



**THE
ALLERGY
GROUP**
OF SOUTHERN CALIFORNIA

18370 Burbank Blvd Suite 307
Tarzana CA 91356 • 818.996.6000

29525 Canwood Street Suite 250
Agoura Hills CA 91301 • 818.735.5555

Pediatric Registration

Patient Name: _____ Sex: M F Date of Birth: _____

Mother/Guardian: _____ Date of Birth: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Employer: _____ Work Phone: _____ Occupation: _____

Driver's License: _____ May we contact you by Email/Text Message for appointment reminders? Yes No

Father/Guardian: _____ Date of Birth: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Employer: _____ Work Phone: _____ Occupation: _____

Driver's License: _____ May we contact you by Email/Text Message for appointment reminders? Yes No

Sibling Name: _____ Sex: M F Date of Birth: _____

Sibling Name: _____ Sex: M F Date of Birth: _____

Children live with: Mother Father Both Guardian _____

Responsible party for payment of medical services: Mother Father Both Guardian _____

Emergency Contact Person: _____ Relationship: _____ Phone: _____

Referred to our office by: _____

Insurance Information

Primary Insurance: _____ Claims Address: _____

Policy #: _____ Group #: _____ Copay: \$ _____

Subscriber Name: _____ Subscriber Date of Birth: _____ Relationship: _____

Secondary Insurance: _____ Claims Address: _____

Policy #: _____ Group #: _____ Copay: \$ _____

Subscriber Name: _____ Subscriber Date of Birth: _____ Relationship: _____

I prefer to do my own insurance filing. Signature: _____ Date: _____

Pharmacy Information

Pharmacy Name: _____ City: _____

Phone: _____ Fax: _____

Authorization of treatment assigned of benefit:

I authorize **The Allergy Group of Southern California** to treat my child. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to **The Allergy Group of Southern California** for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original. Medical care or immunizations cannot be given unless my child is accompanied by one of the following: _____.

I understand that if any child's physician or any person employed by or under the direction and control of my child's physician(s) is directly exposed to my child's bodily fluids in any manner which may, according to the current guidelines for the Center for Disease Control, transmit the Human Immunodeficiency Virus (HIV) or Hepatitis B or C viruses, that I am deemed by law to have consented to testing for infection with HIV or Hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to the release of these test results to the person who is exposed to my child's bodily fluids.

Parent/Guardian Signature: _____ Relationship: _____ Date: _____

Witness' Signature: _____ Date: _____



Pediatric Medical History

Patient Information

Patient Name: _____

Date: _____

Development

Are you concerned about the patient's...

- Physical development? No Yes _____
- Mental or Emotional development? No Yes _____
- Learning Ability? No Yes _____
- Attention Span or activity level? No Yes _____

If in school, has the patient had...

- Tutoring outside of the classroom? No Yes _____
- Placement in a special class? No Yes _____
- To repeat a grade level? No Yes _____
- Educational or psychological testing? No Yes _____
- Behavioral Problems? No Yes _____

Maternal and Newborn History

Pregnancy: Check if the mother had any of the following problems:

- Excessive Weight Gain Rubella None
- Urinary Infections Venereal Disease Other: _____
- Excessive Swelling Diabetes Disease _____
- Toxemia Hepatitis B

Did the mother use drugs or alcohol? No Yes _____

Was delivery difficult or complicated? No Yes _____

Birth History

Birth Weight: _____ Length: _____ Apgar: _____ Was born: Term Early Late

If early, how many weeks gestation? _____ Was labor difficulty or prolonged? Yes No

Was delivery difficult or complicated? No Yes _____

Newborn History (Check if the patient had any of the following problems):

- None Colic Breastfeeding Issues
- Slow Weight Gain Jaundice Formula Feeding Issues
- Blood in Stools Recurring Vomiting Multiple Formula Changes
- Recurring Diarrhea Feeding Problems Other: _____

Patient Information (continued from page one)

Patient Name: _____

Date: _____

Family History (Check if a family member has had any of the following):
(Allow M=mother, F=father, S=sibling, GM=grandmother, GF=grandfather, A=aunt, U=uncle)

- | | | |
|--|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Emotional/Behavioral | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Anemia/Blood disorders | <input type="checkbox"/> Epilepsy or convulsions | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eye or visual problems | <input type="checkbox"/> Mental Retardation |
| <input type="checkbox"/> Bladder/Kidney | <input type="checkbox"/> Heart attack/stroke before 50 yrs. | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Other Hearth problems | <input type="checkbox"/> Respiratory infections |
| <input type="checkbox"/> Deafness | <input type="checkbox"/> Hereditary problems | <input type="checkbox"/> Stomach/GI |
| <input type="checkbox"/> Diabetes before 50 yrs. | <input type="checkbox"/> High blood pressure before 50 yrs. | <input type="checkbox"/> Thyroid/Endocrine problems |
| <input type="checkbox"/> Drug allergies | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Drug/alcohol abuse | <input type="checkbox"/> Immunity problems/HIV | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Ear Infections/PE Tubes | <input type="checkbox"/> Learning problems/Attention span | _____ |

