The Pediatric Center, Inc.

https://www.thepediatriccenterinc.com/

Toledo
3900 Sunforest Court, Suite 223
Toledo, OH 43623
Ph: 419-473-6670
Fax: 419-473-9959

Oregon
2702 Navarre Avenue, Suite #106
Oregon, OH 43616
Ph: 419-697-6777
Fax: 419-697-6712

Lambertville
3417 West Sterns Road
Lambertville, MI 48144
Ph: 734-854-2428
Fax: 734-854-2237

New Patient Registration Form

(Please provide photo I.D., insurance card(s) and (if applicable) custodial documents)

Today's Date: _____

A. PATIENT DEMOGRAPHICS

Patient Name: First Middle Last

Patient Date of Birth (Month/Day/Year) Social Security Number Gender: ◯ M ◯ F

Patient Address City State Zip

Primary Family Phone Cell Phone Primary Family E-Mail

We are required to collect each patient's Ethnicity/Race. Please select all that apply before returning this form. Thank you.

◯ American Indian or Alaskan Native ◯ Asian ◯ Black or African American ◯ Hawaiian Native or Pacific Islander

◯ Hispanic or Latino ◯ White or Caucasian ◯ Unknown ◯ Decline to Specify

Preferred Contact Method: ◯ **Mailing Address** ◯ **Home Phone** ◯ **Cell Phone** ◯ **E-Mail**

B. FAMILY CONTACTS

Custody Situation: ◯ **Joint** ◯ **Single** ◯ **Legal Guardian/Foster** ◯ **Adoption**

Patient's Biological Mother's Name: First Middle Last Authority (access to patient's medical records): ◯ Y ◯ N

Mother's Date of Birth (Month/Day/Year) Social Security Number Address City State Zip

Mother's Primary Phone Day Phone Work Phone Cell Phone Email

Patient's Biological Father's Name: First Middle Last Authority (access to patient's medical records): ◯ Y ◯ N

Father's Date of Birth (Month/Day/Year) Social Security Number Address City State Zip

Father's Primary Phone Day Phone Work Phone Cell Phone Email

C. PERSON RESPONSIBLE FOR PAYMENT IF NO INSURANCE– CUSTODIAL or LEGALLY APPOINTED TO COVER MEDICAL EXPENSES

Parent/Guardian Name: First Middle Last

Parent/Guardian Date of Birth (Month/Day/Year) Social Security Number Authority (access to patient's medical records): ◯ Y ◯ N

Parent/Guardian Address City State Zip

Parent/Guardian Primary Phone Cell Phone E-Mail

Your Relationship to the Patient: ◯ **Biological Mother** ◯ **Biological Father** ◯ **Legal Guardian** ◯ **Foster Parent** ◯ **Adoptive Parent**

Date Child Entered Your Home (if NOT biological parent): _____

FORM COMPLETED BY: _____

Printed Name **Signature** **Relationship to Patient** **Date**

The Pediatric Center, Inc.

https://www.thepediatriccenterinc.com/

Toledo
3900 Sunforest Court, Suite 223
Toledo, OH 43623
Ph: 419-473-6670
Fax: 419-473-9959

Oregon
2702 Navarre Avenue, Suite #106
Oregon, OH 43616
Ph: 419-697-6777
Fax: 419-697-6712

Lambertville
3417 West Sterns Road
Lambertville, MI 48144
Ph: 734-854-2428
Fax: 734-854-2237

Today's Date: _____ Patient Name: _____ Patient Date of Birth: _____

D. INSURANCE INFORMATION (This info can be found on your insurance card; PLEASE present ALL insurance cards.)

Policy Holder's Name: First Middle Last Phone Number

Gender: ○Male ○Female Policy Holder's Date of Birth (Month/Day/Year) Social Security Number

Patient's Relationship to Policy Holder: ○Child ○Other ○Spouse ○Self

PRIMARY Insurance Carrier Name and Provider Phone # Policy I.D. Group I.D. Group Name (If Applicable)

Claims Mailing Address (found on ins card) City State Zip

Policy Holder's Employer Policy Effective Date PCP Co-Payment $ Amount

E. ADDITIONAL INSURANCE INFORMATION IF APPLICABLE (PLEASE present ALL insurance cards.)

Policy Holder's Name: First Middle Last Phone Number

Gender: ○Male ○Female Policy Holder's Date of Birth (Month/Day/Year) Social Security Number

Patient Relationship to Policy Holder: ○Child ○Other ○Spouse ○Self

SECONDARY Insurance Carrier Name and Provider Phone # Policy I.D. Group I.D. Group Name (If Applicable)

Claims Mailing Address (found on insurance card) City State Zip

Policy Holder's Employer Policy Effective Date PCP Co-Payment $ Amount

****PLEASE NOTE: The insurance policy holder is not automatically responsible for patient account balances.****

The parent/guardian who holds custody of patient is responsible for any costs incurred if no active insurance or if any claim amount is unpaid or non-covered by insurance, unless otherwise documented by the courts –see Notice of Financial Responsibility/Insurance Policy for details.

