Waggoner Pediatrics Registration Form

Today's Date:___________________

PATIENT:____ Date of birth:_______________________

PATIENT:____ Date of birth:_______________________

PATIENT:____ Date of birth:_______________________

PATIENT:____ Date of birth:_______________________

<u>Father or Guardian</u>

Name:____ Date of birth:_______________

Address____ City/State_______________________ Zip____________

Home Phone_____________________ Work Phone_____________________ Cell Phone_________________________

Married____ Single____ Divorced____ Widowed____ Separated____ SSN______________________________

Employer____ Email____

<u>Mother or Guardian</u>

Name:____ Date of birth:_______________

Address____ City/State______________ Zip____________

Home Phone_____________________ Work Phone_____________________ Cell Phone_________________________

Married____ Single____ Divorced____ Widowed____ Separated____ SSN______________________________

Employer____ Email____

<u>EMERGENCY CONTACT</u> *****We will always contact parents first. If we are unable to contact parents, we will contact emergency name provided.*****

Name:____ Relationship:______________________

Home Phone___________________ Work Phone___________________ Cell Phone_______________________

INSURANCE

Primary: Insurance is through FATHER/GUARDIAN or MOTHER/GUARDIAN (please circle)

Date of birth of policy holder______________________

Insurance name_________________________________ ID#_________________________ Group#__________________

Effective Date_________________________ Insured's Employer____

Secondary: Insurance is through FATHER/GUARDIAN or MOTHER/GUARDIAN (please circle)

Date of birth of policy holder______________________

Insurance name_________________________________ ID#_________________________ Group#__________________

Effective Date_________________________ Insured's Employer____

AUTHORIZATION FOR INSURANCE REIMBURSEMENT

I hereby authorize the release of such information as may be necessary to implement the coordination of benefits to Waggoner Pediatrics of Central Iowa.

Insurance Signature ____ Date___________________

I hereby authorize payment of medical benefits directly to Waggoner Pediatrics of Central Iowa.

Payment Signature ____ Date___________________

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

I authorize the disclosure of patient individual health information when necessary, including but not limited to when required by law, when working with laboratories and testing facilities, and for billing purposes. For complete HIPAA disclosure conditions and use information, please ask the front desk, or visit waggonerpediatrics.org.

HIPAA Signature ____ Date___________________

Waggoner Pediatrics of Central Iowa

Putting families first for over 25 years.

HIPAA Privacy Communication Authorization Form

Purpose of this section: I give permission to the employees of Waggoner Pediatrics of Central Iowa to contact me and leave me messages as they related to the medical care of myself, or my child or children at Waggoner Pediatrics of Central Iowa.

Patient Name:____ Date of Birth:__________________

Patient Name:____ Date of Birth:__________________

Patient Name:____ Date of Birth:__________________

Patient Name:____ Date of Birth:__________________

Patient Name:____ Date of Birth:__________________

Patient Name:____ Date of Birth:__________________

Primary Contact Info:

Name: ____ Relationship to Patient: _______________________

Phone Number: _______________________________________ Cell ◯ Work ◯ Home ◯ Other ◯

Do you allow Waggoner Pediatrics of Central Iowa to leave a message at this number? Yes ◯ No ◯

Secondary Contact Info:

Name: ____ Relationship to Patient: _______________________

Phone Number: _______________________________________ Cell ◯ Work ◯ Home ◯ Other ◯

Do you allow Waggoner Pediatrics of Central Iowa to leave a message at this number? Yes ◯ No ◯

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

I authorize the disclosure of patient individual health information when necessary, including but not limited to when required by law, when working with laboratories and testing facilities, and for billing purposes. For complete HIPAA disclosures and conditions and use information, please ask the front desk or visit http://waggonerpediatrics.org/HIPAA.

HIPAA Signature: ____ Today’s Date: __________________________

Waggoner Pediatrics of Central Iowa

Today's Date: ____

Patient's Name: ____

Sibling's Name(s): ____

Waggoner Pediatrics of Central Iowa

Putting families first for over 25 years.

History	Father	Mother	Paternal Grandpa	Paternal Grandma	Maternal Grandpa	Maternal Grandma	Siblings
Alive or Deceased	A or D	A or D	A or D	A or D	A or D	A or D	A or D
Check boxes below to indicate if a relative had the corresponding health concern.							
Deafness							
Nasal Allergies							
Asthma							
Tuberculosis							
Heart Disease (before 50)							
High Blood Pressure (before 50)							
High Cholesterol							
Anemia							
Bleeding Disorders							
Liver Disease							
Kidney Disease							
Diabetes							
Bed Wetting (after 10)							
Epilepsy/Convulsions							
Alcohol Abuse							
Drug Abuse							
Mental Illness							
Mentally Challenged							
Immune Problems, HIV, or Aids							
Allergies							
ADD/ADHD							
Arthritis							
Cancer (If so, note type)							
Depression/Anxiety							
Migraine Headaches							
Sinus/Ear Problems							
Skin Problems							
Stroke							
Thyroid							
Obesity							
Please note any other family history conditions:							

Waggoner Pediatrics of Central Iowa

Today's Date: ____

Patient's Name: ____

Sibling's Name(s): ____

What kind of home does the child live in?

