



Welcome to ProHEALTH Care Associates, LLP. PATIENT REGISTRATION FORM

PEDIATRICS

In order to serve you, we need the following information. Please print.

Today's Date:

Thank you for selecting ProHEALTH Care Associates.

PATIENT INFORMATION

Patient's Last Name: _____ First: _____ Middle: _____ Gender: _____ Age: _____ Birth Date: _____

Social Security No.: _____ Preferred Language: _____ Home Phone No.: _____ Student: Part Time
 Full Time

Race: American Indian or Alaska Native Native Hawaiian or Other Pacific Islander Ethnicity: Hispanic or Latino
 Asian White Decline to Answer Not Hispanic or Latino
 Black or African American Two or More Races Decline to Answer

Street Address: _____ City/Town: _____ State: _____ Zip Code: _____

MOTHER/GUARDIAN

Last Name: _____ First Name: _____ Middle Initial: _____ Gender: _____ Age: _____ Birth Date: _____

Maiden Name: _____ Mobile Phone No.: _____ Social Security No.: _____

Employer: _____ Work No.: _____ Email Address: _____

Street Address: _____ City/Town: _____ State: _____ Zip Code: _____

OTHER PARENT/GUARDIAN

Last Name: _____ First: _____ Middle: _____ Gender: _____ Age: _____ Birth Date: _____

Mobile Phone No.: _____ Work No.: _____ Social Security No.: _____

Employer: _____ Street Address: _____ City/Town: _____

State: _____ Zip Code: _____ Email Address: _____ Relationship to Patient:
 Father Other: _____

EMERGENCY CONTACT

Name of Relative (not living at the same address): _____ Relationship to Patient: _____

Primary Telephone No.: _____ Secondary Telephone No.: _____

SIBLINGS

Name: _____ Date of Birth: _____/_____/_____ Male Female

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Name: _____ Date of Birth: _____/_____/_____ Male Female

PRIMARY CARE PHYSICIAN

Primary Care Physician Name: _____

Street Address: _____

City, State, Zip: _____ Telephone No.: _____

REFERRING PHYSICIAN

Referring Physician (if not same as PCP): _____

Street Address: _____

City, State, Zip: _____ Telephone No.: _____

Please provide the name/s and telephone numbers of any other doctors treating the patient at this time.

PHARMACY INFORMATION

Name of Pharmacy: _____ Address: _____ Telephone No.: _____

Fax No.: _____

INSURANCE INFORMATION

**PRIMARY
INSURANCE**

Insurance Name: _____ Claims Address: _____ Group No.: _____
Telephone No.: _____ ID No.: _____
Insured's Name: _____ Insured's S.S. No.: _____ Birth Date: _____

**SECONDARY
INSURANCE**

Insurance Name: _____ Claims Address: _____ Group No.: _____
Telephone No.: _____ ID No.: _____
Insured's Name: _____ Insured's S.S. No.: _____ Birth Date: _____

NO FAULT INFORMATION

You must complete this section if the patient was involved in a Motor Vehicle accident.

Date of Accident: _____ Insurance Carrier Name: _____ Address: _____

Policyholder's Name: _____ Policy No.: _____ Claim No.: _____

Relationship to Insured: _____ Claims Adjuster: _____ Telephone No.: _____

Briefly describe how and where patient's injury occurred:

ATTORNEY INFORMATION - For No Fault

Law Firm Name: _____ Address: _____ Name of Attorney Handling Case: _____ Telephone No.: _____
Fax No.: _____

AUTHORIZATION FOR RELEASE OF INFORMATION BY ProHEALTH Care Associates, LLP

I hereby authorize and direct the above named clinical practice, having treated me, to release to governmental agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such treatment. Upon my request for release of my medical records, I hereby authorize ProHEALTH Care Associates, LLP to furnish all records and results to the parties I specify.

PARENT/GUARDIAN PRINT NAME: _____ **RELATIONSHIP TO PATIENT:** _____

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____/_____/_____

ASSIGNMENT OF BENEFITS

I hereby assign, transfer and set over to the above named clinical practice sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers or others who are financially liable for my medical costs of the care and treatment rendered to myself or my dependent in said practice. I understand I am responsible for any services not covered by my insurance. I accept responsibility for payment of my account.

