

**Horizon Ridge Pediatrics**2621 W. Horizon Ridge Place
Ste. 100
Henderson, NV 89012
(702) 263-1900 (702) 263-0195 Fax**PATIENT REGISTRATION**PATIENT'S INFORMATIONPatient's Name (1st child) _____ Date of Birth _____ M FPatient's Name (2nd child) _____ Date of Birth _____ M FPatient's Name (3rd child) _____ Date of Birth _____ M FPatient's Name (4th child) _____ Date of Birth _____ M F

Address _____

City _____ State _____ Zip code _____

Home Phone _____

MOTHER'S INFORMATION

Name _____

D.O.B. _____ S.S.N.# _____

Address _____

Home # _____ Cell # _____

Email _____

Employer _____

 Married Single DivorcedPATIENT'S INSURANCE INFORMATION PRIMARY

Insurance Company _____

Policy # _____ Group# _____

Insurance Phone # _____

Primary Insured Signature _____

EMERGENCY CONTACT

Name _____

Home # _____ Cell # _____

Relationship to Child _____

FATHER'S INFORMATION

Name _____

D.O.B. _____ S.S.N.# _____

Address _____

Home # _____ Cell # _____

Email _____

Employer _____

 Married Single DivorcedPATIENT'S INSURANCE INFORMATION SECONDARY

Insurance Company _____

Policy # _____ Group# _____

Insurance Phone # _____

Primary Insured Signature _____

Name _____

Home # _____ Cell # _____

Relationship to Child _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage as stated in this registration and assign Dr. Fernandez all insurance benefits for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions.

The above named physician may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed.

_____(Parent Initials)

PROCEDURE WAIVER

As your health care practitioner, we believe you have a right and an obligation to actively participate in your health care and to accept any recommended procedures. We want to be certain that you completely understand both the reasons for the tests we perform, as well as the possible consequences of not performing them.

_____(Parent Initials)

OFFICE POLICIES

I understand that "Co-Pays" or "Deductibles" are due at the time of service.

I understand that "I" (parent/guardian) will be fully responsible for any **denied or unpaid** services by my insurance.

I understand that "I" (parent/guardian) am responsible for **all remaining balances** unpaid by my insurance.

I understand that "I" (parent/guardian) will be responsible for any fees associated in collecting the balance owed including but not limited to attorney, collection or court fees.

I understand that **missed appointments without 24 hour cancellation** are subject to a **\$25.00 charge**.

I understand that **returned checks** are subject to **\$25.00 charge**.

I understand that there will be a **\$.60** per copy of any medical records requested.

_____(Parent Initials)

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more completed description of the uses and disclosures of my health information. I understand that this practices to change its *Notice of Privacy Practices* from time to time and that I may contact this practice at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my request or restrictions, but if you do agree then you are bound to abide by such restrictions.

_____(Parent Initials)

I/we certify that we have read and understand all the information provided and that all information provided by us is true and correct to the best of my/our knowledge. I have reviewed and agree with the office policies and guidelines and financial responsibility. I also received a copy of the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that it is my responsibility to inform Horizon Ridge Pediatrics of any changes of information provided on this registration.

Signature _____

Date _____

**Horizon Ridge Pediatrics**

2621 W. Horizon Ridge Pkwy.
Ste. 100
Henderson, NV 89052
(702) 263-1900 (702) 263-0195 Fax

IMMUNIZATION CONSENT FORM

After considering the benefits and risks associated with these immunizations, I hereby give consent for _____ to be immunized.

Child's Name

- 1. I have discussed with the nurse/doctor about my child's medical condition and the purpose, benefits, and risks of, and alternatives to immunizations with these vaccines.*
- 2. My questions about this health care treatment and its attendant risks have been answered to my satisfaction.*
- 3. I understand that this health care treatment carries with it a very small risk of harm, but I accept such risk on behalf of my child in the hope of obtaining the protective effects of immunization.*
- 4. I understand that the doctor does not warrant the quality of the manufacturer's vaccine or guarantee that adverse reactions will not occur.*
- 5. I also understand that the importance of informing the doctor of my child's present or recent symptoms of illness, know allergies, and prior reactions to any shots or medicine, and certify that I have done so.*
- 6. I understand that I am ultimately responsible for the cost of the immunizations, regardless of the insurance coverage.*

Parent Signature

Date

Relationship to Patient

**Horizon Ridge Pediatrics**2621 W. Horizon Ridge Pkwy.
Ste 100
Henderson, NV 89052
(702) 263-1908 (702) 263-0195 Fax**INITIAL HISTORY QUESTIONNAIRE**

FORM COMPLETED BY _____

DATE _____

PATIENT'S NAME _____	BIRTH DATE _____	AGE _____	SEX <input type="checkbox"/> M <input type="checkbox"/> F
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HOUSEHOLD

Please list all those living in the child's home.

