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

PATIENT REGISTRATION

PATIENT'S INFORMATION

Patient's Name (1st child) ______________________ Date of Birth ____________ ☐ M ☐ F

Patient's Name (2nd child) ______________________ Date of Birth ____________ ☐ M ☐ F

Patient's Name (3rd child) ______________________ Date of Birth ____________ ☐ M ☐ F

Patient'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 ☐ Divorced

FATHER'S INFORMATION

Name ______________________

D.O.B. __________ S.S.N.# __________

Address ______________________

____

Home # __________ Cell # __________

Email ______________________

Employer ______________________

☐ Married ☐ Single ☐ Divorced

PATIENT'S INSURANCE INFORMATION PRIMARY

Insurance Company ______________________

Policy # __________ Group# __________

Insurance Phone # ______________________

Primary Insured Signature

____

PATIENT'S INSURANCE INFORMATION SECONDARY

Insurance Company ______________________

Policy # __________ Group# __________

Insurance Phone # ______________________

Primary Insured Signature

____

EMERGENCY CONTACT

Name ______________________

Home # __________ Cell # __________

Relationship to Child ______________________

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 many 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

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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 ☐ M ☐ F

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 baby born at term? __________ Early? __________ Late? __________

If early, how many weeks' gestation? ____________________

Did mother have any illness or problems with her pregnancy?

☐ Yes ☐ No Explain ____________________

____

Was the delivery ☐ Vaginal ☐ Cesarean

If cesarean, why? ____________________

Obstetrician ____________________

Hospital where baby was born ____________________

Did your baby have any problems right after birth?

☐ Yes ☐ No Explain ____________________

____

During pregnancy, did mother Smoke ☐ Yes ☐ No

Drink alcohol ☐ Yes ☐ No

Use drugs or medication ☐ Yes ☐ No

What? ____________ When? ____________

Was initial feeding ☐ Breast ☐ Bottle

Did your baby go home with mother from the hospital?

☐ Yes ☐ No Explain ____________________

____

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 his/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:

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

Ethnicity

☐Native American ☐Caucasian ☐Spanish

☐Asian ☐African American ☐Pacific Islander

☐Middle Eastern ☐Other____________

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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.