PATIENT REGISTRATION FORM

ORCHARD PEDIATRICS **2018** **FAMILY NAME** _____

PARENT 1 BIRTHDATE	PARENT 2 BIRTHDATE
WHICH PARENT(S) HAVE LEGAL AUTHORITY TO MAKE MEDICAL DECISIONS? _____	
ADDRESS	ADDRESS
CITY STATE ZIP	CITY STATE ZIP
HOME PHONE ( ) CELL PHONE ( )	HOME PHONE ( ) CELL PHONE ( )
WORK PHONE ( ) PREFERRED METHOD OF CONTACT:	WORK PHONE ( ) PREFERRED METHOD OF CONTACT:
EMAIL ADDRESS	EMAIL ADDRESS
SOCIAL SECURITY #	SOCIAL SECURITY #
EMPLOYER	EMPLOYER
INSURANCE COMPANY POLICY#	INSURANCE COMPANY POLICY #

I DO / DO NOT (PLEASE CIRCLE ONE) GIVE PERMISSION TO LEAVE BASIC INFORMATION ON MY PERSONAL VOICE MAIL.

LIST THE **LEGAL NAME OF ALL CHILDREN** THAT ARE PATIENTS IN THIS OFFICE (INCLUDE LAST NAME IF DIFFERENT FROM ABOVE)

NAME	BIRTHDATE	MALE / FEMALE	
_____	_____	_____	ACCT # _____
_____	_____	_____	ACCT # _____
_____	_____	_____	ACCT # _____
_____	_____	_____	ACCT # _____

HAVE THERE BEEN ANY CHANGES IN YOUR CHILDREN'S PERSONAL OR FAMILY HEALTH HISTORY O YES O NO IF YES, PLEASE REQUEST A HEALTH HISTORY FORM

WHICH INSURANCE POLICY ARE THE CHILDREN ON? _____ IF BOTH, WHICH IS THE PRIMARY POLICY? _____

IF MOTHER AND FATHER HAVE DIFFERENT ADDRESSES, WHERE DO THE CHILDREN LIVE? _____

WHO SHOULD RECEIVE BILLING STATEMENTS? _____

EMERGENCY CONTACT PERSON (SOMEONE NOT LIVING IN YOUR HOME) NAME: _____ TELEPHONE: _____

PLEASE READ AND SIGN

I, _____ THE MOTHER / FATHER OF (LIST ALL CHILDREN) _____

1. I GIVE ORCHARD PEDIATRICS, P.C. PERMISSION TO TREAT MY CHILDREN SHOULD ANY OR ALL OF THEM PRESENT TO YOUR OFFICE WHEN NOT ACCOMPANIED BY A PARENT. THIS CONSENT SHALL BE VOID UPON WRITTEN REQUEST.
2. PERMISSION IS GRANTED TO ORCHARD PEDIATRICS, P.C., TO RELEASE REQUESTED INFORMATION TO MY INSURANCE COMPANY FOR BILLING PURPOSES OR PATIENT-CENTERED MEDICAL HOME (PCMH) WELLCENTIVE PATIENT REGISTRY.
3. I AUTHORIZE PAYMENT FOR MEDICAL SERVICES BY MY INSURANCE COMPANY TO ORCHARD PEDIATRICS, P.C.
4. IF MY CHILD'S INSURANCE CARRIER DENIES PAYMENT OF SERVICES, I UNDERSTAND THAT I AM REPSONSIBLE FOR PAYMENT OF ALL CHARGES.
5. PERMISSION IS GRANTED TO ORCHARD PEDIATRICS, PC TO IMPORT MY CHILD'S MEDICAL INFORMATION ELECTRONICALLY.

SIGNATURE _____ DATE_____ OFFICE WITNESS _____DATE_____

rev 2/21/2018

Orchard Pediatrics, P.C.

SCREENING QUESTIONNAIRE FOR TODAY'S IMMUNIZATIONS

PATIENT NAME_____**DATE OF BIRTH**_____**AGE**_____

SIGNATURE_____**RELATIONSHIP TO CHILD**_____**DATE**_____

For parents and guardians: This form helps us decide which vaccines should be given in our office today. If the question is not clear, please ask the nurse or doctor for an explanation.

