Kids First Pediatric Urgent Care, LLC

REGISTRATION

(patient, parent or legal guardian to complete)

PATIENT INFORMATION

Patient's Name: _____

Date of Birth:_____ Age:_____

Cell Phone (if over 18): (____) _____

Gender: ☐ Male ☐ Female

Primary Care Physician: _____

Primary Care Physician Phone: (____) _____

Today's Date:_____ **Arrival Time:** _____

Patient Status: ☐ New ☐ Established

FOR OFFICE USE ONLY

Date of Last Visit:_____

Date of Last Visit Over Three Years: Yes ☐ No ☐

PARENT / GUARDIAN INFORMATION

Father's Name (Guardian): _____

Street Address: _____

City:_____ Zip Code: _____

Home Phone: (____) _____

Cell Phone: (____) _____

Email Address: _____

Occupation:_____

Employer's Name: _____

Employer's Phone: (____) _____

Mother's Name (Guardian): _____

Address:_____

City:_____ Zip Code: _____

Home Phone: (____) _____

Cell Phone: (____) _____

Email Address: _____

Occupation:_____

Employer's Name: _____

Employer's Phone: (____) _____

INSURANCE INFORMATION

Primary Insurance: _____

☐ HMO ☐ PPO/EPO/POS

Subscriber's Name: _____

Subscriber's Date of Birth: _____

Member ID: _____

Group Number: _____

Secondary Insurance: _____

☐ HMO ☐ PPO/EPO/POS

Subscriber's Name: _____

Subscriber's Date of Birth: _____

Member ID: _____

Group Number: _____

HOW DID YOU HEAR ABOUT US?

☐ Doctor Referred You ☐ Saw Your Sign ☐ www.kidsfirstshoals.com

☐ Friend ☐ Direct Mail ☐ Brochure (Location:_____)

☐ Returning Family ☐ Google, Yahoo or Bing ☐ Other: _____

ACCEPTED INSURANCE, PRESCRIPTIONS, PRIVACY PRACTICES, AUTHORIZATIONS & AGREEMENTS

(patient, parent or legal guardian to complete)

Accepted Insurance

If you are not sure whether your insurance plan is contracted with Kids First Pediatric Urgent Care, LLC (KFPUC), please check with our front office staff. As a courtesy, we will process a patient's claim if it is through one of our contracted insurance companies.

The undersigned (patient or patient's parent or legal guardian, if the patient is under the age of 18) agrees to pay all fees and costs for services and materials provided to the patient at the time of service.

Notice of Privacy Practices

A Notice of Privacy Practices ("NPP") is provided to each patient (to patient's parent or legal guardian, if under the age of 18). The NPP identifies the following: (1) KFPUC's responsibilities for maintaining the privacy of a patient's protected health information ("PHI"); (2) KFPUC's use and disclosure of your PHI; (3) KFPUC's use and disclosure in special circumstances; (4) A patient's rights regarding his/her PHI, including manner of communication, requesting restrictions, inspections, amendments, accounting disclosures, paper copies, filing a complaint, and authorization for other uses.

The undersigned (patient or patient's parent or legal guardian, if the patient is under the age of 18) certifies that he/she has received a copy of the NPP, has read the NPP, and authorizes KFPUC to provide its pediatrician notes directly to the patient's primary care physician.

Authorizations & Agreements

The undersigned (patient or patient's parent or legal guardian, if the patient is under the age of 18): (1) Certifies that all information provided on KFPUC's intake forms is true to the best of his/her knowledge; (2) Authorizes insurance benefits to be paid directly to KFPUC; (3) Authorizes KFPUC or his/her insurance company to release any information required to process his/her insurance claims; (4) Understands and agrees that he/she is ultimately responsible for all charges regardless of an insurance company's involvement; and (5) Understands and agrees that it is his/her responsibility to be fully informed as to the requirements, benefits and limitations of his/her insurance coverage, including co-payments and deductibles.

Signature:_____ **Printed Name:** _____

Date:_____ **Relation to Patient:** _____

MEDICAL HISTORY

(patient, parent or legal guardian to complete)

REASON FOR VISIT

Please describe the reason for today's visit: _____

Has patient seen a physician for this problem recently: ☐ Yes ☐ No

If yes, please list physician's orders and any medications prescribed: _____

PAST MEDICAL INFORMATION

Please list patient's ongoing medical problems: _____

Please list any specialists patient has seen: _____

Please list patient's surgical procedures, serious injuries and reasons for hospitalization: _____

Please list all of patient's allergies: _____

Are patient's vaccinations up-to-date: ☐ Yes ☐ No

If no, why: _____

Has patient had bad reaction to a vaccination: ☐ Yes ☐ No

If yes, which vaccines: _____

Please list all medications being taken by patient (including vitamins, supplements and herbal remedies): _____

Please check any diseases that patient's parents or relatives have or had:

☐ AIDS	☐ Allergies	☐ Anemia
☐ Asthma	☐ Blood Problems	☐ Cancer
☐ Develop. Delay	☐ Diabetes	☐ Drug Problems
☐ Eczema	☐ Heart Trouble	☐ High Blood Pressure
☐ High Cholesterol	☐ Hyperactivity	☐ Inherited Illness
☐ Mental Illness	☐ Tuberculosis	