New Patient Registration

FAIRWAY
PEDIATRICS

Patient Registration

Patient Information

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Sex: _____ Race: _____ Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Siblings in practice: _____

Parent/Guardian Information

Mother:_____ Father:_____ Other:_____

Last Name:_____ First Name:_____

Home Address:_____

City:_____ State:_____ Zip:_____

Employer:_____

Employer Phone:_____ Occupation:_____

Date of Birth:_____ Social Security Number:_____

Home Phone:_____ Cell Phone:_____

Email:_____

Mother: _____ Father: _____ Other:_____

Last Name: _____ First Name: _____

Home Address: _____

City: _____ State: _____ Zip:_____

Employer: _____

Employer Phone: _____ Occupation: _____

Date of Birth: _____ Social Security Number: _____

Home Phone: _____ Cell Phone:_____

Email: _____

Patient Registration

EMERGENCY CONTACTS

List additional persons who may bring children for appointments or who we are authorized to communicate medical information.

Name:_____ Relationship to patient:_____

Phone:_____

Name:_____ Relationship to patient:_____

Phone:_____

INSURANCE INFORMATION

Primary Insurance

Insurance Company: _____ INS Phone #: _____

Group Number: _____ Insurance ID: _____ Effective Date: _____

Main Policy Holder: _____ DOB: _____ Relationship to patient:_____

Secondary Insurance

Insurance Company: _____ INS Phone #: _____

Group Number: _____ Insurance ID: _____ Effective Date: _____

Main Policy Holder: _____ DOB: _____ Relationship to patient: _____

PREFERRED METHOD OF APPOINTMENT CONFIRMATION

How would you like to receive your appointment confirmations? **Please indicate only one and provide the preferred number.**

Text: _____

Voice Call: _____

PREVIOUS PHYSICIAN

Name: _____

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

REFERRED BY

How did you hear about us? _____

Medical History

PREGNANCY HISTORY

During pregnancy, did mother use: ____tobacco ____illicit drugs ____alcohol

If any were checked, please explain. (when/what?)_____

_____

Prescription medication during pregnancy:

1.
2.
3.
4.

BIRTH HISTORY

Birth weight:_____

Complications at birth: _____

DISEASES/DIAGNOSIS/CONDITIONS

____Check if none

Date of onset	Condition

SURGICAL HISTORY

____Check if none

Date	Surgery

Medical History

HOSPITALIZATIONS

____Check if none

Date:	Reason:

CURRENT MEDICATIONS

____Check if none

Medication	Dose	Frequency	Reason For Use

ALLERGIES

____Check if none

Medication/Supplement/Food	Reaction

Family History

	Mother	Father	Brother	Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunt	Uncle	Other
Arthritis											
Colon Cancer											
Breast or Ovarian Cancer											
Other Cancers											
Heart Disease											
Hypertension											
Obesity											
Diabetes											
Stroke											
Ulcerative Colitis											
Chron's Disease											
Irritable Bowel Syndrome											
Celiac Disease											
Multiple Sclerosis											
Autoimmune Disease											
Thyroid Disease											
Asthma											
Eczema											
Seasonal/Environmental Allergies											
Food Allergies											
Psoriasis											
Genetic Disorders											
ALS or Other Motor Neuron Disease											
Substance Abuse											
Depression											
Anxiety											
Schizophrenia											
Bipolar Disease											
Other Psychiatric Illnesses											
Autism											
ADHD											

Other:_____

Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, Fairway Pediatrics, LLC creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment and any plans for further care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and Practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operation (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of Protected Health Information about me for the purposes of treatment, payment and healthcare operations. I have the right to revoke this consent in writing, except where disclosures have already been made in reliance on my prior consent. This consent is given freely with understanding that:

1. Any and all records, whether written, oral, or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment, or healthcare operations be restricted. I also understand that the Practice and I must agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

_____

Patient's Name (Printed)

_____ _____

Parent/Guardian Signature Date