PEDIATRIC HEALTHCARE ASSOCIATES

Dear Patient,

Please complete and bring the following forms with you to your next well exam appointment:

- ☐ **Tuberculosis Risk Assessment** (completed at all well exams starting at 6 months of old)
- ☐ **Family History** (updated form must be completed for each patient every year)
- ☐ **Patient Registration for 18 years old and older** (updated form must be completed for each patient every year)

Thank you,
Your Care Team at PHA

PEDIATRIC HEALTHCARE ASSOCIATES PATIENT REGISTRATION FORM (18 YEARS OR OLDER)

(THIS FORM MUST BE COMPLETED IN ITS ENTIRETY)

DATE: ____________________

OFFICE: ____________________

PATIENT INFORMATION

Name ______________________________ Date of Birth ______________________________

Address ______________________________ Home Phone (   ) ______________________________

City ______________________________ Cell Phone (   ) ______________________________

State ______________ Zip Code ______________ Work Phone (   ) ______________________________

Employer Name ______________________________ E-mail Address ______________________________

Primary Care Physician ______________________________

EMERGENCY CONTACTS

Name ______________________________ Relationship ______________________________

Home Phone (   ) ______________ Work Phone (   ) ______________ Cell Phone (   ) ______________

ACCESS TO MEDICAL RECORDS

I give access to my medical records and account information for personal inspection and/or discussion to:

______________________________ **Relationship** ______________________________

I acknowledge that this authorization can only be amended or rescinded by my written authorization.

AUTHORIZATION FOR TREATMENT AND RELEASE OF INFORMATION

________ Initial I ______________________ authorize PHA to contact me by telephone with medical information pertaining to my care. If I am unavailable, this authorization gives PHA permission to leave this information on my cell phone or with a member of my household.

Phone number to call with information: (   ) ______________________________

________ Initial I authorize PHA or whomever they designate to evaluate and treat me and to release to my insurance company any information acquired in the course of my examination or treatment, and to receive all payments for such examination or treatment. PHA has my permission to release any diagnostic studies, reports, etc. to a specialist involved in my care.

PAYMENT POLICIES

________ Initial **Insurance Information**: Insurance card(s) must be presented at the time of service. A copy of your insurance card(s) will be made for your file. It is your responsibility to provide updated insurance information at the time of service. If the insurance card(s) is not presented at the time of service, the charges are your responsibility until a copy of the insurance card(s) is received. In order for services to be billed to your insurance company, a copy of the insurance card(s) must be received within 10 days from the date of service.

________ Initial **Account Balances**: When insurance information is received *after* the timely filing requirements of your insurance company, the charges for those services are your responsibility. **You are responsible for payment of all services not paid by your insurance company, including all screenings and testing done at the time of well visits.** We accept cash, checks or credit cards. PHA reserves the right to reschedule or deny future appointments for delinquent accounts.

________ Initial **Co-Payments:** are expected to be paid at the time service is rendered. If payment is not received at the time of service, there will be an additional $10 fee. All returned checks will be subject to a service charge of $15.

________ Initial **Self-Pay:** Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.

________ Initial **Referrals:** If your plan requires referrals for specialty care recommended by your primary care physician, it is your responsibility to obtain information regarding these requirements and contact the referral specialist at this office to request a referral to be processed *prior* to the specialty appointment.

________ Initial **Evening, Weekend & Holiday Code:** Please be aware, we report all evening, weekend and holiday visits to your insurance carrier. This code may **or may not** be covered.

________ Initial **No Shows:** A $50 no show fee will be assessed for all well and specialty consult visits not previously cancelled.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

________ Initial I acknowledge that I have received the Notice of Privacy Practices, which explains how my health information will be handled in various situations.

PLEASE COMPLETE BOTH SIDES OF THIS FORM

PEDIATRIC HEALTHCARE ASSOCIATES PATIENT REGISTRATION FORM (18 YEARS OR OLDER)

In order to help us comply with federal and state reporting and record keeping when using state provided vaccines, please indicate your race and ethnicity.

