Patient Registration

South Pointe PEDIATRICS

Patient Information

Last Name _____ First Name _____ MI ____ Date of Birth ____/____/____ Sex ____

Primary Language ☐ English ☐ Spanish ☐ Other_____

Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Race ☐ Asian ☐ Black ☐ Native American ☐ White

Mailing Address

Street _____

City _____ State _____ Zip _____ Primary Phone ( )_____-_____

Parent or Guardian 1

Name _____ Relation to Patient _____

Lives with Parent? ☐ Yes ☐ No Date of Birth: ____/____/____ Social Security # ___-__-____

Cell Phone ( )_____-_____ Work Phone( )_____-_____ Email _____

Employer _____ Occupation _____

Address ☐ Same as Above

Street _____ City _____ State _____ Zip _____

Parent or Guardian 2

Name _____ Relation to Patient _____

Lives with Parent? ☐ Yes ☐ No Date of Birth: ____/____/____ Social Security # ___-__-____

Cell Phone ( )_____-_____ Work Phone( )_____-_____ Email _____

Employer _____ Occupation _____

Address ☐ Same as Above

Street _____ City _____ State _____ Zip _____

Insurance

Primary Policy

Policy Holder's Name _____ Relationship to Patient _____

Policy Holder's Birth Date _____ Policy Holder's Sex _____

Insurance Carrier _____ ID# _____ Group # _____

Secondary Policy

Policy Holder's Name _____ Relationship to Patient _____

Policy Holder's Birth Date _____ Policy Holder's Sex _____

Insurance Carrier _____ ID# _____ Group # _____

Additional Contact Questions

Who should receive billing statements?_____

May ALL contacts have access to the patient's records electronically? Yes / No /

*If parents are divorced or separated, please fill out this section:

Who has custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment?
Yes / No
If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

_____

Emergency Contacts, other than parents:

1: _____-_____ Phone: (_____) _____ - _____
Name Relationship

2: _____-_____ Phone: (_____) _____ - _____
Name Relationship

South Pointe Pediatrics, PLLC

PLEASE READ AND SIGN

I understand and agree that, regardless of my insurance status I am ultimately responsible for the balance on my account for any professional services rendered. I will notify you of any changes in my insurance status or any other demographic information. I request that insurance payment of authorized medical benefits, if any, be made to South Pointe Pediatrics on my behalf for any unpaid services rendered by South Pointe Pediatrics.

I consent to the use and sharing of my health records for treatment, payment, and operational purposes as described in our NOTICE OF PRIVACY PRACTICES. Oklahoma law requires that we advise you that the information authorized for disclosure may include information which may be considered a communicable or venereal disease, including, but not limited to, Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS). It also may include mental health or other sensitive information. By signing this agreement, you are consenting to such disclosure.

A complete description of how your medical information will be used and disclosed by this practice is in our NOTICE OF PRIVACY PRACTICES, which you should read before signing this agreement.

_____

Signature of Patient, Parent or Legal Guardian Relationship Date

Treatment Authorization & Guardian Consent Forms

South Pointe PEDIATRICS

I, _____ (print name) _____, give South Pointe Pediatrics permission to speak with the following people regarding my child's health status, including diagnosis, treatment options and plans and payment for health services I receive from South Pointe Pediatrics.

This consent is valid until such time as I provide South Pointe Pediatrics written revocation of it.

Patient Name _____ Patient's DOB _____/_____/_____

South Pointe Pediatrics may speak with

Name _____

Relationship _____

Name _____

Relationship _____

Name _____

Relationship _____

Patient/Guardian Signature

_____ Date _____/_____/_____

This form is to be filed in the patient's medical chart.

CONTINUED ON BACK

Authorization for Treatment to Minor

Minor's name in full _____ Date of birth _____/_____/_____

I/we, the undersigned parent(s)/legal guardian(s), of the minor person listed above do authorize the physicians of South Pointe Pediatrics to provide health services to this minor in the absence of a parent or legal guardian. This health service may include, but is not limited to: examination, preventative and/or curative treatment, x-ray, laboratory examination, anesthetic, medical or surgical diagnosis, and any consultation deemed necessary at the physician's discretion. Services shall not include research or experimentation.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required and is given to encourage the physician to exercise his or her best judgment as to the requirements of such diagnosis or medical treatment in my/our absence.

NOTE: Not used as permission for vaccines.

This consent shall remain in effect until revoked, in writing, by parent(s) or legal guardian(s),or until child may legally consent for him or herself.

I declare under penalty of perjury under the laws of the State of Oklahoma that the foregoing is true and correct.

_____

Signature-Parent or Guardian Date

This form is to be filed in the patient's medical chart.

Medical Records Release

South Pointe PEDIATRICS

phone: 918-254-6822

Patient Information

PRINT Patient Name in Full _____ Date of Birth ____/____/____

I hereby authorize SOUTH POINTE PEDIATRICS and its agents and employees to ___release or ___obtain (please check the appropriate space) information and copies of records pertaining to my medical care and treatment which could include information about communicable or venereal disease, mental health, or drug, substance or alcohol abuse.

