4605 N. College Drive
Cheyenne, WY 82009
P# (307) 459-5437

Dellrange PEDIATRICS

Emily Baker
DNP, APRN, FNP-C

PATIENT REGISTRATION FORM

Today's Date: _____ New Patient (circle one): YES | NO

PATIENT INFORMATION

Gender: Male | Female

Patient Legal First Name: _____ Patient Legal Last Name: _____

Preferred Name:_____ Date of Birth: _____ SSN#: _____

Marital Status: S | M | D | W Spouse's Name (if applicable): _____

Ethnicity (circle one): Hispanic or Latino YES | NO | DECLINE
Race (circle one): African American | American Indian or Native Alaskan | Asian | Native HI or Pacific Islander | Caucasian | Other | DECLINE

ACCOUNT INFORMATION

Address: _____

APT/LOT#: _____ City: _____State: _____ Zip Code: _____

Cell Phone #: _____ Secondary Phone #: _____

Email: _____

Employer:_____ Work Phone #:_____

Emergency Contact : _____ Phone #: _____

Patient Portal

Consent to Patient Portal (circle one): YES | NO (Username will be primary phone number including dashes)

Insurance Information

Primary Insurance

Insurance Co. _____
ID#: _____ Group#: _____
Policy Holder: _____
SSN#: _____ Date of Birth: _____
Employer: _____

Secondary Insurance

Insurance Co. _____
ID#: _____ Group#: _____
Policy Holder: _____
SSN#: _____ Date of Birth: _____
Employer: _____

Preferred Pharmacy:

Pharmacy Name: _____ Location: _____

I authorize the release of any medical or other information necessary to process claims. I also request payment of government benefits to DellRange Pediatrics, who accept assignments. I authorize payment of medical benefits to Laramie Pediatrics for all services rendered by its providers and/or staff.

Signature: _____ Date: _____

Medication and Allergies

Current Prescription Medications:

Name: _____ Dose: _____Frequency: _____

Name: _____ Dose: _____Frequency: _____

Name: _____ Dose: _____Frequency: _____

Name: _____ Dose: _____Frequency: _____

Current Over-the-Counter Medications (include Vitamins & Supplements):

Name: _____ Dose: _____Frequency: _____

Name: _____ Dose: _____Frequency: _____

Name: _____ Dose: _____Frequency: _____

Medication Allergies: _____

_____

Non-Medication Allergies: _____

How did you hear about us? (circle one) Google | Facebook | Other: _____

Patient Medical History

Does you have any serious or chronic illnesses?	[ ] Y	[ ] N	Explain_____
Have you had any serious injuries or accidents?	[ ] Y	[ ] N	Explain_____
Have you had any surgeries?	[ ] Y	[ ] N	Explain_____
Have you been hospitalized?	[ ] Y	[ ] N	Explain_____
Have you been diagnosed with a mental health condition?	[ ] Y	[ ] N	Explain_____

Does you have or ever had:

Asthma, recurrent cough, bronchitis, or pneumonia	[ ] Y	[ ] N	Explain_____
Nasal allergies or eczema	[ ] Y	[ ] N	Explain_____
Issues with sleep	[ ] Y	[ ] N	Explain_____
Problems with ears or hearing	[ ] Y	[ ] N	Explain_____
Problems with eyes, vision, or teeth	[ ] Y	[ ] N	Explain_____
Frequent headaches or other neurologic problems	[ ] Y	[ ] N	Explain_____
Frequent abdominal pain	[ ] Y	[ ] N	Explain_____
Constipation that requires doctor visits	[ ] Y	[ ] N	Explain_____
Recurrent urinary tract infections	[ ] Y	[ ] N	Explain_____
Any heart problem or heart murmur	[ ] Y	[ ] N	Explain_____
Anemia or bleeding problem	[ ] Y	[ ] N	Explain_____
Thyroid or other endocrine problem	[ ] Y	[ ] N	Explain_____
Diabetes	[ ] Y	[ ] N	Explain_____
ADHD/ADD	[ ] Y	[ ] N	Explain_____
Mental Health Issues (anxiety, depression, etc.)	[ ] Y	[ ] N	Explain_____
Use of alcohol or drugs	[ ] Y	[ ] N	Explain_____