I CONFIRM THAT THE ABOVE INFORMATION IS CORRECT:

_____

Signature of Parent/Guardian ***Date***

The Pediatric Center, Inc.

https://www.thepediatriccenterinc.com/

Toledo
3900 Sunforest Court, Suite 223
Toledo, OH 43623
Ph: 419-473-6670
Fax: 419-473-9959

Oregon
2702 Navarre Avenue, Suite #106
Oregon, OH 43616
Ph: 419-697-6777
Fax: 419-697-6712

Lambertville
3417 West Sterns Road
Lambertville, MI 48144
Ph: 734-854-2428
Fax: 734-854-2237

Today's Date: _____ Patient Name: _____ Patient Date of Birth: _____

F. NOTICE OF FINANCIAL RESPONSIBILITY/INSURANCE POLICY

1. All active insurance policies must be presented with their current insurance cards each time services are rendered. If no active insurance policies presented on behalf of the patient, then you will be considered Self-Pay.
2. If you or anyone else hold Private insurance as Primary for patient with Medicaid as Secondary, you must provide this information at the time of service. If you fail to disclose the primary insurance, your claim will be denied.
3. Our practice accepts all insurances; however, if a patient has insurance in which we do not participate, then it is the responsibility of the billing guarantor for payment in full at the time of service.
4. It is the patient/guarantor's responsibility to pay any copayment, deductible, or any portion of the charges as specified by the insurance policy(s). Payments for medical services not covered by an individual's insurance policy are the patient/guarantor's responsibility, and payment in full is due at time of visit.
5. Please notify our office if there are any changes in your insurance coverage (including the addition or change with insurance carriers).
6. In cases of child custody, the parent court ordered to cover medical expenses for the patient will be responsible for payment of services rendered.

This is to certify that I the undersigned, voluntarily consent to the administration of the practice of diagnostic procedure/imaging/photography and medical treatment by providers, authorized agents and employees of the practice as may, in their professional judgment deemed necessary or beneficial. Unless otherwise specified, all healthcare providers may obtain additional consents for individual procedures. I (we) acknowledge that no guarantees have been made to me (us) as to the effect of such examination or treatment.

I understand that the insurance benefits are provided directly for the patient/guarantor and I, the undersigned, further agree and understand that I am solely responsible for all financial obligations to The Pediatric Center, Inc. If for any reason I fail to meet my financial obligations to The Pediatric Center, Inc. to seek a collection agency or court action as a means of collection, I understand that I will be responsible for the balance due on my collections plus all fees related to the collection.

G. CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

I hereby consent to the use or disclosure of my individually identifiable health information ("protected health information") by The Pediatric Center, Inc. to carry out treatment, payment, or health care operations. I understand that I can review The Pediatric Center Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information, and I have the right to review such Notice prior to signing this Consent Form.

The Pediatric Center, Inc. reserves for itself the right to change the term for its Notice of Privacy Practices for Protected Health Information at any time. If The Pediatric Center, Inc. does change the terms of Notice of Privacy of Practices for Protected Health information, I may obtain a copy of the revised notice by calling the office and requesting a revised copy be sent in the mail or asking at the time of my next appointment. I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Pediatric Center, Inc. is not required to agree to such requested restriction(s); however, if The Pediatric Center, Inc. does agree to my requested restriction(s), such restriction(s) are then binding on The Pediatric Center, Inc. At all times, I retain the right to revoke this consent in writing to The Pediatric Center, Inc. except to the extent that action has already been taken.

The Pediatric Center may refuse to treat Patient if he/she (or authorized representative) does not sign this Consent Form (except to the extent The Pediatric Center, Inc. is required by law to treat individuals). If Patient (or authorized representative) signs this Consent Form and then revokes Consent, The Pediatric Center, Inc. has the right to refuse to provide further treatment to patient as of the time of revocation (except to the extent that The Pediatric Center is required by law to treat individuals).

