



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

Father/Legal Guardian

Name: _____

Name: _____

DOB: ____/____/____

DOB: ____/____/____

Address: _____

Address: _____

City State Zip Code

City State Zip Code

Home Phone: _____

Home Phone: _____

Cell Phone: _____

Cell Phone: _____

Email: _____

Email: _____

Marital Status (Check One)

[]Single []Married []Divorced []Widowed

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 IDENTIFICATION 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 PERMISSION 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

	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