

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)

<u>NAME</u>	<u>BIRTHDATE</u>	<u>MALE / FEMALE</u>	ACCT #
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

HAVE THERE BEEN ANY CHANGES IN YOUR CHILDREN'S PERSONAL OR FAMILY HEALTH HISTORY YES 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 RESPONSIBLE 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 _____

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? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. Does the patient have allergies to medications, yeast, eggs, latex or any previous vaccines? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3. Has the patient had a serious reaction to a vaccine in the past? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 4. Has the patient had a seizure or a changing neurological disorder? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 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? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 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? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 7. Has the patient received blood, plasma, or gammaglobulin the past six months? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 8. Is the patient pregnant or at risk of becoming pregnant within the next three months? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

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 –

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
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HIGH CHOLESTEROL RISK FACTORS QUESTIONNAIRE

- 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: _____