THE PEDIATRIC 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

Patient Registration

Patient Information

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 Pediatric 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 Pediatric 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**:______________

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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:_____________________________

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Pediatric Medical History

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)

□ _____Allergies
□ _____Anemia/Blood disorders
□ _____Asthma
□ _____Bladder/Kidney
□ _____Cancer
□ _____Deafness
□ _____Diabetes before 50 yrs.
□ _____Drug allergies
□ _____Drug/alcohol abuse
□ _____Ear Infections/PE Tubes
□ _____Emotional/Behavioral
□ _____Epilepsy or convulsions
□ _____Eye or visual problems
□ _____Heart attack/stroke before 50 yrs.
□ _____Other Hearth problems
□ _____Hereditary problems
□ _____High blood pressure before 50 yrs.
□ _____High cholesterol
□ _____Immunity problems/HIV
□ _____Learning problems/Attention span
□ _____Liver Disease
□ _____Mental Illness
□ _____Mental Retardation
□ _____Obesity
□ _____Respiratory infections
□ _____Stomach/GI
□ _____Thyroid/Endocrine problems
□ _____Tuberculosis
□ _____Other_____________________
____

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):

☐ Name

☐ Address

☐ State/Zip Code only

☐ Telephone

☐ Age

☐ Gender

☐ Race

☐ Other: ☐ Medical Data/Information as related to:

☐ Specific condition(s)

☐ Specific professional service(s)

☐ Specific medication(s)

☐ 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