# PATIENT REGISTRATION FORM

DATE: _____

**Patient Name:** _____ M F DOB: _____
(as listed with Insurance Company)

Child Lives With:

Parent/Guardian _____ DOB: _____ Y N

Address _____ Home #: _____

City/State/Zip _____ Cell #: _____

Employer _____ Work #: _____

Email _____ SSN: _____

Parent/Guardian _____ DOB: _____ Y N

Address _____ Home #: _____

City/State/Zip _____ Cell #: _____

Employer _____ Work #: _____

Email _____ SSN: _____

Step-Parent: _____ Cell #: _____ Y N

Step-Parent: _____ Cell #: _____ Y N

Emergency Contact: _____ Phone: _____ Relationship: _____

Referred to us by: _____

**Siblings:**

| Last Name | First Name | Date of Birth |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

With my signature:

* I authorize the release of all medical information to the insurance companies to process all claims and payment of medical benefits for services.
* I am responsible for the account and agree to pay any amount that is not paid by insurance.
* I understand that the office has employed nurse practitioners to assist in the delivery of medical pediatric care and that I hereby consent to the services of a nurse practitioner for my health care needs. I understand that I can refuse to see the nurse practitioner and request to see my physician.
* I received a copy of the financial policy in the new patient handbook.
* I understand that payments are expected at the time of the visit. I understand that the office is not a party in divorce settlements and that the parent who brings a minor child for care will be responsible for the payment. The office will provide a receipt as proof of payment for reimbursement.

Signature Date Relationship to patient

# PATIENT/FAMILY HISTORY

DR: _____

DATE: _____

**Patient Name:** _____ DOB: _____

**Person Completing Form/Relationship to patient:** _____

| | Patient | Father | Mother | Brother | Sister | Father Side | Mother Side | List any specific information |
|---|---|---|---|---|---|---|---|---|
| Alcoholism/Drug/Tobacco Dependency | | | | | | | | |
| Allergies (ex: hay fever, ragweed) | | | | | | | | |
| Asthma/Wheezing | | | | | | | | |
| Bedwetting | | | | | | | | |
| Behavior Problems | | | | | | | | |
| ADD/ADHD | | | | | | | | |
| Aggressive Behavior | | | | | | | | |
| Eating Problems | | | | | | | | |
| Molestation | | | | | | | | |
| Nervousness/Fidgety | | | | | | | | |
| Learning/School Problems | | | | | | | | |
| Birth Defects | | | | | | | | |
| Blood Disorders (ex: Sickle Cell, anemia) | | | | | | | | |
| Bone/Joint Disorders (ex: arthritis, gout) | | | | | | | | |
| Cancer | | | | | | | | |
| Cholesterol Problems | | | | | | | | |
| Constipation | | | | | | | | |
| Croup | | | | | | | | |
| Developmental Problems | | | | | | | | |
| Diabetes | | | | | | | | |
| Eczema | | | | | | | | |
| Fainting Spells | | | | | | | | |
| Genetic Disorders (ex: Down Syndrome, Cystic Fibrosis) | | | | | | | | |
| Heart Problems (ex: heart attack, hypertension, congenital) | | | | | | | | |
| Hearing Problems (ex: deafness, hearing aids) | | | | | | | | |
| Hepatitis | | | | | | | | |
| Kidney Disease | | | | | | | | |
| Lung Disorders (ex: tuberculosis, positive Tb test) | | | | | | | | |
| Miscarriages/Stillbirth | | | | | | | | |
| Mononucleosis | | | | | | | | |
| Muscle Disorders (ex: Multiple Sclerosis, stiffness) | | | | | | | | |
| Nervous Disorders (ex: migraines, seizures, epilepsy) | | | | | | | | |
| Pneumonia | | | | | | | | |
| Psychiatric Disorders (ex: depression, suicide, anxiety) | | | | | | | | |
| Rheumatic Fever | | | | | | | | |
| Sore/Strep Throat, Recurrent | | | | | | | | |
| Speech Problems (ex: stuttering, delay, lisp) | | | | | | | | |
| Stomach Problems (ex: ulcer, Crohn's disease, celiac) | | | | | | | | |
| Sudden Death | | | | | | | | |
| Thyroid Problems | | | | | | | | |
| Urinary Tract Infections | | | | | | | | |
| Venereal Disease (ex: herpes, gonorrhea, chlamydia) | | | | | | | | |
| Vision Problems (ex: blindness, lazy eye, crossing eyes) | | | | | | | | |
| Other: | | | | | | | | |
| Have parents been divorced or separated? | | YES | NO | | | | | |