NAME	RELATIONSHIP TO CHILD	BIRTH DATE	HEALTH PROBLEMS

Are there siblings not listed? if so, please list their names and ages and where they live.
_____If mother and father are not living together or if child does not live with parents, what is the child's custody status?
_____If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home?
_____**BIRTH HISTORY**

Birth weight _____	Length _____	Head circumference _____	Was the delivery <input type="checkbox"/> Vaginal <input type="checkbox"/> Cesarean
Was the baby born at term? _____ Early? _____ Late? _____	If cesarean, why? _____		
if early, how many weeks' gestation? _____	Obstetrician _____		
Did mother have any illness or problems with her pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____	Hospital where baby was born _____		
_____	Did your baby have any problems right after birth? <input type="checkbox"/> No <input type="checkbox"/> Yes Explain _____		
_____	_____		
During pregnancy, did mother Smoke <input type="checkbox"/> Yes <input type="checkbox"/> No	Was initial feeding <input type="checkbox"/> Breast <input type="checkbox"/> Bottle		
Drink alcohol <input type="checkbox"/> Yes <input type="checkbox"/> No	Did your baby go home with mother from the hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____		
Use drugs or medication <input type="checkbox"/> Yes <input type="checkbox"/> No	_____		
What? _____	When? _____		

GENERAL

- Do you consider your child to be in good health? Yes No Explain _____
- Does your child have any serious illness or medical condition? Yes No Explain _____
- Has your child had serious injuries or accidents? Yes No Explain _____
- Has your child had any surgery? Yes No Explain _____
- Has your child ever been hospitalized? Yes No Explain _____
- Is your child allergic to any medicines or drugs? Yes No Explain _____

DEVELOPMENT

- Are you concerned about your child's physical development? Yes No Explain _____
- Are you concerned about your child's mental or emotional development? Yes No Explain _____
- Are you concerned about your child's attention span? Yes No Explain _____
- If your child is in school:
- How is he/her behavior in school? _____
- Has he/she failed or repeated a grade in school? _____
- How is he/she doing in academic subjects? _____
- Is he/she in special or resource classes? _____

FAMILY HISTORY

Have any family members had the following:

- Dizziness Yes No When _____
- Nasal allergies Yes No Explain _____
- Asthma Yes No Explain _____
- Tuberculosis Yes No Explain _____
- Heart disease (before 50 years old) Yes No Explain _____
- High blood pressure (before 50 years old) Yes No Explain _____
- High cholesterol Yes No Explain _____
- Anemia Yes No Explain _____
- Bleeding disorder Yes No Explain _____
- Liver disease Yes No Explain _____
- Kidney disease Yes No Explain _____
- Diabetes (before 50 years old) Yes No Explain _____
- Bed wetting (after 10 years old) Yes No Explain _____
- Epilepsy or convulsions Yes No Explain _____
- Alcohol abuse Yes No Explain _____
- Drug abuse Yes No Explain _____
- Mental illness Yes No Explain _____

Mental retardation Yes No Explain _____

Immune problems, HIV, or AIDS Yes No Explain _____

Additional family history Yes No Explain _____

PAST HISTORY

Does your child, or has he/she ever had:

Chickenpox	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When _____
Frequent ear infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When _____
Problems with ears or hearing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When _____
Asthma, bronchitis, broncholitis, or pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When _____
Any heart problem or heart murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When _____
Anemia or bleeding problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When _____
Blood transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When _____
Frequent abdominal pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When _____
Constipation requiring doctor visits	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When _____
Bladder or kidney infection	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When _____
Bed-wetting (after 5 years old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When _____
For girls - Has she started her menstrual periods	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When _____
For girls - Are there problems with her periods	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When _____
Any chronic or recurrent skin problem (Acne, eczema, etc)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When _____
Frequent headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When _____
Convulsions or other neurologic problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When _____
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When _____
Thyroid or other endocrine problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When _____
Any other significant problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When _____
Use of alcohol or drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When _____

Ethnicity

Native American Caucasian Spanish

Asian African American Pacific Islander

Middle Eastern Other _____

**Horizon Ridge Pediatrics**

2621 W. Horizon Ridge Place,
Ste. 100
Huntsville, TN 35893-7
(256) 266-0700 / (256) 266-0705 / fax

GENERAL CONSENT FOR ACCOMPANYING CHILD TO PEDIATRICS OFFICE FOR MEDICAL TREATMENT

I, _____, Legal parent or Guardian for _____
(mother or father's name) (child's name)

Grant _____

Grandparent Aunt/Uncle Friend Court-appointed custodian

Other _____

The permission to accompany my child to his/her medical appointment with Dr. Fernandez at Horizon Ridge Pediatrics.

It is understood that the above noted adult acts on my behalf and is permitted to make decisions regarding the treatment of my child in the event that I cannot be reached.

It is understood that I remain financially responsible for the account of my child.

Parent Signature _____

Date _____

PLEASE NOTE:

This authorization will remain on file and active until such time the child is no longer a patient with our office or the parent or legal guardian sends written instruction to remove the above named person/persons from responsibility to accompany child.



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Release of Information

I hereby authorize the use/disclosure of my child's health information as described below. I understand that this authorization is voluntary. I understand that any and all records, where written authorization except as otherwise provided by law. I understand that a photocopy or fax of this authorization is a valid as the original.

Patient Name: _____ D.O.B. _____

Patient Name: _____ D.O.B. _____

Patient Name: _____ D.O.B. _____

Patient Name: _____ D.O.B. _____

Patient Name: _____ D.O.B. _____

Records to be disclosed from:

Physician: _____

Records are being requested by:

Records to be released from:

Horizon Ridge Pediatrics

2621 W. Horizon Ridge Pkwy #100

Henderson, NV 89052

Tel (702) 263-1908 Fax (702) 263-0195

Tel# _____ Fax# _____

Please check:

All Records _____ Certain records _____

I understand that I may revoke this authorization at any time by notifying the office in writing. I also understand that the revocation will not apply to information that has already been released in response to this authorization. I authorize that my records be released from the above address to Horizon Ridge Pediatrics.

Signature of Parent/Guardian _____

Date _____