COASTAL PEDIATRIC ASSOCIATES

FAMILY REGISTRATION FORM

ANNUAL REVIEW

STAFF INITIALS _____DATE ___/___/_____

PATIENT INFORMATION: Please note it is your responsibility to notify us of any changes.

LAST NAME	FIRST NAME	MI	CHILD'S DATE OF BIRTH	M/F	ID #(OFFICE USE ONLY)
1					
2					
3					
4					

How did you hear about us? (please circle one) Friend Coworker OB/Physician Internet Other:

MOTHER'S INFORMATION: Guarantor _

NAME: LAST	FIRST	MI	DATE OF BIRTH	SOCIAL SECURITY NUMBER

STREET ADDRESS CITY STATE ZIP

HOME PHONE CELL PHONE WORK PHONE EMAIL ADDRESS

EMPLOYER EMPLOYER PHONE NUMBER

FATHER'S INFORMATION: Guarantor _

NAME: LAST	FIRST	MI	DATE OF BIRTH	SOCIAL SECURITY NUMBER

STREET ADDRESS CITY STATE ZIP

HOME PHONE CELL PHONE WORK PHONE EMAIL ADDRESS

EMPLOYER EMPLOYER PHONE NUMBER

PRIMARY INSURANCE INFORMATION: Relationship to child_____Please provide staff with copy of insurance card.

INSURANCE CARRIER NAME COPAY EFFECTIVE DATE

NAME OF SUBSCRIBER SUBSCRIBER'S DATE OF BIRTH SOCIAL SECURITY #

ID# GROUP # EMPLOYER'S NAME

SECONDARY INSURANCE INFORMATION: Relationship to child _____Please provide staff with copy of insurance card.

INSURANCE CARRIER NAME COPAY EFFECTIVE DATE

NAME OF SUBSCRIBER SUBSCRIBER'S DATE OF BIRTH SOCIAL SECURITY #

ID# GROUP # EMPLOYER'S NAME

EMERGENCY CONTACT: This individual will be added to the Authorization/Disclosure Form if not already done so.

NAME RELATIONSHIP TO CHILD DAYTIME PHONE NUMBER

Signature of Guarantor/Guardian:	Print Name:	Date:

COASTAL PEDIATRIC ASSOCIATES

Authorization/Disclosure Form

The purpose of this authorization is to meet the patient's request for information disclosures and uses. This authorization form permits Coastal Pediatric Associates (CPA) to use or disclose protected health information listed below to the individuals or organization listed for the following patient:

Patient Name _____ Date of Birth_____

This authorization shall be enforced until revoked by the patient, parent, legal guardian, or personal representative (as defined by HIPAA).

Please provide the front desk with a copy of any legal paperwork describing guardianship or financial responsibility if other than the biological parent(s). Please note that both biological parents are legally entitled to receive medical information on a minor unless otherwise ruled by the Judicial System and documentation is presented to CPA. Once the minor reaches 18 years of age he/she will be required to complete all patient paperwork unless otherwise stated by the Judicial System with proper documentation presented to CPA.

Please list two phone numbers with voicemail where CPA may leave a message or send text messages pertaining to appointments, financial or insurance details, and clinical information.

Primary:	Secondary:

With my permission, I hereby authorize the following individual(s):

Name or Organization:	Relationship to Patient:	Contact Phone Number:

to consent to any and all medical care and attention for this child in which is deemed necessary and appropriate by a healthcare provider at CPA. This consent includes, but is not limited to, emergency services, lab tests, procedures and immunizations. The listed individuals are given the authority to discuss and change appointments, financial or insurance details, and clinical information including lab results.

By verifying the identity of the individual calling, I give Coastal Pediatric Associates the authority to send vaccination records via fax or e-mail to specified daycare centers, schools, or other health care facilities once verbally requested. Verification information will include, but is not limited to: patient's address, phone numbers, insurance, and appointment information.

I understand that I have the right to refuse to sign this authorization and that treatment will not be conditioned on signing. I understand that I have the right to revoke this authorization at any time by sending a written notification to the practice. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Signature of Patient, Parent, Legal Guardian (include court documentation), or Personal Representative (as defined by HIPAA):

Signature	Print Name	Date

Description of Personal Representative's Authority (attach documentation, if necessary):

Office Use Only: Receiving Employee _____ Date Received _____

COASTAL PEDIATRIC ASSOCIATES

Consents, Authorizations, Notifications, and Agreements

Patient Name _____ *Date of Birth*_____

Consent for Medical Treatment

I/we voluntarily consent to medical treatment and diagnostic procedures provided by Coastal Pediatric Associates (CPA). I/we consent to testing for infectious diseases, such as, but not limited to syphilis, AIDS, hepatitis and testing for drugs if deemed advisable by my physician, nurse practitioner, or physician assistant. I/we also consent to minor, procedural treatment, such as, but not limited to circumcision, ingrown toenail removal, frenulectomy, and cryotherapy if deemed advisable by my physician. I/we am/are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations. I/we have read or have had read to me/us this consent and understand and agree to its contents.

