Hawaiian Native [ ] White [ ] Decline [ ] Other_____

Ethnicity: [ ] Hispanic/Latino [ ] Not Hisanic/Latino [ ] Decline **Preferred Language**: _____

Medical Insurance:

Primary:_____ Secondary:_____ Employer:_____

Policy Holder: _____ SSN:_____ DOB:_____

Address:_____

_____ Relationship:_____

Emergency Contact:_____ Relationship:_____

Emergency Contact Phone: Home:_____ Cell:_____

To Whom may information be released/relayed: [ ] Mother [ ] Father [ ] Other: _____

May we leave a message on your answering machine? [ ] YES [ ] NO

How did you hear about us? [ ] Doctor Referral [ ] Friend/Family [ ] Insurance Directory
[ ] Internet [ ] Mailer [ ] Newspaper [ ] Phone Book [ ] Signage [ ] Website [ ] Other:_____

Your Pharmacy:_____ [ ] I prefer printed prescriptions

Health Insurance Information:

A copy of your insurance card(s) will be scanned to your file. If proper insurance information is not provided on the date of service, you will be responsible for back charges. It is your responsibility to be aware of the medical benefits your insurance provides

I understand that I am responsible for any bill I receive from the lab.

Patient/Guardian Signature:_____ **Date:**_____

Health Summary Questionnaire

Patient Name: _____ **Today's Date**_____

Reason you are being seen today: _____

RECENT SYMPTOMS: **Please circle any symptoms you are having or have had recently.**

CONSTITUTIONAL	APPETITE CHANGE	CHILLS	FATIGUE
	FEVER	SWEATS	WEIGHT LOSS
CARDIOVASCULAR	Chest Pain/Pressure	Fainting	Palpitations
NEUROLOGICAL	HEADACHE	LIGHT HEADEDNESS	NUMBNESS
	POOR BALANCE	TINGLING	WEAKNESS
PSYCHIATRIC	ANXIETY/NERVES	DEPRESSION	
LYMPHATIC	FREQUENT INFECTIONS	SWOLLEN GLANDS	
EYES	BLURRED VISION	CONTACT LENSES	DOUBLE VISION
	EYE DISCHARGE	EYE PAIN	EYE GLASSES
ENT	DIZZINESS	EAR PAIN	NASAL CONGESTION
	NOSE DISCHARGE	SNEEZING	SORE THROAT
RESPIRATORY	CONGESTION	COUGH	SHORT OF BREATH
	WHEEZING		
GASTROINTESTINAL	ABDOMINAL PAIN	DIARRHEA	NAUSEA
	RECTAL PROBLEM	BOWEL CHANGES	VOMITING
URINARY	DISCHARGE	FREQUENT URINATION	NIGHTTIME URINATION
	PAINFUL URINATION	SEXUAL DIFFICULTY	
MUSCULAR	JOINT PAIN	MUSCLE PAIN	SWELLING
SKIN	BRUISING	ITCHING	LACERATION
	RASH	REDNESS	SKIN SORES

[ ] None of the above [ ] Additional Problems/Information: _____

_____

_____

_____

_____

Last Normal Menstral Period: _____ **Are You Pregnant?** [ ] yes [ ] No [ ] Unsure

CURRENT MEDICATIONS: [ ] No Change From Prior Visit [ ] **NONE** _____

_____

CURRENT ALLERGIES: [ ] No Change From Prior Visit [ ] **No Allergies**_____

_____

MEDICAL HISTORY: [ ] No Change From Prior Visit [ ] **No Medical Problems or History**

Birth History: Full Term [ ] No [ ] Yes Gestation if Premature: _____
Complications:_____

_____

CIRCLE ALL PROBLEMS THAT APPLY:

Arthritis	Heart Problems	Stroke or seizure
Blood Disorder	High Blood Pressure	Psychiatric
Cancer - Type:_____	High Cholesterol	Sexually Transmitted Disease
Diabetes	Kidney Problems	Skin Disorders
Ear, Nose or Throat Problems	LungProblems	Thyroid Problem
Gastrointestinal (stomach)	Liver Problems, Hepatitis	Other:
Genitourinary	Musculoskeletal	