Reproductive/Sexual Health:

Are you sexually active?	[ ] Y [ ] N
Partners? (circle one)	Male | Female | Both
Do you use birth control or protection?	[ ] Y [ ] N Explain_____
Any history of STIs or current concerns?	[ ] Y [ ] N Explain_____
(For Females) When was your last menstrual period?	Date_____
Are your cycles regular? (if no, explain)	[ ] Y [ ] N Explain_____
(For Males) Any urinary or sexual function concerns?	[ ] Y [ ] N Explain_____

Immunizations and Preventative Care:

Are you up to date on your vaccines?
Please check any that you are up to date on and provide dates

- ☐ Flu Shot (date:_____)
- ☐ COVID-19 (date:_____)
- ☐ TDaP (tetanus) (date:_____)
- ☐ Pneumonia (date:_____)
- ☐ Shingles (date:_____)
- ☐ HPV (date:_____)
- ☐ Colonoscopy (date:_____)
- ☐ Mammogram (date:_____)
- ☐ Pap smear (date:_____)

Current Symptoms (check all that apply):

- ☐ Unexplained weight loss/gain
- ☐ Chest pain or palpitations
- ☐ Abdominal Pain
- ☐ Constipation/Diarrhea
- ☐ Joint Pain or Swelling
- ☐ Headaches or Dizziness
- ☐ Mood (circle one) Good | Fair | Poor
- ☐ Fatigue
- ☐ Shortness of breath
- ☐ Nausea/Vomiting
- ☐ Urinary Issues
- ☐ Rashes or New Skin Changes
- ☐ Vision or Hearing Changes
- ☐ Stress, Anxiety, Depression

Any thoughts of self-harm? [ ] Y [ ] N

Any other medical or mental health issues/problems _____

Do you see any specialist? [ ] Y [ ] N If yes, who? _____

For what reason or diagnosis? _____

When was your last physical exam? _____ When were your last routine labs? _____

Do you have any other issues or concerns not listed? _____

Family Medical History

Alcohol/Drug Abuse	[ ] Y [ ] N Who?_____	Allergies	[ ] Y [ ] N Who?_____
Anesthesia Risk	[ ] Y [ ] N Who?_____	Arthritis	[ ] Y [ ] N Who?_____
Blood Disease	[ ] Y [ ] N Who?_____	Cancer	[ ] Y [ ] N Who?_____
Diabetes	[ ] Y [ ] N Who?_____	Genetic	[ ] Y [ ] N Who?_____
Gastroenteritis	[ ] Y [ ] N Who?_____	Heart	[ ] Y [ ] N Who?_____
Hypertension	[ ] Y [ ] N Who?_____	Lipids	[ ] Y [ ] N Who?_____
Neurologic Diagnosis	[ ] Y [ ] N Who?_____	Psychiatry	[ ] Y [ ] N Who?_____
Stroke	[ ] Y [ ] N Who?_____	Skin	[ ] Y [ ] N Who?_____
Genitourinary	[ ] Y [ ] N Who?_____	Thyroid	[ ] Y [ ] N Who?_____

Additional Family History/Comments _____

_____

Social History

Occupation: _____	Who lives with you?_____
Tobacco Use (circle one):	Never | Former | Current – how much? _____
Alcohol Use (circle one):	Never | Occasionally | Regularly – how often?_____
Recreational Drug Use:	[ ] N [ ] Y -- Type?_____

Signature: _____ Date: _____

Office Policy

Please initial on each line*

_____(Initial) ***Well Check-Ups***

If your appointment is for a well check-up and a medical concern is addressed during that same appointment, your insurance may apply additional charges. This is not a clinic fee, it is required by insurance billing rules. Examples: Lab testing, X-Rays and ultrasounds, illness (ear infection, rash, etc.), specialist referrals, minor procedures, treatment evaluation for asthma, ADHD, stomach pain, rashes, or other concerns.

