23 Sunnybrook Rd.
Suite 116
Raleigh, NC 27610

Patient Registration Form

Date:______________________

Patient Information

Last Name: ______________________________ First Name: ____________________________ Middle Initial:______

Date of Birth: __________/________/________ Age: _________ Sex: ________SSN#: ________-________-________

Race: ☐African-American ☐Asian ☐Native American ☐White ☐Other ☐Decline to Respond

Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Decline to Respond

Insurance Information

Primary Insurance Company Name: ____

Policy Number: ______________________________________ Group Number: ________________________________

Policy Holder Name: ____ DOB: ___________________________

Relationship to Patient: ________________________________

Secondary Insurance Company Name: ____

Policy Number: ______________________________________ Group Number: ________________________________

Policy Holder Name: ____ DOB: ___________________________

Relationship to Patient: ________________________________

Mother/Legal Guardian

Name: ____

Address:_______________________________________

____
City State Zip Code

Home Phone: __________________________________

Cell Phone: ____________________________________

Email: ____

Marital Status (Check One)

☐Single ☐Married ☐Divorced ☐Widowed

Father/Legal Guardian

Name: ____

Address:_______________________________________

____
City State Zip Code

Home Phone: __________________________________

Cell Phone: ____________________________________

Email: ____

Marital Status (Check One)

☐Single ☐Married ☐Divorced ☐Widowed

Who is the primary care giver? ☐Both ☐Mother ☐Father ☐Other

If applicable, who has primary custody? ☐Both ☐Mother ☐Father

Other ______________________ (*Please provide legal documents for any alternative custody arrangements.)

Emergency Contact (Other than Parent)

Name: ______________________ Relationship: ______________________

Home Phone: ______________________ Cell Phone: ______________________

PLEASE LIST ALL PERSONS WHO MAY SCHEDULE APPOINTMENTS, CALL FOR MEDICAL ADVICE OR BRING YOUR CHILD TO THE OFFICE FOR TREATMENT (I.E GRANDPARENTS, BABYSITTER, AUNT). THESE INDIVIDUALS WILL BE ASKED TO PRESENT IDIENTIFICATION AT THE TIME OF THE VISIT. IF SOMEONE OTHER THAN THESE PERSONS CONTACTS US RELATIVE TO YOUR CHILD, WE WILL CONTACT THE PARENT OR GUARDIAN FOR PERMISION TO TREAT OR ADVISE. IN THE EVENT OF AN EMERGENCY, WE WILL TREAT AND MAKE EVERY ATTEMPT TO CONTACT THE PARENT OR GUARDIAN.

NAME	RELATIONSHIP	PHONE NUMBER

Additional Information

Preferred Language: ______________________

Preferred Provider: ______________________

Pharmacy Name: ______________________

Pharmacy Address: ______________________

Pharmacy Phone Number: ______________________

Authorization

As a courtesy, Kids First Pediatrics will verify and file insurance, but the practice cannot guarantee payment. I understand that I am financially responsible for services rendered as and when charges are incurred. I hereby authorize Kids First Pediatrics and/or the rendering physician(s) to release all medical information required by my insurance company to file claims for medical benefits. I authorize payment of all applicable benefits directly to Kids First Pediatrics of Raleigh.

Uses of Protected Health Information to Contact You

We may use your protected health information to contact you by phone or via e-mail at home or any other location that you may specify and leave a message regarding appointment reminders, insurance items and any calls pertaining to your child's clinical care, including lab and x-ray results with information about treatment alternatives or other health related benefits and services that in our opinion may be of interest to you.

This authorization will remain in effect until revoked by me in writing. A photocopy is to be considered as valid as the original.

Consent to release information acquired in the course of examination and/or treatment in regards to treatment, payment of services and operations is understood and explained to you in the posted Notice of Privacy Practices.

______________________ ______________________

Parent/Guardian Signature Date

Medical History Form

General Questions:

How did you hear about us? (Please Circle One)

Family Member Friend Internet Advertisements Hospital Referred Other

Are you the child's…….? (Please Circle One)

Mother Father Grandparent Foster Parent Other Relative Other Self (Are you the patient?)