Family

Are patient's mother and father: Married Separated Divorced

If separated or divorced, what is the patient's custody status? _____

If one or both of the parents are not living at home, how often does the child see that parent(s)? _____

Are there siblings living away from home? No Yes (if yes, please state ages and where they are currently living): _____

Current Medical History

Is patient having any medical problems? No Yes (if yes, please explain): _____

Is patient generally in good health? Yes No (if no, please explain): _____

Are immunizations up to date? Yes No (if no, please explain): _____

Please list current medications: _____

Does patient have any drug allergies? No Yes (if yes, please list): _____

Has patient had any past surgeries? No Yes (if yes, please explain): _____

Are there any other concerns you have regarding your child? No Yes (if yes, please explain): _____



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Financial Policy and Patient Agreement

Our office is committed to providing excellent, affordable medical care. You have the right and responsibility of knowing the cost of your medical treatment. If you have health insurance and even if we bill your insurance company directly, you may be responsible for co-payment, co-insurance, deductible and non-covered amounts. For your convenience, our office accepts personal checks, credit cards and cash. When appropriate, we can provide you with a mutually agreed upon payment plan. *Please read the following carefully, as it outlines our financial policy.*

It is important that insurance patients understand how insurance billing works. Insurance companies require us to break down every component of your office visit into universal, numerical procedure codes and charge for each code. The insurance companies will arbitrarily change, combine and disallow procedure codes and then apply their company's individual fee schedule. The result is the insurance company's determination of "reasonable and customary" changes, which is the amount they are willing to cover. The insurance company usually reduces the actual reimbursement further by the individual policy's annual deductible, co-payment or co-insurance.

This method of billing, designed by the insurance industry, forces us to bill at full price procedure codes that the insurance company will likely reduce, combine or simply deny. This system, in fact, has the insurance company determining our fees. If we have a contract with your insurance company, we write-off the amount over the "reasonable and customary" and bill you for your co-insurance and deductible. If we do not have a contract with your insurance carrier, you are responsible for that amount as well as any deductible and co-insurance amount.

We are required by all insurance carriers to collect from patients any deductible and co-payment or co-insurance amounts. These fees can be reduced only in those cases where true financial hardship can be demonstrated. If you feel that you are in a position of financial hardship, please discuss your financial hardship with our patient account supervisor. In the unlikely event you stop payment, are notified of Non-Sufficient Funds or your account is turned over to Collections, you will be responsible for all related costs.

Patient Agreement:

I have read and understand **The Pediatric Group and/or The Allergy Group of Southern California** financial policy as outlined above. The following constitutes an agreement between the undersigned patient/guarantor and **The Pediatric Group and/or The Allergy Group of Southern California**.

In the event **The Pediatric Group and/or The Allergy Group of Southern California** agrees to seek payment initially from my insurance company, I request payment to be made directly to them of all medical benefits otherwise payable to me for services rendered. I understand any final obligations for payment are mine. Any portions of my bill not paid by insurance are my responsibility and are due and payable upon demand. I hereby authorize **The Pediatric Group and/or The Allergy Group of Southern California** to release all information necessary to secure payments of benefits.

The Pediatric Group and/or The Allergy Group of Southern California charges a 1.5% service charge per month for balances remaining unpaid after 60 days.

Patient/Guardian Legal Name (please print clearly): _____

Patient/Guardian Signature: _____ **Date:** _____



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Patient Authorization To Use or Disclose Protected Health Information (HIPPA)

I, _____, understand that **The Pediatric Group and/or The Allergy Group of Southern California** is not authorized by me to use or disclose protected health information for a purpose other than treatment, payment or health care operations.

I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information and the recipient(s) of that information. I specifically authorize any current employee or owner of **The Pediatric Group and/or The Allergy Group of Southern California** or any other individual listed below to disclose my protected health information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

Description of the information to be used or disclosed (check all that apply):

The patient's entire medical record.

The patient's demographic information (check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Name | <input type="checkbox"/> Race |
| <input type="checkbox"/> Address | <input type="checkbox"/> Other: <input type="checkbox"/> Medical Data/Information as related to: |
| <input type="checkbox"/> State/Zip Code only | <input type="checkbox"/> Specific condition(s) |
| <input type="checkbox"/> Telephone | <input type="checkbox"/> Specific professional service(s) |
| <input type="checkbox"/> Age | <input type="checkbox"/> Specific medication(s) |
| <input type="checkbox"/> Gender | <input type="checkbox"/> Other: _____ |
| | _____ |

Name of person(s) other than myself authorized by this form to use and disclose the protected health information (family members, etc): _____

I authorize **The Pediatric Group and/or The Allergy Group of Southern California** to contact me by mail, fax or phone regarding information or services that may be helpful or beneficial to me:

Printed Patient/Guardian Name

Signature of Patient/Guardian

Date