House ◯ Apt ◯ Condo ◯ Shelter ◯ Other (please specify) ___________________________________

Was your home built before 1970? Yes ◯ No ◯

Do parents work? If yes, please list occupation.

Mother Yes ◯ __________________ No ◯ Father Yes ◯ __________________ No ◯

Does your home have any of the following?

Smoke Detectors ◯ Carbon Monoxide Detectors ◯ Pool ◯ Hot Tub ◯ Nearby lake, pond, or stream ◯

Does your child go to daycare? Yes ◯ No ◯

If yes, please mark which type: Relative ◯ Before/After School Program ◯ Nanny/In House Sitter ◯

Licensed Daycare Center ◯ Private Home (Licensed) ◯ Private Home (Unlicensed) ◯

Does your child go to school? Yes ◯ No ◯ Homeschool ◯

School Name + Child's Grade: ____

Perinatal History

Where was the child born? ____

Child's Birth Weight: ____

Was the child premature? Yes ◯ No ◯ If yes, how many weeks early? ______________________________

Any problems during pregnancy? Yes ◯ No ◯ If yes, please explain ___________________________________

How was the baby delivered? Vaginally ◯ C-Section ◯

Were there any problems during delivery? Yes ◯ No ◯ If yes, please explain ___________________________

Did baby need any special help after delivery? Yes ◯ No ◯

If yes, what? Oxygen ◯ Jaundice Lights ◯ Antibiotics ◯ Other ◯ ________________________________

Waggoner Pediatrics of Central Iowa

Today's Date: ____

Patient's Name: ____

Sibling's Name(s): ____

Waggoner Pediatrics of Central Iowa

Putting families first for over 25 years.

Past Medical History

◯ Serious injuries or accidents	◯ Heart problems or heart murmur	◯ If female, any problems with periods?
◯ Surgeries	◯ Anemia or bleeding problem	◯ Chronic or recurrent skin problems (acne, eczema, etc.)
◯ Hospitalizations	◯ Blood transfusion	◯ Frequent headaches
◯ Chicken Pox	◯ Frequent abdominal pain	◯ Convulsions or other neurologic problems
◯ Frequent Ear Infections	◯ Constipation requiring doctor visits	◯ Diabetes
◯ Problems with Ears and/or Hearing	◯ Bladder or kidney infection	◯ Thyroid or other endocrine problems
◯ Asthma, Bronchitis, Pnuemonia	◯ Bed-wetting (after 5 years of age)	◯ Use of alcohol or drugs
◯ Animals	◯ If female, have menstrual periods started?	◯ Other significant problems
◯ Outdoor Allergens		
◯ Indoor Allergens		

If your child has been hospitalized overnight since birth, when did it occur and for what reason?

If your child has had any surgeries, when did it occur and for what reason?

Are there any specialists who take care of your child (i.e. allergist, ENT)? Who and for what reason?

Comments on any other items selected above:

Social History

Who does the child live with? Mother ◯ Father ◯ Relative/Guardian (Specify) ◯ ________________________

Parents are: Married ◯ Divorced ◯ Separated ◯ Single ◯

If parents are not together, what is the custody arrangement?

____

____

Please list the names, sex, and age of siblings. Also, if full, half, step or adoptive siblings.

____

____

Do you have pets in the home? Yes ◯ No ◯ If yes, please list all pets:

____

____

Does anyone smoke in the home? Father ◯ Mother ◯ Sibling ◯ Caregiver ◯ Other ◯

Do you have guns in the home? Yes ◯ No ◯ If yes, are guns locked/secured? Yes ◯ No ◯

If yes, are the guns stored separately from ammunition? Yes ◯ No ◯

Waggoner Pediatrics of Central Iowa

Today's Date: ____

Patient's Name: ____

Sibling's Name(s): ____

Waggoner Pediatrics of Central Iowa

Putting families first for over 25 years.

Problems

Are there any potential stress issues in your home?

- ◯ None
- ◯ Alcoholism
- ◯ Chronic illness
- ◯ Disability
- ◯ Domestic violence
- ◯ Drug use
- ◯ Financial difficulties
- ◯ Martial difficulties
- ◯ Mental issues
- ◯ Recent death in the family
- ◯ Unsafe neighborhood
- ◯ Other

Allergies

Please list your child's allergies (if any)

Medications ____________________________________
____

Foods ____
____

Seasonal _______________________________________
____

Animals ____
____

Other ____
____

Medications

Does your child take any medications? (Please include vitamins and herbal) Yes ◯ No ◯

If yes, please list all ____

Immunizations

Has your child received immunizations? Yes, up to date ◯ No, none ◯ Behind ◯

If your child is behind, what shots and why? ____