EL NORTE MEDICAL GROUP

PEDIATRIC PATIENT REGISTRATION

How did you hear about us?
- ☐ Newspaper
- ☐ Social media/Web site
- ☐ Insurance referral
- ☐ Family/Friend

PATIENT'S NAME AND ADDRESS

LAST	FIRST	MI	MALE ( ) FEMALE ( )
SOC. SEC. #	BIRTHDATE	AGE	PRIMARY DOCTOR
STREET ADDRESS	APT#	CITY	STATE / ZIP
PHONE ( ) ☐ CELL ☐ HOME ☐ DAY		EMAIL	
RACE	ETHNICITY	LANGUAGE	

EMERGENCY CONTACT INFORMATION

NAME	PHONE ( ) ☐ CELL ☐ HOME ☐ DAY
RELATIONSHIP TO PATIENT	

PATIENT'S INSURANCE

PRIMARY INSURANCE COMPANY NAME AND ADDRESS	POLICY #
GROUP #	POLICYHOLDER'S NAME
SOC. SEC. #	POLICYHOLDER'S BIRTHDATE / RELATIONSHIP TO PATIENT
SECONDARY INSURANCE COMPANY NAME AND ADDRESS	POLICY #
GROUP #	POLICYHOLDER'S NAME
SOC. SEC. #	POLICYHOLDER'S BIRTHDATE / RELATIONSHIP TO PATIENT

PARENTS' INFORMATION

MOTHER'S NAME	MAIDEN NAME
BIRTHDATE	SOC. SEC. #
STREET ADDRESS / APT# / CITY / STATE / ZIP	
CELL PHONE ( )	HOME PHONE ( )
EMPLOYER NAME / DAY PHONE ( ) / EMAIL	
MARITAL STATUS ☐ MARRIED ☐ DIVORCED ☐ SINGLE ☐ WIDOWED ☐ OTHER_____	
FATHER'S NAME	
BIRTHDATE	SOC. SEC. #
STREET ADDRESS / APT# / CITY / STATE / ZIP	
CELL PHONE	HOME PHONE
EMPLOYER NAME / DAY PHONE / EMAIL	
MARITAL STATUS ☐ MARRIED ☐ DIVORCED ☐ SINGLE ☐ WIDOWED ☐ OTHER_____	

CUSTODIAL INFORMATION

CUSTODIAL PARENT IS ☐ MOTHER ☐ FATHER ☐ OTHER _____

FINANCIAL POLICY: Payment in full or co-payment is expected at the time of service. Services provided that are not a covered benefit of your health plan will be your responsibility. CONSENT TO TREATMENT/RELEASE OF INFORMATION: I grant El Norte Medical Group, Inc. to administer medical treatment and perform medical procedures as deemed necessary. I authorize the release of medical information to my insurer, or the insurer's agents to process my payments for service. To the best of my knowledge, all of the information above is true and correct.
ASSIGNMENT OF BENEFITS: I thereby assign all benefits payable by my insurance company to Graybill Medical Group.
TREATMENT IF PARENT OR GUARDIAN IS NOT PRESENT: Child MUST have a note from a parent or guardian giving permission for El Norte Medical Group to examine child. Please include in this note the date of visit, any known allergies, the name of the person bringing in the child and his or her relationship to the child, and reason for visit. Forms are available if you'd like to have one for reference. Please ask the Receptionist for details.

_____ _____ _____

PARENT/GUARDIAN SIGNATURE DATE RELATIONSHIP TO PATIENT

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PATIENT
FINANCIAL AGREEMENT

- All co-pays are due at the time of your office visit.
- If you are a **Medicare** beneficiary, we will bill Medicare for you. You will be responsible for deductibles and all non-covered services according to Medicare guidelines. Please provide a copy of your most recent Medicare cards and any secondary insurance or supplement you may have.
- **It is your responsibility to know your insurance, including Medicare.** Preventive care, such as routine exams, may not always be covered by your insurance. Please be aware that if an additional new problem is addressed at the time of your visit, an additional co-pay, deductible or office visit fee may be charged. If services are denied for payment by your insurance or we have not received your correct insurance information, you will be responsible for payment for these services.
- We will bill your insurance company for you. If we receive notification that you are not eligible for coverage or we are not contracted with your insurance, you will be responsible for all charges incurred.
- Payment from your insurance company is expected within **45 days**. After 45 days, we will look to you for payment in full. Accounts that are 90 days past due are subject to submission to a collection agency or small claims court for the unpaid bills.
- If you are a **cash pay** patient, the amount you pay for today's scheduled office visit may not be your final payment. Other costs that may be accrued for today's appointment include, but are not limited to: laboratory tests, x-rays, injections, special procedures or additional office visit charges.
- Any laboratory procedures that are ordered during today's visit will be billed separately by the laboratory.
- If at any time you should experience financial hardship and need to make special arrangements, please contact our Billing Office at (760) 291-6621.
- A **$25 cancellation fee** will apply for missed appointments or failure to cancel within one business day.

