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

- **Co-Payments:** Your insurance company requires us to collect co-payments at the time of service. Waiver of co-payments may constitute fraud under state and federal law. Please help us in upholding the law by paying your co-payment at each visit.
- **Deductible Payments:** If your insurance requires you to meet a deductible before services are covered, payment must be made at the time of service. A $100.00 payment will be due at the time of service. Please note the $100.00 payment does not constitute payment in full and any additional balance must be paid upon receiving notification from our practice.
- **Claims Submission:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Payment from your insurance company is expected within 45 days. After 45 days, we will look to you for payment in full. You will be responsible for all non-covered services according to Medicare guidelines. We must have a copy of your most recent cards and any secondary insurance or supplement you may have. Accounts that are 90 days past due are subject to being sent to a collection agency or small claims court for the unpaid bills. 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. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.
- **Preventive Care Services:** Routine exams are not always covered by your insurance. Please be aware that if an additional problem is addressed at the time of your visit, a co-pay, deductible or office visit fee may be charged. If services are denied for payment by your insurance or you have failed to provide us with your correct insurance information, you will be responsible to pay for these services.
- **Cash Pay Patients:** 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 are including, but not limited to, laboratory tests, x-ray tests, any injections, special procedures or additional office visit charges.
- **Laboratory Bills:** Any laboratory procedures that are ordered during today's visit will be billed to you directly by the laboratory. Please contact your laboratory directly for any questions regarding your lab bill.
- **Missed Appointments:** Please note a $25.00 cancellation fee will apply for missed appointments or failure to cancel within 24 hours prior to your scheduled appointment time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.
- If at any time you should experience financial hardship and need to make special payment plan arrangements, please contact our billing office.

Assignment of Benefits: Authorization is hereby granted to release information as may be necessary to process and complete my insurance claim, and payment of medical benefit is to be paid directly to the physician for all services rendered. *Initials:* _____

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 or Guardian Signature	Date
Patient or Guardian Name (please print)	
Patient Name (if different from above; please print)	Patient Date of Birth

Acuerdo Financiero del Paciente

- **Co-Pagos:** Su seguro médico nos requiere cobrar el co-pago al momento de su visita. La exoneración del co-pago puede constituir fraude bajo leyes estatales y federales. Por favor ayúdenos a respetar la ley pagando su co-pago en cada visita.
- **Pago de Deducibles:** Si su seguro médico le requiere satisfacer la cantidad de su deducible antes de cubrir los servicios, usted deberá hacer su pago al momento de su visita. La cantidad de $100.00 será requerida al momento de su visita. Por favor tenga en cuenta que el pago de $100.00 no constituye el pago en su totalidad y cualquier saldo pendiente se le notificará por medio de esta oficina.
- **Envió de Facturas:** Nosotros enviaremos su factura y le asistiremos de cualquier manera razonable para que sus facturas sean pagadas. El pago de su seguro médico es esperado dentro de un plazo de 45 días. Después de 45 días, esperaremos de usted el pago en su totalidad. Usted será responsable por cualquier servicio no cubierto por su seguro médico según las reglas y pólizas de Medicare. Debemos tener una copia de su tarjeta más reciente de su seguro médico y cualquier seguro suplementario o secundario que pueda tener. Cuentas vencidas por más de 90 días están sujetas a ser enviadas a una Agencia de Colección o a una Corte De Demandas Pequeñas por facturaciones no pagadas. Si recibimos notificación de que usted no es elegible o no estamos contratados con su seguro médico, usted será responsable por los cargos incurridos. Puede ser que su seguro médico le mande cierta información directamente a usted. Es su responsabilidad cumplir con esta petición.
- **Servicios de Cuidado Preventivo:** Los exámenes de rutina no siempre son cubiertos por su seguro médico. Tenga en cuenta que si un problema adicional es observado en su visita, podría incurrir un cobro adicional de un co-pago o deducible por esta visita médica. Si los servicios son negados por su seguro médico o no nos ha proporcionado la información correcta de su seguro médico, usted será responsable de pagar por estos servicios.
- **Pago en Efectivo:** La cantidad que usted pague hoy por su visita médica, pueda no ser su pago final. Otros costos pueden ser incurridos por su visita de hoy incluyendo, pero no limitado a, pruebas de laboratorio, exámenes de rayos x, cualquier inyección, procedimientos especiales o cobros adicionales por su visita.
- **Cobros de Laboratorio**: Cualquier procedimiento de laboratorio ordenado durante su visita de hoy será facturado por separado por el laboratorio. Favor de llamar directamente al laboratorio para cualquier pregunta que tenga sobre su cobro.
- **Citas Perdidas:** Por favor tenga en cuenta que un cobro de $25 será aplicado por citas perdidas o no canceladas dentro de un día laboral. Este cobro será su responsabilidad y será facturado directamente a usted. Por favor ayúdenos a servirle mejor manteniendo su cita programada. Si en algún momento usted experimenta dificultades financieras y necesita hacer arreglos de pago, favor de ponerse en contacto con nuestra oficina de facturación.

Asignación de Beneficios – Autorización queda concedida para revelar la información necesaria para procesar y completar la factura del seguro médico y el pago de beneficios es directamente pagado a Graybill Medical Group por todos los servicios rendidos. *Iniciales:* _____

He leído y entendido la declaración antedicha. Estoy de acuerdo en cumplir con las pólizas financieras de la oficina y soy financieramente responsable por mi cuenta.

Firma de Paciente/Tutor	Fecha
Nombre de Paciente/Tutor (favor de imprimir)	
Nombre de Paciente (si es diferente del anterior; favor de imprimir)	Fecha de Nacimiento

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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