AUTHORIZED SIGNATURE

I have read and fully understand the **FINANCIAL/INSURANCE POLICY** and the **CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS** **and agree to abide by these policies.**

_____ _____

Printed Name of Parent/Legal Guardian **Relationship to Patient (if other than patient)**

_____ _____

Signature of Parent/Legal Guardian **Today's Date**

Toledo
3900 Sunforest Court, Suite 223
Toledo, OH 43623
Ph: 419-473-6670
Fax: 419-473-9959

Oregon
2702 Navarre Avenue, Suite #106
Oregon, OH 43616
Ph: 419-697-6777
Fax: 419-697-6712

Lambertville
3417 West Sterns Road
Lambertville, MI 48144
Ph: 734-854-2428
Fax: 734-854-2237

Today's Date: _____ Patient Name: _____ Patient Date of Birth: _____

H. CONSENT FOR TREATMENT OF A MINOR IN THE ABSENCE OF A PARENT OR GUARDIAN

I, _____ hereby authorize the following person(s) to bring my child in for medical treatment. I also allow them to make any medical decisions that are in the best interest of my child. I understand that this person in required to bring a picture ID with them to the visit along with my child's insurance card(s) and any co-payment that is due at the time of visit. Without a picture ID the child will NOT be seen. Failure to present insurance card(s) and any co-payments due may result in the child not being seen as scheduled. In the event of an emergency, The Pediatric Center, Inc. assumes we have implied consent since you sent child with someone not on this list.
I can be reached at _____-_____-_____for any questions and/or concerns.
Person(s) authorized to bring the child to medical appointments:

1) _____ Relationship _____ Authority (access to patient's medical records): ○Y ○N

2) _____ Relationship _____ Authority (access to patient's medical records): ○Y ○N

3) _____ Relationship _____ Authority (access to patient's medical records): ○Y ○N

I. CONSENT FOR IMMUNIZATION OF A MINOR

As of today's date, I give The Pediatric Center, Inc. permission to immunize my child during the duration of care, or until child turns 18. I understand that these immunizations will be as recommended by the State of Ohio, Michigan, and American Academy of Pediatrics and agree to maintain vaccination appointments in order to keep patient(s) up-to-date on all immunizations.

AUTHORIZED SIGNATURE

I have read and fully understand the **CONSENT FOR TREATMENT OF A MINOR** and the **CONSENT FOR IMMUNIZATION OF A MINOR POLICIES and agree to abide by these policies.**

_____ _____
Printed Name of Parent/Legal Guardian **Relationship to Patient (if other than patient)**

_____ _____
Signature of Parent/Legal Guardian **Today's Date**

J. LEGAL DOCUMENTS

I, _____(PRINTED NAME OF PERSON COMPLETING THIS FORM) understand that it is my obligation to provide The Pediatric Center, Inc with any and all legal documents pertaining to this child including all custody limitations. Both parents have legal access to all medical records unless legal documentation is provided outlining restrictions. The Pediatric Center, Inc will not be held liable for allowing patient access without legal documentation.

_____ _____
Signature of Parent/Legal Guardian **Today's Date**

The Pediatric Center, Inc.

https://www.thepediatriccenterinc.com/

Toledo
3900 Sunforest Court, Suite 223
Toledo, OH 43623
Ph: 419-473-6670
Fax: 419-473-9959

Oregon
2702 Navarre Avenue, Suite #106
Oregon, OH 43616
Ph: 419-697-6777
Fax: 419-697-6712

Lambertville
3417 West Sterns Road
Lambertville, MI 48144
Ph: 734-854-2428
Fax: 734-854-2237

Today's Date: _____ **Patient Name:** _____ **Patient Date of Birth:** _____

PATIENT MEDICAL HISTORY

****New patients**: Date of last well visit:_____ Previous Physician:_____**

How did you find us? ☐Website ☐Social Media ☐Office sign ☐Established sibling
☐Advertisement; please list source:_____ ☐ Referred by:_____