	Yes	No	Unknown
1. Is the patient sick today with anything more than a cold?	O	O	O
2. Does the patient have allergies to medications, yeast, eggs, latex or any previous vaccines?	O	O	O
3. Has the patient had a serious reaction to a vaccine in the past?	O	O	O
4. Has the patient had a seizure or a changing neurological disorder?	O	O	O
5. Does the patient have cancer, an immune system disorder, or does the patient take medications that suppress the immune system such as steroids (by mouth or injection) or anti-cancer drugs?	O	O	O
6. Does someone with whom the patient lives (or has close contact) have cancer, an immune system disorder, or take medications that suppress the immune system such as steroids (by mouth or injection) or anti-cancer drugs?	O	O	O
7. Has the patient received blood, plasma, or gammaglobulin the past six months?	O	O	O
8. Is the patient pregnant or at risk of becoming pregnant within the next three months?	O	O	O

Vaccines have a very short shelf life once prepared, and have to be discarded if not used. I realize that in signing this consent, the vaccines will be prepared especially for my child. If after the nurse prepares the vaccines, I elect NOT to have my child receive them, I agree to be financially responsible for the vaccine charges.

I have read, or have had explained to me, the information about the vaccine(s) listed below (VIS). I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s). My signature will authorize you to submit all vaccine dates to the Michigan Childhood Immunization Registry (MCIR).

ACCT#_____

FOR OFFICE USE	SITE	MANUF.	LOT#	NURSE	VIS DATE
DTaP					
IPV					
HIB					
HEP B					
MMR					
PREVNAR					
VARICELLA					
HEP A					
Tdap					
ROTATEQ					
MENACTRA					
GARDASIL					

Orchard Pediatrics, PC

– Newborn through Adolescent Care –

Athlete School Sports Participation Examination

Name_____Sex_____Age_____Date of Birth_____

Grade_____School_____Sport(s)_____

Cardiovascular

Personal History of:	YES	NO	DON'T KNOW
Chest pain/discomfort with exercise	☐	☐	☐
Unexplained passing-out	☐	☐	☐
Nearly passing-out during or after exercise	☐	☐	☐
Excessive and unexplained difficulty breathing or fatigue associated with exercise	☐	☐	☐
A known heart murmur	☐	☐	☐
Elevated blood pressure	☐	☐	☐
Racing heart or skipped beats during exercise	☐	☐	☐
Getting tired or out-of-breath sooner than your friends during exercise	☐	☐	☐

FEMALES ONLY

When was your first menstrual period? _____

When was your most recent menstrual period? _____

What was the longest time between menstrual periods in the last year? _____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

_____ Signature of athlete

_____ Signature parent / guardian

_____ Date

6900 Orchard Lake Road • Suite 206 • West Bloomfield, MI 48322 • Phone (248) 855-7510

Orchard Pediatrics, PC
– Newborn through Adolescent Care –

Athlete School Sports Participation – Parent

To be completed by Parent

Name_____Sex_____Age_____Date of Birth_____

Grade_____School_____Sport(s)_____

General Health	YES	NO	DON'T KNOW
Has the athlete ever had a concussion?	☐	☐	☐
Has the athlete ever had a seizure?	☐	☐	☐
Has the athlete had an injury to a bone or joint requiring stopping sports?	☐	☐	☐
Does the athlete have a chronic illness or see a specialist for a chronic illness?	☐	☐	☐
Does the athlete take any medicines, herbs or supplements?	☐	☐	☐
Does the athlete have only one of any paired organ (eyes, ears, kidneys, testicles, ovaries, etc)	☐	☐	☐

Cardiovascular

Has the Athlete had a history of:

☐ high blood pressure
☐ high cholesterol
☐ Kawasaki Disease
☐ heart murmur
☐ heart infection
☐ other heart conditions

Personal history of requiring heart tests ordered by your doctor (EKG, heart ultrasound)	☐	☐	
Family History of:			
Premature death (sudden and unexpected, or otherwise) before age 50 yrs due to heart disease in one or more relatives	☐	☐	☐
Disability from heart disease in a close relative <50 years of age	☐	☐	☐
Specific knowledge of certain cardiac conditions in family members:			
Hypertrophic or dilated cardiomyopathy (enlarged or weak heart)	☐	☐	☐
Long-QT Syndrome (heart rhythm problem)	☐	☐	☐
Marfan Syndrome	☐	☐	☐
Other heart rhythm problems	☐	☐	☐

