Farrington Pediatrics

# Patient Registration Form

**Patient Information**

| Last Name | First Name | MI | DOB | Gender | |
|---|---|---|---|---|---|
| _____ | _____ | _____ | _____ | ☐ M | ☐ F |
| _____ | _____ | _____ | _____ | ☐ M | ☐ F |
| _____ | _____ | _____ | _____ | ☐ M | ☐ F |

**Parent 1** (Responsible for payment)

Legal Name: _____
Relationship to Child: _____
Birthdate: _____
Address 1: _____
Address 2: _____
City: _____
State: _____
ZIP Code: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____
Email: _____
Employer: _____
Occupation: _____
☐ Child lives with me

**Parent 2**

Legal Name: _____
Relationship to Child: _____
Birthdate: _____
Address 1: _____
Address 2: _____
City: _____
State: _____
ZIP Code: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____
Email: _____
Employer: _____
Occupation: _____
☐ Child lives with me

**Emergency Contact (Other Than a Parent)**

| Name | Relationship | Phone Number |
|---|---|---|
| _____ | _____ | _____ |

List anyone allowed to bring your child to visits and speak with the physician regarding their health.

| Name | Relationship |
|---|---|
| _____ | _____ |

Whom may we thank for referring you to our office? _____

| **Filled by** | **Relationship to Patient** | **Date** | **Signature** |
|---|---|---|---|
| _____ | _____ | _____ | _____ |

Farrington Pediatrics

# Pediatric Medical History Form

Child's Name: _____ Date of Birth: _____

**Birth History:**

Any medical problems during pregnancy? _____

Medications taken during pregnancy: _____

Any drug or alcohol use during pregnancy? ☐ No ☐ Yes _____

Delivery: ☐ Elective C-Section ☐ Emergent C-Section ☐ Forceps ☐ Vacuum Extraction ☐ Normal Vaginal Delivery

Number of weeks gestation: _____ Birth weight: _____

Did the baby receive the Hepatitis B vaccine? ☐ No ☐ Yes If yes, date given: _____

Any medical problems during the newborn period? _____

Name of hospital where infant was born: _____

**Current Medications:**

| Medication | Dose | How many times a day |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Allergies:** ☐ No ☐ Yes

If yes, to what? _____

What was the reaction? _____

Do you carry an EpiPen? ☐ No ☐ Yes

**Immunization History:**

To the best of my knowledge, my child is up to date on his/her immunizations: ☐ No ☐ Yes

If no, why? _____

**Hospitalizations:**

Has your child ever stayed overnight in a hospital? ☐ No ☐ Yes

If yes, when and why? _____

**Surgical/Outpatient Procedure History:**

Please list any surgeries or outpatient procedures (e.g., ear tubes, tonsillectomy). Include the year:

_____

_____

**Social History:**

Is the child receiving care from individuals other than the biological parents? ☐ No ☐ Yes

If yes, by whom and how frequently? _____

Does anyone in your home smoke? ☐ No ☐ Yes

Siblings (please note if step or half):

_____

_____

**Personal Medical History:**

Please check if your child has had any of the following medical problems:

| | | | |
|---|---|---|---|
| ☐ ADD/ADHD | ☐ Chicken pox | ☐ Headaches | ☐ Liver disease/Hepatitis |
| ☐ Allergies | ☐ Concussion | ☐ Hearing problems | ☐ Recurrent ear infections |
| ☐ Anemia | ☐ Diabetes | ☐ Heart murmur | ☐ Reflux/GERD |
| ☐ Asthma | ☐ Eczema | ☐ congenital heart disease | ☐ Seizures |
| ☐ Bleeding disorder | ☐ Fracture | ☐ High blood pressure | ☐ Urinary Tract Infections |
| ☐ Bronchiolitis | ☐ Handicaps/Disabilities | ☐ kidney disease | ☐ Vision problems |