PATIENT History Question (If yes, please comment)	**NO**	**YES**	**COMMENT:**
Any visits to another doctor for any problems or medications			**Please list if YES:**
Abdominal pain/Gastroesophageal Reflux			
Allergic Rhinitis or other allergy			
Anemia or bleeding problem			
Asthma, Bronchitis, Bronchiolitis, Pneumonia or Croup			
Bed-wetting (after 5 years of age)			
Bladder or Kidney infection or other urological problem			
Blood Transfusion			
Chronic or recurrent skin problems (acne, eczema, etc)			
Constipation requiring doctor visits			
Diabetes			
Emotional problems			
Eye conditions/corrective lenses			
Frequent ear infections or sinus infections			
Frequent headaches			
Heart problems or heart murmur			
Hospitalizations			
If female, any problems with periods			
If female, have menstrual periods started			
Known allergens			
Mental health concerns			
Orthopedic problems			
Other infections problems			
Pharyngitis/tonsillitis			
Problems with ears or hearing			
Seizures, developmental delays, ADD/ADHD or other neurological disorder			
Serious injuries or accidents			
Surgeries			
Thyroid or other endocrine problems			
Use of alcohol or drugs			

The Pediatric Center, Inc.

https://www.thepediatriccenterinc.com/

Toledo
3900 Sunforest Court, Suite 223
Toledo, OH 43623
Ph: 419-473-6670
Fax: 419-473-9959

Oregon
2702 Navarre Avenue, Suite #106
Oregon, OH 43616
Ph: 419-697-6777
Fax: 419-697-6712

Lambertville
3417 West Sterns Road
Lambertville, MI 48144
Ph: 734-854-2428
Fax: 734-854-2237

Today's Date:_____ Patient Name: _____Patient Date of Birth:_____

BIOLOGICAL FAMILY MEDICAL HISTORY

(Biological mother and father, sibling [full and half], grandparents only)

FAMILY History Question: **(IF YES, CHECK RELATIONSHIP)**	**NO**	**YES**	Natural Mother	Natural Father	Sibling	Maternal Grandparent (mother side)	Paternal Grandparent (father side)
Nasal or other allergies							
Asthma/lung disease							
Heart disease or heart condition							
High blood pressure							
High cholesterol							
Diabetes or other endocrine problem							
Cancer							
Anemia							
Bleeding disorders							
Epilepsy or convulsions							
Mental retardation or developmental disorders							
Neurological disorder including ADHD							
Liver disease							
Other GI disease/disorder							
Kidney disease							
Bed-wetting (after 10 years of age)							
Hearing impairment							
Vision impairment or eye disorder							
Immune problems, recurrent infections or HIV/AIDS							
Alcohol abuse							
Drug abuse							
Mental illnes							
Tuberculosis							
Additional conditions							

The Pediatric Center, Inc.

https://www.thepediatriccenterinc.com/

Toledo
3900 Sunforest Court, Suite 223
Toledo, OH 43623
Ph: 419-473-6670
Fax: 419-473-9959

Oregon
2702 Navarre Avenue, Suite #106
Oregon, OH 43616
Ph: 419-697-6777
Fax: 419-697-6712

Lambertville
3417 West Sterns Road
Lambertville, MI 48144
Ph: 734-854-2428
Fax: 734-854-2237

Today's Date:_____ Patient Name: _____Patient Date of Birth:_____

SOCIAL HISTORY

Social Question	RESPONSE:
Patient resides with: (list relationships that live in same house as patient i.e; mom, dad, sibling, grandparent(s) etc.)	
Who has legal custody	
Any caregiver smokes or vapes inside or outside the house	□NO □YES Include response if YES:
Pets	□NO □YES Please list:
Guns in the home	□NO □YES
Guns are locked and kept separate from ammunition	□NO □YES
Within the past 12 months, you worried that your food would run out	□NO □YES
In the next 2 months you may not have stable housing that you own or rent	□NO □YES
Neglect going to the doctor because of distance or transportation	□NO □YES
In past 12 months has the electric, gas, oil, or water company given shut off notice	□NO □YES
Does the parent(s) have a job	□NO □YES Employed by:

BIRTH HISTORY

(For **NEW** patients under 2 years of age **ONLY**)

Birth Statistics	COMMENT:
Birth Hospital:	
Birth date:	
Part of multiple birth □NO □YES	
Gestational age □full term □postdate □preterm #weeks:	
Type of delivery □ Vaginal □C-section	
Feeding: □Breast milk □Formula □ BOTH	Formula type:
Newborn hearing completed □PASS □ FAIL	
Newborn screening done at hospital □NO □YES	
Adopted □NO □YES	
Birth measurements Weight: Length:	
Discharge Date: Weight: Length:	