

Pediatric Consultants of Ashland

~Patient Registration and Medical History Form~

Date: _____

How did you hear of Pediatric Consultants of Ashland? _____

I have received a copy of PCAI policies and procedures. _____

Signature of responsible party

Patient Information:

Name: _____ SS# _____ DOB _____ Sex: M _____ F _____

Mother: _____ SS# _____ DOB _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____

Father: _____ SS# _____ DOB _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____

Parents: (circle one) Married Living Together Divorced Step-Parent name (if applicable): _____

If Divorced- Custodial parent: Mom _____ Dad _____ Please provide any court orders or divorce decree.

Legal Guardian (if other than parent) _____ Phone: _____

Address: _____ City: _____ Zip: _____

Emergency Contact (Other than Parents) _____ Relationship: _____ Phone: _____

Address: _____ City: _____ Zip: _____

(THIS PORTION MUST BE FILLED OUT AND A COPY OF CARD PROVIDED)

Self Pay? : Yes / No

Person responsible to pay bills:

Name: _____ Address: _____ Ph#: _____

Relationship to patient: _____ Court Ordered as responsible party? Yes No

Insurance:

Primary Insurance: _____

Policy Holder: _____ DOB _____

Group #: _____ ID # _____

Customer Service #: _____

Claims Address: _____

Medicaid billing # _____

Secondary Insurance: _____

Policy Holder: _____ DOB _____

Group #: _____ ID # _____

Customer Service #: _____

Claims Address: _____

Social History:

Members of Household:

Mother ___ Father ___ Boyfriend/Girlfriend ___ Stepmother ___ Stepfather ___ Grandparent(s) ___

Minor Children living at home:

1. _____
NAME SEX DOB

2. _____
NAME SEX DOB

3. _____
NAME SEX DOB

4. _____
NAME SEX DOB

5. _____
NAME SEX DOB

6. _____
NAME SEX DOB

Daycare: None ___ Part-time ___ Full-time ___ Other _____

School Name: _____ Grade Level _____ Sports/Clubs/Activities _____

Type of Water: Well ___ Bottled ___ Bottled with fluoride ___ City _____

Tobacco Smoke Exposure: ___ Y ___ N

Lead Risks: ___ Pre-1960 Home ___ Pre-1980 Home recently renovated ___ Siblings with high lead level

Birth History: (if < 5yrs. old or abnormal, complete the following)

Length of pregnancy: _____ Complications: _____

Type of Delivery: _____ Weight: _____ Length: _____

Complications during labor or delivery: _____

Type of feeding (breast/formula): _____ Hospital or Location of delivery: _____

Family History:

Do any of the patient’s close relatives have any of the following? Please circle the abbreviation for the relative who has the condition on the line provided. Abbreviations: Mother-M, Father-F, Brother-B, Sister-S, Maternal Grandmother-MGM, Maternal Grandfather-MGF, Paternal Grandmother-PGM, and Paternal Grandfather-PGF.

Allergies	M F B S MGM MGF PGM PGF	High Blood Pressure	M F B S MGM MGF PGM PGF
Anemia	M F B S MGM MGF PGM PGF	High Cholesterol	M F B S MGM MGF PGM PGF
Asthma	M F B S MGM MGF PGM PGF		
ADD/ADHD	M F B S MGM MGF PGM PGF	Kidneys	M F B S MGM MGF PGM PGF
Blindness	M F B S MGM MGF PGM PGF	Learning Disability	M F B S MGM MGF PGM PGF
Blood Disorder	M F B S MGM MGF PGM PGF	Mental Retardation	M F B S MGM MGF PGM PGF
Cancer	M F B S MGM MGF PGM PGF	Migraines	M F B S MGM MGF PGM PGF
Deafness	M F B S MGM MGF PGM PGF	Muscle/Joint	M F B S MGM MGF PGM PGF
Depression	M F B S MGM MGF PGM PGF	Obesity	M F B S MGM MGF PGM PGF
Developmental Delays	M F B S MGM MGF PGM PGF	Psychiatric Disorder	M F B S MGM MGF PGM PGF
Diabetes	M F B S MGM MGF PGM PGF	Thyroid	M F B S MGM MGF PGM PGF
Easily Bruises/Bleeds	M F B S MGM MGF PGM PGF	Seizures/ Epileptic	M F B S MGM MGF PGM PGF
Eczema/Skin problems	M F B S MGM MGF PGM PGF	Urinary Tract or Digestive Problems	M F B S MGM MGF PGM PGF
Heart Problems	M F B S MGM MGF PGM PGF		

Other Family History: _____

Authorization of Treatment and Assignment of Benefit

I authorize Pediatric Consultants of Ashland to give Medical Care and Immunizations to this patient only if accompanied by one of the following individuals: _____

I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to Pediatric Consultants of Ashland for all medical or surgical benefits otherwise payable to me under the terms of my insurance. **I understand that I am financially responsible for all co-payments and any charges not paid by my commercial insurance or Medicaid.** A photocopy of this authorization shall be considered as effective and valid as the original. I understand that if my child’s physician, or any person employed by or under the direction and control of my child’s physician(s), is directly exposed to my child’s body fluids in any manner which may, according to the then current guidelines for the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or hepatitis B or C viruses, that I am deemed by law to have consented to testing for infection with HIV or hepatitis B or C viruses. I further understand that by law I will have deemed to consent to the release of these test results to the person who is exposed to my child’s body fluids.

Parent/Guardian’s signature _____ Relationship _____ Date _____

Witness’ Signature _____ Date _____