Pulmonary

Does the athlete have Asthma (wheezing) during or after exercise?	☐	☐	☐
Does the athlete have coughing spells during or after exercise?	☐	☐	☐

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

_____ _____
Signature parent / guardian Date

6900 Orchard Lake Road • Suite 206 • West Bloomfield, MI 48322 • Phone (248) 855-7510

Orchard Pediatrics, PC

– Newborn through Adolescent Care –

Media Safety – Ages 10 TO 16

1. It is recommended that children do not have televisions in their bedrooms. Television viewing should always be supervised and is best if it is a family activity.
2. Limit flat screen viewing (TV, video games, etc.) to a maximum of 2 hours a day.
3. Video games should all have E (Everyone) ratings for ages 10-12 and teen (not adult or mature) for ages 13-16.
4. Internet use should be in a common area of your home. Do not allow internet enabled devises in your child's room or other unsupervised areas of your home. If your child uses a laptop for school, it should be put away in their backpack once homework is finished.
5. Put a parental password on all internet enabled devises. This requires your presence when your child is on the internet.
6. If your child uses a smart phone, disable the internet access. Monitor your child's texting.
7. Avoid social networking for ages 10-12. For age 13 and over, if your child uses social networking, get full access to it and check it daily.
8. Consider downloading parent/child contracts for cell phone and social networking sites. A sample Family Cell Phone Contract is on the reverse side. www.commonsensemedia.org has sample contracts for media safety.

Orchard Pediatrics, PC

– Newborn through Adolescent Care –

CHILDS NAME _____ **DATE OF BIRTH**_____

TB RISK FACTOR QUESTIONNAIRE

Dear Parents:

The American Academy of Pediatrics no longer recommends annual TB skin testing for low risk children. In order to identify those children with an increased risk of TB (tuberculosis), we would like you to complete the following:

My child:

Y	**N**	**Has contact with a person with TB or has a positive TB skin test?**
Y	**N**	**Is HIV positive?**
Y	**N**	**Was your child born in any of the following countries and has not been tested for TB?**
Y	**N**	**Has your child travelled and spent more than a week in any of the following countries and has not been tested for TB upon returning?**

Africa (entire continent) **Azerbaijan** **Bangladesh** **Belarus** **Brazil** **Cambodia** **China**	**DPR Korea** **India** **Indonesia** **Kazakhstan** **Kyrgyzstan** **Myanmar**	**Pakistan** **Papua New Guinea** **Peru** **Philippines** **Rep Moldova** **Russian Federation**	**Thailand** **Ukraine** **Uzbekistan** **Viet Nam**

HIGH CHOLESTEROL RISK FACTORS QUESTIONAIRE

Y	**N**	**A parent with a cholesterol level greater than 240.**
Y	**N**	**A parent or grandparent who had a heart attack or required a heart procedure at a young age (males ≤ 55, females ≤ 65).**

HEALTH HISTORY AND FAMILY HISTORY UPDATE

Please list your child's NEW medical diagnosis or surgeries (since your last check-up) _____

_____

Please list any NEW medical problems or social changes in your child's family (parents, grandparents or siblings

_____

ANEMIA RISK FACTORS

Does your child eat a low-iron diet (eg non-meat or vegetarian)? _____ **If yes, does your child receive a daily iron supplement?** _____

How much milk per day does your child drink, on average? _____**ounces**

Does your child (if a daughter) have very heavy menstrual periods? _____

Orchard Pediatrics, PC

– Newborn through Adolescent Care –

Patient's Name: _____

Insurance Co: _____

Advance Beneficiary Notice (ABN)

Note: You will need to make a choice about receiving these health care items or services.

Your health insurance may not pay for the item(s) or service(s) that are described below. Health insurers do not necessarily pay for all of your health care costs. Insurance only pays for covered items and services. The fact that insurance may not pay for a particular service does not mean that you should not receive it; your doctor recommends that you do receive this service.

Item(s) or Service(s):

VISION SCREENING
PROCEDURE 99173

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Also, by signing below you agree to take financial responsibility for the cost of the item(s) or service(s), if your health insurance does not include this as a covered item(s) or service(s). **The cost for vision screening is $23.00**

Responsible party signature: _____

Date: _____

6900 Orchard Lake Road • Suite 206 • West Bloomfield, MI 48322 • Phone (248) 855-7510