PARENT/GUARDIAN PRINT NAME: _____ **RELATIONSHIP TO PATIENT:** _____

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____/_____/_____

Patient Name: _____

Date of Birth: _____

Have you seen Dr.Lewis over the past 3 years? Yes No
-If yes for this problem? Yes Another Problem? Yes (please explain) _____

Does your primary care physician know about the child's problem for today's visit? Yes No

What is the problem? _____

When did it start? _____

Has anyone else in the family had the same problem? No Yes (please explain) _____

How did the injury happen? _____

Location of problem? _____ Type of pain: Sharp Dull Throbbing Occasional

Severity: Mild 1 2 3 4 5 6 7 8 9 10 Most Severe How long does the pain last? _____

When is it painful? _____ Context: Getting better Getting worse Recurrent

What make it better? _____ What make it worse? Stairs Sitting Walking Running

Associated Sign and Symptoms: Bruising Swelling Numbness Tingling/Burning

Does pain wake you up at night? Yes No Does it require medicine to get back to sleep? Yes No

How have you treated this problem? Ice Elevation Brace Physical Therapy Other _____

Medicine _____

History:

Parents age: Mom: _____ Dad: _____ Siblings: _____

Does the patient have history of :

Cardiac (Heart Problems) No Yes If yes, describe _____

Lung or Breathing problems No Yes If yes, describe _____

Eye Problems No Yes If yes, describe _____

ENT/Mouth problems No Yes If yes, describe _____

Gastrointestinal problems No Yes If yes, describe _____

Musculoskeletal/Arthritis No Yes If yes, describe _____

Skin Problems No Yes If yes, describe _____

Neurological Problems No Yes If yes, describe _____

Psychiatric/Depression No Yes If yes, describe _____

Seizures No Yes If yes, describe _____

Endocrine Problems No Yes If yes, describe _____

Hematologic/Lymphatic No Yes If yes, describe _____

Allergic/Immunologic No Yes If yes, describe _____

Other Medical History: _____

Social History:

Birth History: Birth Weight: _____ Natural Delivery C-Section (why?) _____

Full Term Premature _____ weeks gestation

Time in hospital after birth _____ Time In NICU _____

Birth Complications: Head First Breech Other: _____ Age First Walked: _____

Prior Surgeries & Hospitalization: _____

Prior Injuries: _____

Current Medications: _____

Allergies to Medications: _____

If child is female: Has she started menstrual periods: No Yes(when?) _____ Reg. Irreg.

Family History: Arthritis Hip Dysplasia Club Foot Cancer Diabetes Heart Disease

Stroke Hypertension Muscular/Bone Disease Rheumatoid Arthritis

Scoliosis (who?) _____

Sports Participation: Team: _____ Recreational: _____

Signature of Patient/Parent/Guardian: _____ Date: ____ / ____ / ____



As a result of the Health Insurance Portability and Accountability Act (HIPAA), enforced by the US Department of Health and Human Services office of Civil Rights, we are not permitted to release patient information except as stated in the Notice of Privacy Practices, or in accordance with your wishes as stated below.

This waiver authorizes ProHEALTH Care Associates to send/give my medical information as noted:

Leave a voice mail recording including my Personal Health Information on my home/cell phone:
 Yes No

Leave a voice mail recording including my Personal Health Information on my business phone:
 Yes No

Use of electronic communication systems (i.e. fax, electronic messaging) to transmit prescription, treatment, disorder related information, lab or other results:
 Yes No

Use of email to transmit treatment or disorder related information which may include a diagnosis, lab or other results sent to me, even if the email is not encrypted (not protected over the Internet):
 Yes No

Permit the individual stated below (Personal Representative) to receive prescriptions and/or test results:
 Yes No

Speak to a family member of my choosing (Personal Representative) regarding my Personal Health Information:
 Yes No

Name of Personal Representative: _____

On this date _____, I received and reviewed ProHEALTH's Notice of Privacy Practices, which describes how my medical information may be used and disclosed and explains how I can get access to this information.

I had an opportunity to raise questions regarding this policy and all of my questions have been answered.

The authorizations made above will remain effective until such time as I notify ProHEALTH Care Associates in writing, by certified mail, of requested changes.

Patient Name (Print)

Date of Birth

Patient or Parent/Guardian Signature

Date

Patient's Social Security Number

Email Address

Home Address

Telephone Number