New Patient Registration

Today's Date:			
PATIENT INFORMATION			
Last Name:	First Name:	Middle Name:	Preferred Name:
Home Address:	Date of Birth:	Primary Phone Number:	Primary Language:
PARENT OR LEGAL GUARDIAN #1 INFORMATION			
Last Name:	First Name:	Occupation:	Date of Birth:
Lives with patient? (Circle one) **YES** or **NO** If no, please write address below:	Allowed to receive health information regarding patient and bring patient to appointments? (Circle one) **YES** or **NO**	Primary Phone Number:	Genetic mother/father? **YES** or **NO**
		Email Address:	
PARENT OR LEGAL GUARDIAN #2 INFORMATION			
Last Name:	First Name:	Occupation:	Date of Birth:
Lives with patient? **YES** or **NO** If no, please write address below:	Allowed to receive health information regarding patient and bring patient to appointments? (Circle one) **YES** or **NO**	Primary Phone Number:	Genetic mother/father? **YES** or **NO**
		Email Address:	
IN CASE OF EMERGENCY			
Full Name:	Relationship to patient:	Home Phone Number:	Work/Cell Phone Number:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature _____ Date _____

Health Questionnaire

Patient Name _____ Date of Birth _____ Completed by_____ Today's Date_____

CURRENT MEDICATIONS

Name of Medicine	Strength of Dose	How Often Taken	Reason Taken

ALLERGIES/REACTIONS

Name of medication/food/other	Describe type of reaction	Date of age of last reaction

Past Medical History (please check all that apply)

☐ NONE

Respiratory

- ☐ Asthma
- ☐ Bronchitis, recurrent
- ☐ Eczema
- ☐ Food Allergies
- ☐ Seasonal Allergies
- ☐ Immune Disorder
- ☐ Pneumonia

Cardiology

- ☐ Congenital Heart Disease
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ High Cholesterol

Developmental/Learning

- ☐ ADD/ADHD
- ☐ Autism
- ☐ Asperger's
- ☐ Development Delay
- ☐ Dyslexia
- ☐ Speech/Language Delay

ENT

- ☐ Ear Infection, recurrent
- ☐ Hearing problems
- ☐ Sinusitis, chronic
- ☐ Strep, recurrent

Gastrointestinal

- ☐ Crohn's Disease
- ☐ Constipation
- ☐ GERD/Reflux

Hematology/Oncology

- ☐ Anemia
- ☐ Blood Transfusion
- ☐ Cancer _____

Mental Health

- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Eating Disorder
- ☐ Substance Abuse

Surgical History

- ☐ NONE
- ☐ Ear Tubes
- ☐ Tonsillectomy
- ☐ Other, _____

Other

- ☐ Eye or vision problem
- ☐ Diabetes, age ____
- ☐ Thyroid Disorder
- ☐ Kidney Disease
- ☐ UTI, recurrent
- ☐ Liver Disease
- ☐ Hepatitis A B C
- ☐ Neurologic Disorder
- ☐ Seizures
- ☐ Tic Disorder
- ☐ Skin condition, _____
- ☐ Other _____

Family History

Natural Mother = M
Natural Father = F
Brother = B
Sister = S
Maternal Grandmother = MGM
Maternal Grandfather = MGF
Paternal Grandmother = PGM
Paternal Grandfather = PGF

- ☐ Alcoholism_____
- ☐ Anemia_____
- ☐ Anxiety/depression_____
- ☐ Arthritis_____
- ☐ Asthma/bronchitis_____
- ☐ Cancer (include type)_____
- ☐ Cystic Fibrosis_____
- ☐ Diabetes_____
- ☐ Eczema_____
- ☐ Heart Attack_____
- ☐ High Blood Pressure_____
- ☐ High Cholesterol_____
- ☐ Kidney Disease_____
- ☐ Liver Disease_____
- ☐ Seizures_____
- ☐ Seasonal Allergies_____
- ☐ Thyroid Disease_____
- ☐ Tuberculosis_____

Social History

- ☐ Daycare
- ☐ Adopted
- ☐ Both parents in home
- ☐ Single parent household
- ☐ Shares 2 households
- ☐ Lives with guardian
- ☐ Deceased parent (M/F)
- ☐ Deceased Sibling
- ☐ Vegetarian Family
- ☐ Pet(s) in home

Please specify kind of pet(s):
_____

Patient Privacy Form

SHARING INFORMATION

Please complete the information below to authorize Einstein Pediatrics to release information about the patient listed below to **someone other than the patient's parents or legal guardians.**

- ☐ Results of lab tests/xrays
- ☐ Appointment information
- ☐ Billing information
- ☐ Medical information

Name	Relationship to patient	Able to bring to appts? **YES** or **NO**
_____	_____	
_____	_____	
_____	_____	

COMMUNICATION

I authorize Einstein Pediatrics to leave a message at this phone number _____ regarding (please check all that apply):

- ☐ Results of lab tests/xrays
- ☐ Appointment information
- ☐ Billing information
- ☐ Medical information

PATIENTS RIGHTS

I understand that I have the right to revoke this authorization at any time by sending notification to Einstein Pediatrics. 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 authorization may result in re-disclosure by the recipient and may no longer be protected by federal or state law. Information received by this office is for our own use and will continue to be protected by our HIPAA Privacy Policy. I understand that I have the right to inspect or copy the protected health information disclosed as described in this document. I can do this by written notification to Einstein Pediatrics. I understand that I have the right to refuse to sign this authorization.

I have read and understand the HIPAA Privacy Policy and Payment Policy for Einstein Pediatrics.

Patient Name (Please Print) _____ Date of Birth _____

Parent/Guardian (Please Print) _____

Signature of Parent/Guardian _____ Today's Date _____