**Other Providers:** (Please list any other specialists your child sees. Ex: physical therapy, ENT, etc)

_____

_____

**GYN History (if applicable):**

Age of first period _____ years  Has not had menses yet_____

**Family History:**

Please indicate if your child has a family history (parents, siblings, maternal/paternal grandparents, aunts, or uncles) of any of the following: ****Please specify maternal/paternal relation**

| Diagnosis | Family Member | Diagnosis | Family Member |
|---|---|---|---|
| ☐ ADD/ADHD | _____ | ☐ Hearing disability | _____ |
| ☐ Alcohol/Drug Abuse | _____ | ☐ High cholesterol | _____ |
| ☐ Allergies | _____ | ☐ High blood pressure | _____ |
| ☐ HIV/AIDS | _____ | ☐ Asthma | _____ |
| ☐ Birth defects | _____ | ☐ Learning disability | _____ |
| ☐ Mental illness | _____ | ☐ Blood disorders | _____ |
| ☐ Migraines | _____ | ☐ Cancer, type | _____ |
| ☐ Heart disease | _____ | ☐ Scoliosis | _____ |
| ☐ Seizure disorder | _____ | ☐ Hearing problems | _____ |
| ☐ Speech problems | _____ | ☐ Depression | _____ |
| ☐ TB/Lung disease | _____ | ☐ Developmental delay | _____ |
| ☐ Stroke | _____ | ☐ Diabetes | _____ |
| ☐ Genetic disorder | _____ | ☐ Thyroid disease | _____ |
| ☐ Hepatitis/Liver disease | _____ | ☐ Other | _____ |

| Filled by | Relationship to Patient | Date | Signature |
|---|---|---|---|
| _____ | _____ | _____ | _____ |

# Farrington Pediatrics

# Office Policy Acknowledgment Form

Our goal is to provide and maintain a good physician-patient relationship. Understanding our office policy allows for clear communication and a smooth experience. Please read each section carefully, initial where indicated, and sign at the bottom. If you have any questions, please ask a member of our staff.

## Appointments

1. We value your time and do not double-book appointments. If you cannot keep an appointment, please provide at least 24-hour notice. A $20 fee applies for missed appointments.
2. Emergencies take priority over scheduled visits. We appreciate your patience.
3. Before scheduling an annual physical, confirm with your insurance whether it is covered as a well-child visit.
   **Initial: _____**

## Insurance Plans

1. It is your responsibility to provide accurate and updated insurance information. Incorrect information may result in financial responsibility for the visit.
2. If we are your designated Primary Care Physician, ensure our name or phone number appears on your insurance card. Else, you may be financially responsible for your visit.
3. Understand your insurance benefits regarding covered services and participating laboratories.
   - Not all plans cover annual well-child visits, sports physicals, or hearing/vision screenings. If not covered, you are responsible for payment.
   - Some plans limit the number of well-child visits for children under 2 years old. If exceeded, you will be responsible for payment.
4. It is your responsibility to know if a referral, authorization, or preauthorization is required.
   **Initial: _____**

## Referrals

1. Non-emergent referrals require 3 to 5 business days' notice.
2. Ensure your chosen specialist participates in your insurance plan.
3. All referrals must be approved before issuance.
   **Initial: _____**

## Financial Responsibility

1. You are responsible for all co-payments, deductibles, and co-insurances.
2. Co-payments are due at the time of service.
3. Self-pay patients must pay in full at the time of the visit.
4. If we do not participate in your insurance plan, full payment is required at the time of service. An invoice will be provided for you to seek reimbursement.
5. Patient balances are due within 10 business days of receiving your bill. Outstanding balances over 90 days will be sent to a collection agency.
6. Prior balances must be paid before scheduled appointments.
7. Payment methods accepted: Cash, Checks, Credit Cards (2.5% surcharge), HSA/FSA (no surcharge), Zelle to farringtonpediatrics@gmail.com.
8. Additional school, camp, or sports forms require a $10 fee per form, payable at drop-off. A 3-day turnaround time applies.
   **Initial: _____**

## Transfer of Records

1. If transferring to another physician, we provide a copy of immunization records and the last visit record free of charge with 48 hours' notice.
2. A complete record copy is available for $1 per page.
3. We provide records only for visits at Farrington Pediatrics. For prior records, request them from previous providers.
   **Initial: _____**

## Prescription Refills

1. Monthly medication refills require 48 hours' notice during regular business hours. Plan accordingly.
   **Initial: _____**

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## Acknowledgment and Agreement

I have read, understand, and agree to the office policy. I accept responsibility for any payments due as outlined above.

**Patient Name(s):** _____

**Responsible Party Name:** _____ **Relationship:** _____

**Responsible Party Signature:** _____ **Date:** _____

Upon completion, a copy of this form will be provided for your records.