DICKERSON PEDIATRICS
FAMILY REGISTRATION FORM

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 (please circle one) Yes or No		
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 (please circle one) Yes or No		
NAME: LAST FIRST MI	DATE OF BIRTH	SOCIAL SECURITY NUMBER
STREET ADDRESS	CITY STATE ZIP	
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	SUBCRIBER'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	SUBCRIBER'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:***

DICKERSON PEDIATRICS, P.A.

Consents, Authorizations, Notifications, and Agreements

Consent for Medical Treatment

I/we voluntarily consent to medical treatment and diagnostic procedures provided by Dickerson Pediatrics. 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 _______

Authorization for Release of Information and Assignment of Insurance Benefits

Dickerson Pediatrics 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 (IMMTRAC), 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 Policies

I hereby acknowledge that I have received the Dickerson Pediatrics 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 Dickerson Pediatrics:

Signature	***Print Name***	***Date***

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: ____

DICKERSON PEDIATRICS, P.A.

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			
Development/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**
Parent's marital status?		New to Sugar Land?	
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?		Smoke alarm in home?	
Extended family support?		Pets? Type? How many?	
Well water?		Other?	

Family Medical History (Immediate Family)				Birth History	
Condition	**Y**	**N**	**If Yes, please describe**		
Cancers				Weight	
Heart/BP/Cholesterol				Gestational Age	
Lungs				Vaginal or C-Section	
Glands/Thyroid				Hospital Name	
Diabetes/Metabolic				**Circle if applies:**	Adopted IVF Surrogate
Allergies/Asthma/Eszema				Complications with Delivery:	
Neurological/Developmental					
School/Learning/Behavioral					
Psychiatric					

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

Signature ***Print Name*** ***Date***