SURGICAL HISTORY: [] No Surgeries _____

SOCIAL HISTORY: [ ] No Change From Prior Visit

Tobacco Use: [} Never [} Quit: When _____; How long did you smoke?_____
[ ] Current: packs per day_____; For how many years? _____
Alcohol use: [ ] None [ ] Quit [ ] Rare [ ] Occasional [ ] Daily
Street/Unprescribed Drugs: _____ 2nd Hand Smoke: [} Home [} Elsewhere: _____
Recent Travel: [ ] No [ ] Yes: Where? _____
Education: School: _____ Grade Level: _____ Average Grades: ____
Held back/skipped Grade: [} No [} Yes recent Change in Grades: [} No [} Yes
Living Arrangement: _____

FAMILY HISTORY: [ ] No Change From Prior Visit [} **No Family History** [ ] **Unknown**

Please Specify: M=Mother; F=Father; S=Sibling; GP=Grandparent

Heart Disease [M] [F] [S] [GP]	High Cholesterol [M] [F] [S] [GP]
Cancer: type:_____[M] [F] [S] [GP]	High Blood Pressure [M] [F] [S] [GP]
Lung Disease [M] [F] [S] [GP]	Brain Aneurism [M] [F] [S] [GP]
Diabetes [M] [F] [S] [GP]	Alzheimer's [M] [F] [S] [GP]
Psychiatric [M] [F] [S] [GP]	Other: _____ [M] [F] [S] [GP]

Preventive (Vaccines):
All Childhood vaccinations Up to Date [ ] Yes [ ] No ; If NO, reason for delay? _____

_____

[ ] Influenza/flu shot): Date: _____
If over 18, Tetanus: [ ] < 5 years [ ] > 5 years Approximate Date: _____

SURFSIDE PEDIATRICS

Patient Name: _____

Assignment of Benefits:

I authorize payment of medical benefits to Surfside Pediatrics for any services furnished. I understand that I am responsible for any amount not covered by my insurance carrier.

Authorization for Release of Information:

I authorize Surfside Pediatrics to release information concerning health care, advice, treatment or supplies provided to me for the purposes of billing my insurance company, any medical professional involved in my present or future care and, if relevant, to my school athletic director, athletic trainer or sports coach.

Authorization to Treat:

I authorize Surfside Pediatrics to perform the treatments and/or procedures considered necessary for my wellbeing. I understand that such treatments and/or procedures will be clearly explained to me in advance. I fully understand that it is impossible to make any guarantees regarding the outcome of any medical treatment or procedure.

Privacy Policy:

I understand that a copy of Surfside Pediatrics' **Patient Bill of Rights** and **Privacy Practices** are available in the waiting room, and that a personal copy of these documents is available in the front office upon request.

Signature _____ Date _____

Patient, Parent or Guardian

_____

Name of Parent or Guardian (if under 18 years of age)

CONSENT TO TREAT FOR PATIENT BEING BROUGHT TO THE OFFICE BY SOMEONE OTHER THAN THE PARENT OR LEGAL GUARDIAN

[ ] ONGOING [ ] SPECIFIC DATE(S) _____

I, the parent/legal guardian of _____ hereby give permission to_____ to bring my child to the Surfside Pediatrics for medical examination and treatment as necessary.

Please be aware that immunizations and/or procedures cannot be performed without the parent or legal guardian's verbal consent.

I will be available to give verbal consent to the administration of immunizations and/or any procedures at the following phone numbers:

1. (____) _____ Name: _____
2. (____) _____ Name: _____

****

CONSENT FOR A PATIENT WHO IS 16 YEARS OF AGE AND PRESENTING TO THE SURFSIDE PEDIATRICS ALONE

Please be aware that, for your child's safety, we will not perform immunizations or procedures if there is not an adult accompanying the patient.

I, the parent/legal guardian of _____ hereby give Dr. Feltus-Atkinson and/or Teena Sanders ARNP permission to treat him/her without me being present at Surfside Pediatrics.

I will be available at the following phone numbers:

1. (____) _____ Name: _____
2. (____) _____ Name: _____

Signature of Parent/Guardian: _____

Name of Parent/Guardian: _____

Date: _____