Initials _____

CPA offers patients the opportunity to connect to a provider through video visits (Skype/Facetime). By signing this, you are agreeing that you have had a chance to read through the eCONNECT informed consent and financial disclosure and agree to the terms set forth by the policy as well as had the opportunity to ask questions. I agree & understand that if I use eCONNECT I may be financially responsible for the service/visit and understand the risks and benefits of telemedicine.

Initials _____

Consent for Clinical Trials

Since 2012, Coastal Pediatric Associates has been investigating medications, vaccines, and devices to better nourish and champion the health of all children and their families. Our experienced research team works alongside our capable clinic staff to provide you and your child the opportunity to participate in various clinical research studies! Studies may investigate anything from infant formula to adolescent medications, and we are always exploring new research areas. All study-related visits, procedures, and products are provided at no cost, and compensation for time and travel may be available.

Would you be interested in learning more about our clinical research program and how you can get involved?

_____Yes _____No

Authorization for Release of Information and Assignment of Insurance Benefits

CPA is authorized to release any medical information required in the processing of applications or submission of information for financial coverage and the continuation of care, such as, but not limited to third party referrals to receive therapy services and treatment from specialists, including information referring to psychiatric care, drug and alcohol abuse, sexual assault, or tests for infectious disease including AIDS/HIV. I/we also agree to the release of medical, vaccination, medication history or other information about me/the minor to the state vaccination registry (CARES), pharmacy benefit managers via Surescripts, and/or government regulatory agencies (federal or state) as required by law. For Medicaid/Medicare beneficiaries: I/we have provided all necessary information for proper assignment of Medicaid/Medicare benefits.

Initials _____

Acknowledgement of Receipt of CPA Policies

I hereby acknowledge that I have received the CPA Notice of Privacy Practices, Financial Policy, Immunization Policy and Well-Exam Visit Helpful Facts.

Initials _____

I/we understand that I have the right to refuse to sign this authorization and that my/our child's treatment will not be conditioned on signing. I/we understand that I/we have the right to revoke this authorization at any time by providing a written notification to the practice. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I/we understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

By signing below, I acknowledge that I have read and understand the above statements of Coastal Pediatric Associates:

Signature	Print Name	Date

COASTAL PEDIATRIC ASSOCIATES

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OFFICE USE ONLY

Documentation of "Good Faith" Attempt to get acknowledgement signature

- _ Document presented to parent/patient, but parent/patient refused to sign acknowledgment.
- _ Patient presented with an emergency situation and there was no time to give the Notice or receive a signature. Attempt to give the Notice, and get any acknowledgement will be handled as soon as possible.
- _ Documentation was presented to the parent/patient but a communication failure prevented us from receiving the acknowledgement.
- _ The documentation was mailed to the parent/patient but never returned to us.
- _ Other_____

_____

Employee preparing the document _____Date_____

Employee Signature: _____

COASTAL PEDIATRIC ASSOCIATES

Patient Information Database

Patient's Full Name: _____ Patient's Date of Birth: _____

Mother's Name _____ Employed? _____ Employer: _____

Father's Name _____ Employed? _____ Employer: _____

Please complete the following information to the best of your knowledge and sign below.

Patient's Past Medical History							
System	Y	N	If yes, Please describe here	System	Y	N	If yes, please describe here
Genetic/Neurologic				Genitourinary/Kidneys/Bladder			
Vision/Eyes				STD/Menstrual			
Developmental/Learning				Bones/Muscle			
Psychiatric/Behavioral				Dermatologic/Skin			
Hearing/Ears				Allergies (Please Specify if any Drug allergies)			
Past Surgeries				Blood/Cancers			
Speech/Swallowing				Endocrine/Glands			
Heart/Vasculature				Infectious			
Respiratory/Lungs				Other			
GI/Digestive				Other			

Social History			
Question	Answer	Question	Answer
Parents' marital status?		New to Charleston Area?	
Number of Siblings?		Smoking status? Amount?	
Siblings' names?		Smoking in home?	
Sleeps in own bed/crib?		Dietary preferences?	
Childcare?		Guns in home?	
Day Care Attendance?		Seat belt/car seat used routinely?	
Regular Dental Visits? Dentist:		Smoke alarm in home?	
Extended family support?		Pets? Type? How many?	
Well Water?		Other?	

Family Medical History (Immediate Family)			
Condition	Y	N	If Yes, please describe here
Cancers			
Heart/BP/Cholesterol			
Lungs Glands/Thyroid			
Diabetes/Metabolic			
Allergies/Asthma/Eczema			
Birth Defects/Syndromes			
Neurological/Developmental			
School/Learning/Behavioral			
Psychiatric			
Other/Unknown Due to Adoption or Foster Care			

Birth History	
Weight	
Gestational Age	
Vaginal or C-section	
Hospital Name	
Circle if applies: Adopted IVF Surrogate	
Complications with Delivery:	

If patient is currently in foster care or has special care arrangements in place, such as custody arrangements, please see the front desk staff.

By signing below, I acknowledge that to best of my ability everything listed above is correct:

Signature of Guarantor/Guardian	Print Name	Date

Updated August 2016