RACE:

- ☐ Caucasian
- ☐ Black
- ☐ Hispanic
- ☐ Asian
- ☐ Native American
- ☐ Asian Pacific American
- ☐ Pacific Islander
- ☐ Subcontinent Asian American
- ☐ American Indian or Alaskan Native
- ☐ Native Hawaiian
- ☐ Black Non-Hispanic
- ☐ Other Race or Ethnicity
- ☐ White Non-Hispanic
- ☐ Race Not Reported – Refusal
- ☐ Race Not Reported – Don't Know
- ☐ Race Not Reported – Not Ascertained

ETHNICITY: ☐ Latino/Hispanic ☐ Not Latino or Hispanic ☐ Other ☐ Refused

Language predominantly spoken ______________________________

COMPLETION OF THIS SECTION IS OPTIONAL

GENDER IDENTITY **Child's Name:** ______________________________

☐ (M)ale – person specifies gender identity as male.

☐ (F)emale – person specifies gender as female.

☐ (FTM) Transgender Male / Female-to-Male – person specifies gender identity as transgender male.

☐ (MTF) Transgender Female / Male-to-Female – person specifies gender identity as transgender female.

☐ (G) Genderqueer – neither exclusively Male nor Female.

☐ (O)ther – person specifies a gender identity that is other than the options of Male, Female, Transgender Male, Transgender Female, or Genderqueer.

☐ (D)eclined

My signature below indicates I am the patient listed on the front page and that I have provided accurate information to the best of my knowledge and I understand and agree to all the provisions as stated.

Patient Signature ______________________________ Date ____________________

FAMILY HISTORY FORM **DATE** ____________

PEDIATRIC HEALTHCARE ASSOCIATES

Patient's Name ______________________ Nickname ____________ Date of Birth _________

Other children with same parents: ____

	Date of Birth	Height	Illness/Medical Problems
Father of child			
Mother of child			

	Illness/Medical Problem	Age Died	Cause
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Does anyone in your family have any of the following diseases? If so, state the relationship to the child.

	Yes	No	Relationship
ADHD			
Alcoholism/Drug Use			
Allergies			
Asthma			
Autism			
Birth Defects/Genetic Problems			
Bleeding Problems			
Blood Clots			
Cancer & type			
Congenital Cataract			
Celiac Disease			
Developmental Delays/Learning Disabilities			
Diabetes, type 1 or 2			
Eating Disorders			
Eczema			
Epilepsy (seizures)			
Food Allergy			
Gastrointestinal Disease (colitis, Crohn's)			
Glaucoma			

	Yes	No	Relationship
Hearing Loss			
Heart Disease			
Hemochromatosis			
High Cholesterol			
Hypertension (high blood pressure)			
Immune Disorders			
Infertility/PCOS			
Lazy Eye			
Mental Illness (depression, bipolar, anxiety)			
Migraines			
Overweight/Obesity			
Renal Disorder (kidney)			
Retinoblastoma			
Rheumatologic Disorder			
School Problems			
Scoliosis			
Sickle Cell/Thalassemia			
Smoking			
Thyroid Disease			

Are there any other medical problems that run in your family? ______________________________

____

Tuberculosis Risk-Assessment Questionnaire

1. Was this child born in a country other than the United States? YES NO

   If yes, where was he/she born? ______________________

2. Was this child's mother or father born in a country other than the United States? YES NO

   If yes, where were they born? ______________________

3. Has this child traveled to another country since their last physical exam? YES NO

   If yes, where did he/she travel? ______________________

   With whom did he/she stay? Friends Relatives Hotel

   How long did he/she travel? Less than 1 week 1 week or more

4. Has this child been exposed to anyone with tuberculosis since his/her last physical exam? YES NO

5. Does this child have close contact with anyone with a positive tuberculosis skin test since his/her last physical exam? YES NO

6. Does this child spend time with anyone who has been in jail or a shelter, uses illegal drugs, or has HIV/AIDS since his/her last physical exam? YES NO

7. Does any person live or work in this child's home who was born in a country other than the United States or has had significant foreign travel to high risk areas? YES NO

   If yes, in what country were they born? __________________

PATIENT: ______________________ DOB: ______________________ DATE: __________

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the **last 2 weeks**, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING __0__ + ______ + ______ + ______

=Total Score: ______

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

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