I have read and understand the above statements. I agree to comply with the financial policies of the office and I am financially responsible for my account.

Patient Name (please print) _____ Patient DOB _____

Parent/Guardian Name (please print)_____ Date _____

Parent/Guardian Signature _____

Assignment of Benefits

Authorization is hereby granted to release information as may be necessary to process and complete my insurance claim. Payment of medical benefit is to be paid directly to Graybill Medical Group for all services rendered. *Initials* _____

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PARENTS' QUESTIONNAIRE

Patient's Name _____ Date of Birth _____ Date _____

CHILD'S BIRTH HISTORY

PROVIDER: Write additional information in this column

During your pregnancy with this child did you:

Have high blood pressure?	☐ Yes ☐ No	Have diabetes or sugar in your urine?	☐ Yes ☐ No
Have a urine or kidney infection?	☐ Yes ☐ No	Have any other infections?	☐ Yes ☐ No
Have a venereal disease such as gonorrhea or syphilis?	☐ Yes ☐ No	Take any medications, drugs or alcohol?	☐ Yes ☐ No
Have any problems with labor or delivery?	☐ Yes ☐ No	Was the pregnancy planned?	☐ Yes ☐ No
How long was the pregnancy? _____ months		How much did the baby weigh? ____lbs ____oz	

Did your child have any problems after birth? ☐ Yes* ☐ No

*if yes please describe: _____

_____

Did the mother and child come home from the hospital together? ☐ Yes ☐ No

How many days did the mother and child stay in the hospital? Mother _____ days Child _____ days

In which hospital was your child born?_____

SOCIAL HISTORY

Child lives with: ☐ Mother ☐ Father ☐ Both Parents ☐ Other Relatives ☐ Foster Parents

WHO LIVES IN THE HOME WITH YOUR CHILD? (Please print clearly):

NAME	RELATIONSHIP TO CHILD
1.	
2.	
3.	
4.	
5.	
6.	

Does your child spend time regularly with a babysitter? ☐ Yes ☐ No

If yes, how many times per week? _____

Does your child spend time at a day care center? ☐ Yes ☐ No

If yes, how many times per week? _____ How many hours per day? _____

FAMILY HISTORY

	Father	Mother	Father's Family	Mother's Family	Child's Brothers	Child's Sisters
Asthma						
Diabetes						
Heart attack at age less than 50 years						
Seizures (epilepsy)						
Sickle Cell Disease						

PLEASE COMPLETE BOTH SIDES

PARENTS' QUESTIONNAIRE

Patient's Name _____ Date of Birth _____ Date _____

CHILD'S MEDICAL HISTORY

PROVIDER: Write additional information in this column

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

YEAR	NAME OF HOSPITAL	REASON
1.		
2.		
3.		

Has the child ever had:

Eczema (allergic skin rash?)	☐ Yes ☐ No	Asthma?	☐ Yes ☐ No
Chicken Pox	☐ Yes ☐ No	Rheumatic Fever?	☐ Yes ☐ No
Anemia (low blood)?	☐ Yes ☐ No	Seizure, convulsions, fits?	☐ Yes ☐ No

Has the child ever experienced:

Eye or vision problems?	☐ Yes ☐ No	Ear or hearing problems?	☐ Yes ☐ No
Frequent ear infections?	☐ Yes ☐ No	Heart problems?	☐ Yes ☐ No
Stomach or bowel problems?	☐ Yes ☐ No	Broken or fractured bones?	☐ Yes ☐ No
Problems with urinating?	☐ Yes ☐ No	Ate paint, clay or plaster?	☐ Yes ☐ No

Do you give the child vitamins, iron or fluoride dietary supplements? ☐ Yes* ☐ No

*If yes, please describe:

CHILD'S DEVELOPMENT

Has your child developed (for example, started sitting, walking, talking) at the same rate as his or her brothers, sisters, relatives or friends? ☐ Yes ☐ No*

*If no, please explain:

CHILD'S SCHOOL HISTORY

If school age, name of school currently attending: Grade level _____

Has your child ever failed a class?	☐ Yes ☐ No	Attended a special class?	☐ Yes ☐ No
Had behavior problems in school?	☐ Yes ☐ No		

If yes to any of the above, please explain:

CHILD'S BEHAVIOR

Has your child had frequent nightmares?	☐ Yes ☐ No	Had problems being overly shy?	☐ Yes ☐ No
Been overly clinging to parents or friend?	☐ Yes ☐ No	Been easily upset?	☐ Yes ☐ No
Been overly nervous?	☐ Yes ☐ No	Been unreasonably jealous?	☐ Yes ☐ No
Does your child lie a lot?	☐ Yes ☐ No	Does your child fight a lot	☐ Yes ☐ No
Does your child steal?	☐ Yes ☐ No		

HOW WOULD YOU DESCRIBE THE CHILD AND HIS/HER BEHAVIOR?

