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 –

18 Month Visit
ANEMIA RISK FACTORS

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

2. How much milk per day does your child drink, on average? _____

Orchard Pediatrics, PC

– Newborn through Adolescent Care –

Patient Name_____Date of birth_____

DENTAL HEALTH QUESTIONNAIRE (12, 18, 24, 30 month old)

1. Does your child drink fluid other than water out of a bottle or sippy cup? yes____no____

2. How many between-meal snacks does your child eat per day? ____

3. Does your child have special health care needs? yes____no____

4. Is your child eligible for Medicaid? yes____no____

5. What type of water does your toddler drink?

   well _____

   reverse osmosis_____

   city _____

   bottled _____

   none _____

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 99177

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 $37.00**

Responsible party signature: _____

Date: _____