	Yes	No	I Don't Know	Explanation
Do you consider your child to be in good health?				
Does your child have any serious illnesses or medical conditions?				
Do you have any concerns about your child's behavior or development?				
Is your child in daycare?				
Is your child in school?				What type?
Do you feel your family has enough to eat?				

Birth History:

	Yes	No	I Don't Know	Explanation
Were there any prenatal or neonatal complications?				
Was a NICU stay required?				
During pregnancy, did mother use tobacco?				
During pregnancy, did mother drink alcohol?				
During Pregnancy, did mother use drugs or medications?				
During pregnancy, did mother take prenatal vitamins?				

Social History:

Where is your child currently living? (Please Circle One)

In a house or apartment with family In a house or apartment with relatives or friends

In a house or apartment with foster family Shelter Other

How many times have you moved in the past year? (Please Circle One)

0 1-2 3-4 5 or more

	Yes	No	I Don't Know
Does your child live with both of his/her parents?			
Do you feel your child lives in a safe place?			
Are there pets in the child's home?			
Are there smoke alarms in the child's home?			
Are there any guns in the child's home?			
Does anyone in your household smoke? Cigarettes, E-cigarettes, or other?			

	Always	Often	Sometimes	Rarely	Never	Not Applicable
How often does your child wear a helmet when riding a bicycle?						
How often does your child wear a seatbelt (carseat)?						
How often does your family eat meals together?						
How often do you read bedtime stories to your child?						

Biological Family History:

Please place an **X** in the box if the listed relative has ever been diagnosed with the following medical conditions.

	Mother	Father	Siblings	Grandparents	Other Relatives
Asthma					
Diabetes					
High Cholesterol					
Heart Disease					
High Blood Pressure					
Cancer					
Learning Problems					
Mental Illness					
Kidney Disease					
Seizures					
Liver Disease					
Other Concerns					

Past Medical History:

- ☐ Asthma
- ☐ Reactive Airway Disease
- ☐ Wheezing
- ☐ Bronchitis
- ☐ Bronchiolitis
- ☐ Pneumonia
- ☐ Other Breathing Problems
- ☐ Seasonal Allergies
- ☐ Eczema
- ☐ Chronic Skin Problems
- ☐ Allergy to bees
- ☐ Allergy to peanuts
- ☐ Other Allergy Problems
- ☐ Broken Bones
- ☐ Concussion
- ☐ Needed Stitches
- ☐ In a Car Accident
- ☐ Other Injury
- ☐ Dental Decay
- ☐ Problems with eyes or vision
- ☐ Wears Glasses
- ☐ Wears Contact Lenses
- ☐ Frequent Ear Infections
- ☐ Hearing Loss
- ☐ Other Problems with ears/hearing
- ☐ Frequent Headaches
- ☐ Seizures
- ☐ Cerebral Palsy
- ☐ Other Neurologic Problems
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Other Heart Problems
- ☐ Obesity
- ☐ Diabetes
- ☐ Frequent Abdominal Pain
- ☐ Constipation requiring doctor's visits
- ☐ Kidney Infection
- ☐ Bed-wetting (after 5 years old)
- ☐ Recurrent Urinary Tract Infections
- ☐ Urologic Malformation
- ☐ Other kidney or urologic problems
- ☐ Metabolic or Genetic Disorder
- ☐ Cystic Fibrosis
- ☐ Anemia
- ☐ Bleeding Problem
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Tumors
- ☐ Bone Marrow Transplant
- ☐ Chemotherapy
- ☐ Snoring
- ☐ Sleep Apnea
- ☐ Other Sleeping Problems
- ☐ ADHD
- ☐ Mood Problems
- ☐ Anxiety
- ☐ Depression
- ☐ Other Behavioral Problems
- ☐ Speech Delay
- ☐ Developmental Delay
- ☐ Uses Alcohol/Drugs
- ☐ Uses Tobacco Products