Physician Reviewed: _____

# NEW PATIENT RECORD

DATE: _____

**Patient Name:** _____ DOB: _____ DR.: _____

**Birth History:**

Hospital: _____ Complications/Toxic Exposures: _____

□ Breast □ Bottle □ Both Under lights? Y N _____

Delivery: TERM / PREMATURE _____weeks □ Vaginal Delivery □ Cesarean Delivery

Date of Discharge: _____ Blood Type: _____ Birth Weight: _____

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**Past Medical History:** ☐ Check here if NONE.

Hospitalizations since birth (List reason and date)

_____

_____

Surgeries (List surgery and hospital/surgical center)

_____

_____

Specialists following child (List name of dr. and what for)

_____

_____

_____

Major Illness/Recurrent Illness

_____

_____

_____

_____

Temporary Problems

_____

_____

_____

_____

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**Current Prescription Medications:** ☐ Check here if NONE.

| **Name** | **Dose** | **Frequency** | **Reason** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

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**Allergies (List any known allergies to medications or foods)** ☐ Check here if NONE.

_____

_____

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**Social History**

Who lives at home with the patient? ___mother ___father ___other adult (specify _____)

Pets? Y / N Smokers? Y / N

School/Daycare: Y / N If yes, where? _____

Recent foreign travel? Y / N If yes, where?_____

Is there a gun kept in the place where your child lives? Y / N Locked up/ammo separate? Y / N

Physician Reviewed: _____

**AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION – NEW PATIENT**

| | | | |
|---|---|---|---|
| Patient Name (please print) | Date of Birth | Patient Name | Date of Birth |
| Patient Name | Date of Birth | Patient Name | Date of Birth |

I, _____, hereby authorize the use and/or disclosure of protected health
(parent/guardian)
information (PHI).

TO: _____Raymond A. Kahn, M.D. _____Paige Garrison, M.D.

**5819 Highway 6 S, Suite 330**
**Missouri City, TX 77459**
**(281) 499-6300**
**Fax (281) 499-7180**

FROM: Dr.'s Name/Person/Organization: _____
Address: _____
City, State, Zip _____
Telephone: _____ Fax No.: _____

I specifically authorize the use and disclosure of the following PHI:

□ Dates of Service _____
□ Consult Records
□ Laboratory Reports
□ ADHD Reports
□ Immunization Record
□ Radiology Reports
□ Entire Medical Record

I understand that the information in my record may include information relating to sexually transmitted diseases which may include, but are not limited to diseases such as hepatitis, syphilis, gonorrhea, the human immunodeficiency virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information will be used for:

□ Consultation
□ Insurance
□ Personal
□ Other: _____
□ Continuing Care
□ Legal
□ Second Opinion

I understand that I can revoke or terminate this authorization by submitting a written revocation to the address listed below except to the extent that disclosure made in good faith has already occurred in reliance on this consent. Without prior revocation, this authorization will automatically expire six months from this date. If I have questions about disclosure of my health information, I can contact Laura Eaton, privacy officer, at (281) 499-6300.