PLEASE COMPLETE BOTH SIDES

EL NORTE MEDICAL GROUP

TB EXPOSURE RISK ASSESSMENT FOR CHILDREN

Patient's Name _____ Date of Birth _____ Date _____

Has the Mother ever tested positive for active TB?	☐ Yes ☐ No
Has the Father ever tested positive for active TB?	☐ Yes ☐ No
Has any family member/person whom your child sees regularly been diagnosed or suspected of being sick with active TB?	☐ Yes ☐ No
Does your child have family members/frequent visitors who were born in high TB-prevalent areas (Asia, Africa, Latin America, Mexico, parts of Eastern Europe)?	☐ Yes ☐ No
Was your child born in, or has your child traveled to, high TB-prevalent areas (Asia, Africa, Latin America, Mexico, parts of Eastern Europe)?	☐ Yes ☐ No
Has your child lived in out-of-home placements such as foster care or residential facilities or been incarcerated in the last 5 years?	☐ Yes ☐ No
Does your child have HIV infection or any other immunosuppressive condition?	☐ Yes ☐ No
Has your child lived among or frequently been around individuals who are homeless, have a history of incarceration, migrant workers, users of street drugs, residents in nursing homes, or have HIV infection?	☐ Yes ☐ No
Does your child have close contact with a person who has a positive TB skin test?	☐ Yes ☐ No
Has your child ever consumed raw milk or unpasteurized cheese?	☐ Yes ☐ No

PLEASE COMPLETE BOTH SIDES

EL NORTE MEDICAL GROUP

PEDIATRIC HISTORY

Patient's Name _____ Date of Birth _____ Date _____

MOTHER'S NAME_____ DOB_____/_____/_____

FATHER'S NAME_____ DOB_____/_____/_____

SIBLING(S)/AGE(S)_____

Are there any special cultural or religious beliefs that might affect your child's healthcare? _____

_____

HISTORY

Complications w/pregnancy _____ Birth: ☐ Vaginal ☐ C-section Birth weight _____ Birth length _____

Special diet? ☐ Yes ☐ No Medications: _____

Drug/medication allergies? ☐ Yes* ☐ No *If yes, describe: _____

Surgeries (age, diagnosis): _____

Hospitalizations (age, diagnosis): _____

Any problems at school? ☐ Yes* ☐ No *If yes, describe: _____

Other problems: _____

FAMILY HISTORY

☐ Cystic fibrosis	☐ High blood pressure	☐ TB	☐ Seizures
☐ Sickle cell disease	☐ Scoliosis	☐ Kidney disease	☐ Lazy eye
☐ Diabetes	☐ Melanoma/Skin cancer	☐ Anemia/bleeding	☐ Allergies/Asthma/Eczema
☐ Hip problems	☐ Recurrent ear infections	☐ Deafness	☐ Attention Deficit Disorder

IMMUNIZATION DATES (Please bring copy of immunization record)

DATE	DATE	DATE	DATE
DPT 1 _____/_____/_____	OPV 1 _____/_____/_____	Rotovirus 1 _____/_____/_____	HIB 1 _____/_____/_____
DPT 2 _____/_____/_____	OPV 2 _____/_____/_____	Rotovirus 2 _____/_____/_____	HIB 2 _____/_____/_____
DPT 3 _____/_____/_____	OPV 3 _____/_____/_____	Rotovirus 3 _____/_____/_____	HIB 3 _____/_____/_____
DPT 4 _____/_____/_____	OPV 4 _____/_____/_____	Rotovirus 4 _____/_____/_____	HIB 4 _____/_____/_____
DPT 5 _____/_____/_____	MMR 1 _____/_____/_____	DT _____/_____/_____	HEPB 1 _____/_____/_____
Prevnar 1 _____	MMR 2 _____/_____/_____	TB _____/_____/_____	HEPB 2 _____/_____/_____
Prevnar 2 _____	Chicken Pox ____/____/_____	TB _____/_____/_____	HEPB 3 _____/_____/_____
Prevnar 3 _____			
Prevnar 4 _____			

DO YOU HAVE ANY OTHER QUESTIONS OR CONCERNS REGARDING YOUR CHILD'S HEALTH OR DEVELOPMENT?_____

_____

_____

_____

PLEASE COMPLETE BOTH SIDES