Release to:	Obtain from:
Name of designated Facility or Provider	Name of designated Facility or Provider
Address	Address
City, State, Zip Code	City, State, Zip Code
Phone Number Fax Number	Phone Number Fax Number

Information to be released:
___ All Medical Records
___ The most recent 2 years of pertinent information (chart notes, labs, x-rays, and special tests)
___ Specific Information (please specify): _____

Purpose for which request is being made (please check on of the following):
___ Physician ____Medical Claims Processing ____Self ____Attorney ____Other_____

I understand that if I am requesting records/information for release to me or a patient representative:
- laws may prevent certain records from being released to the patient
- in certain situations, records denied for release to the patient may allow patient to request and obtain a review of the denial

Drug/Alcohol Abuse Treatment Records: This category of medical information/records is protected by federal confidentiality rules(42 CFR Part 2). The federal rules prohibit anyone receiving this information on records from making further release unless further release if expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I, the undersigned, hereby authorize the release of my (or give relationship) _____ medical record as specified above. This authorization includes the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug related conditions, alcoholism and/or psychiatric/psychological conditions to the above mentioned entity(s).

The information authorized for release may include records which may indicate the presence of a communicable disease or non-communicable disease.

My Rights:
I understand that I do not have to sign this authorization in order to obtain health care benefits. I may revoke this authorization in writing by following the process described in the Notice of Privacy Practices posted in the office. I understand that the provider has no control over any information and records released to any other person, firm or agency under this Authorization and it is, therefore, possible that a release of this information or records may occur by such other party.
Reasonable Fee:
State law provides that a health care provider may charge a reasonable fee.

I release the provider, its employees and agents from and liability in connections with the use or disclosure of the information and records released to any party pursuant to this Authorization.

_____ _____
Signature of Patient or Patient's Authorized Representative Date

_____ _____
Reason Patient Unable to Sign Relationship to Patient

New Patient Medical History

South Pointe PEDIATRICS

This form must be completed and returned before or on 1st visit
We require immunization records before we can administer any vaccines.

The following is **very important** to your child's health. Please complete it **accurately** and **completely**.

Child's name: _____ **Birth date:** __/__/__

Has your child **ever** previously been seen by any of the doctors **in this practice**? Y___ N___

BIRTH HISTORY	
Birth weight:_____lbs._____oz. Vaginal birth? C-section?	
Baby was born at_____weeks. If early, length of NICU stay:_____weeks	Where was your child born? _____
Did the baby have any problems right after birth?	
Did mother have any problems with the pregnancy?	

PATIENT ALLERGIES	**No**	**Yes**	***Please List:***
Does this child have any known drug allergies?			
Does your child have any known food allergies?			
Any other allergies?			

PATIENT SOCIAL HISTORY	**No**	**Yes**	**If Yes – explain**
Is patient in foster care?			
Is patient adopted?			
Who does patient live with?			
Does patient live with both mother and father in same house?			
Does non-custodial parent have visitation rights?			
Are there Siblings?			Live in same house? Yes___No___
Are there pets in the home?			
Are there smokers in the home?			
Are there guns in the home?			
Are guns locked and kept separate from ammunition?			

PATIENT - PAST MEDICAL HISTORY	No	Yes	If Yes – explain
Serious accidents or injuries			
Surgeries			*Procedure & approx. date or age:*
Hospitalizations			*What reason & approx. date or age:*
Chicken Pox Disease			
Frequent ear infections or sinus infections(>4/yr)			
Frequent sore throats or tonsillitis(>4/yr)			
Other infectious illnesses			
Allergic rhinitis or other allergy			
Asthma, bronchitis, bronchiolitis, pneumonia or croup			
Heart problems or heart murmur			
Abdominal pain/reflux			
Constipation requiring doctor visits			
Bladder or kidney infection or other urologic problem			

Bed-wetting (after age 5)			
Eye conditions / wear corrective lenses			
Problems with ears or hearing			
Chronic or recurrent skin problems/ acne			
Anemia or bleeding problem			
Past blood transfusion			
Frequent headaches			
Convulsions or past concussions?			
Mental health concerns			
Seizures			
Developmental delays			
ADD/ADHD			
Orthopedic problems			
Diabetes			
Thyroid, diabetes or other endocrine problems			

PATIENT - PAST MEDICAL HISTORY (CONTINUED)	No	Yes	Please List:
If female, have menstrual periods started?			
If female, any problems with periods?			
Use of alcohol or drugs			
Emotional or mental health problems			
Other significant issues:			

Current Medications and Dosage: (include any over the counter, herbal, or supplements):

Does your child see any specialists? If so, who and where?

Please check off which **BIOLOGICAL RELATIVE** has the condition:

FAMILY – PAST MEDICAL HISTORY	Mom	Dad	Brother	Sister	Maternal Gr Mth	Maternal Gr Fth	Paternal Gr Mth	Paternal Gr Fth
Nasal allergies or other allergies								
Asthma/lung disease								
Heart disease or heart condition								
High blood pressure								
High cholesterol								
Diabetes or other endocrine problem								
Cancer								
Anemia								
Bleeding disorders								
Epilepsy or convulsions								
Mental retardation or developmental disorders								
Neurological disorder including ADHD/ADD								
Liver disease								
Other GI disease / disorder								
Kidney disease								
Bed-wetting (after age 10)								
Hearing impairment								

FAMILY – PAST MEDICAL HISTORY (CONTINUED)	Mom	Dad	Brother	Sister	Maternal Gr Mth	Maternal Gr Fth	Paternal Gr Mth	Paternal Gr Fth
Eye disorder								
Immune problems, recurrent infections or HIV-AIDS								
Alcohol Abuse								
Drug Abuse								
Mental Illness								
Tuberculosis								
Other issues:								

Is there anything else regarding your child's health that you think we should know that has not already been asked? _____

I attest that all the medical history information is true and correct to the best of my knowledge:

Signature: _____ ____/____/_____
Date

Print Name: _____

Relationship to Patient: _____

For Office Use:

Provider Review:_____

Date: _____