If neither federal nor Texas privacy law apply to the recipient of the information, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or Texas privacy law.

| | |
|---|---|
| Signature of Patient or Legal Representative | Printed Name |
| Relationship to Patient (If Legal Representative) | Date |

We will no longer be able to accept written requests from another office that is not HIPAA compliant. In this case, we will need to send you a copy of our request form and ask that it be filled out and signed.

**Date request completed** _____ **By:** _____ **12/6/2016 4:41 PM**

# Acknowledgement of Receipt and Consent to Use Protected Health Information (PHI)

As indicated in the *Notice of Privacy Practices*, disclosures may be made without additional patient permission, if they are related to the treatment of the patient, obtaining payment for services, or office operations, unless the patient has requested such disclosure not be made or be made in an alternative fashion.

- Disclosures made for purposes of treatment, payment or operations will be consistent with the information supplied to patients in the *Notice of Privacy Practices*. See *Notice of Privacy Practices* policy and procedure. (Copies can be obtained from our office or website.)
- For purposes of payment or operations, the minimum amount of information necessary to accomplish the intended purpose will be released, but disclosures related to treatment will be made as necessary to assure quality patient care.
- This office may disclose PHI to another covered entity or a health care provider for the payment activities of the entity that receives the information.

I, the undersigned, hereby acknowledge or affirm that:

1. I have received a copy of Notice of Privacy Practices.
2. I understand that authorization is not necessary for the use and disclosure of PHI for the purpose of treatment, payment or operations.
3. I understand that any use or disclosure of PHI outside of treatment, payment and operations will require separate written permission.

This Acknowledgement of Receipt and Consent to Use Protected Health Information pertains to the following child(ren):

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

_____

Signature of Parent/Guardian Date

# CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

Patient Name:_____DOB:_____

I understand that as part of my health care, information describing the health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care of treatment will be maintained by either paper and/or electronic records.

I hereby consent to the clinic's use and disclosure of identifiable health information for the purposes listed in the **Notice of Privacy Practices** and other purposes relating to treatment, payment of health care and other health care operations of the clinic. In addition, I acknowledge that I received, on the date indicated below, a copy of the **Notice of Privacy Practices**.

By checking one of the boxes below, I authorize the clinic to leave a voice mail message concerning appointments, tests or lab results in the even they are unable to contact me directly via telephone.

_____ **MAY leave voice mail messages**

_____ **MAY NOT leave voice mail messages**

By checking one of the boxes below, I authorize the clinic to communicate with me via UNSECURED email concerning appointments, tests or lab results in the event they are unable to contact me directly via telephone.

_____ **MAY send unsecured email messages**

_____ **MAY NOT send unsecured email messages**

_____

Signature of Patient /Parent/Guardian Date

_____

Relationship of Patient

# AUTHORIZATION TO CONSENT TO TREATMENT
# MINOR (Under 18 years of age)

## FOR PATIENTS UNDER 18 YEARS OF AGE:

I / We, parent(s) of _____, a minor (any child under the age of 18),
(child's name)
do hereby authorize the individual(s) named below to consent to medical treatment to be rendered at the office.

These authorizations shall remain effective (choose one):

- ❑ This date range: _____ through _____
- ❑ Indefinitely
- ❑ Until told otherwise
- ❑ **No access allowed to anyone but undersigned**

List the name(s) of all those allowed to consent to treatment for the above named child (must be 18 years of age or older):

1._____ 2._____ 3._____

4._____ 5._____ 6._____

X_____
Signature of Parent/Guardian Date

## Advance Practice Nurse

This office has on staff an advance practice nurse to assist in the delivery of medical care. An advance practice nurse is not a doctor. An advance practice nurse is a registered nurse who has received advanced education and training in the provision of health care. An advance practice nurse can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. In addition, the advance practice nurse may treat minor lacerations and other minor injuries.

I have read the above, and hereby consent to the services of an advance practice nurse for my health care needs.

I understand that at any time I can refuse to see the advance practice nurse and request to see a physician.

X_____
Signature of Parent/Guardian Date