_____(Initial) ***Appointments will be provided in a timely manner***

All routine appointments for new and established patients are accommodated within 2 weeks; all urgent appointments for new and established patients will be attempted to be scheduled on a same-day basis, unless the family prefers another day.

_____(Initial) ***Mutual Respect of Time***

We pride ourselves on punctuality at DellRange Pediatrics. Although there can be emergency situations that are out of our control resulting in our running behind schedule, we pledge to provide quality care with minimal wait times to the best of out ability. In order to respect your time, we make the following requests:

1. Arrive early or on time for your appointments. We have to reschedule or squeeze you in whenever there is space, if you arrive more than 10 minutes late.
2. We will provide you with all the time you need, but you must tell us when making the appointment, **ALL** of the reasons you would like to be seen. This prevents us from running out of time and having to schedule another appointment to address other concerns.
3. If you are running late, call the office. We may be able to accommodate you with advance notice.

_____(Initial) ***Payment is Required at the time services are rendered***

This includes applicable coinsurance, co-payments, and deductibles. If you have not met your deductible or participate in a high-deductible insurance plan, we require a minimum of **$80.00** at the time of service. If payment cannot be made at the time of service, a budget agreement can be made.

_____(Initial) ***Private-Pay Accounts***

If you do not have insurance, please come prepared to pay at least **$100.00**. We offer a 20% discount for all private pay services. If payment cannot be made at the time of service, a budget agreement can be made to have the service paid for within 6 months.

_____(Initial) ***Missed Appointments***

Broken appointments represent a cost to us, you, and other patients who could have been seen in the time set aside for you. Patients with **5** missed appointments in a 12-month period will be asked to transfer their records to another practice.

_____(Initial) ***Credit Card on File Policy (Commercial Insurance Only)***

As you may be aware, the current healthcare market has resulted in insurance policies increasingly transferring costs to you, the insured. Some insurance plans require deductibles and co-payments in amounts not known to you or us at the time of your visit. As a result, we do have the ability to keep a credit card or debit card on file. Please be assured that this payment method in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment. If you have any questions about this payment method, please do not hesitate to ask.

_____(Initial) ***Medicaid ONLY***

If your child has Wyoming Medicaid, and is also covered under private insurance, we are required by law to file claims with the private insurance policy first. Wyoming Medicaid plans are **always** considered a secondary insurance. If Wyoming Medicaid is not informed that your child also has private insurance, they have the right to retract payment from previously paid claims. If this occurs, then the entire balance will be the **responsibility of the parent/guardian on file.**

By signing this notice, you acknowledge receipt and understanding of the **Office Policy as outlined above and understand the consequences. **

Signature: _____ Date: _____

Holly Hink DNP, APRN, CPNP

Emily Baker DNP, APRN, FNP-C

American Academy of Pediatrics Member

HIPAA Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of Laramie Pediatrics, PC. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Immunization will be sent to schools, public health, and other doctor offices upon request.

Our Notice of Privacy Practices is subject to change, and we have reserved the right to change it. If we change our notice, you may obtain a copy of the revised notice by contacting our Privacy Officer.

Patient Name (Please Print): _____

Patient Signature : _____ Date: _____

Authority of Personal Representative to Sign for Patient (check one):

____Parent ____Guardian ____Power of Attorney ____Other: _____

Release of Information

I authorize the release of information including diagnosis, records, examination results, medication, and claims information to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

It is your right to refuse to sign this Acknowledgement of Receipt

Office Staff Only

I tried to obtain written acknowledgement by the individual noted above of receipt of our Notice of Privacy Practices but it could not be obtained bud to one of the following:

____ An emergency prevented us from obtaining acknowledgement.

____ A communication barrier prevented us from obtaining acknowledgement.

____ The individual was unwilling to sign.

____ Other: _____

Staff Member Signature: _____ Date: _____

Media Release Form

Patient Name: _____

Patient Testimonial, Video, Photo, Audio Release Consent Purpose of Consent: By signing this form, you are hereby consenting to allow **DellRange Pediatrics** to use and disclose your testimonial, audio, photos and/or videos and you acknowledge that they may be distributed to public.

Right to Revoke: You have the right to revoke this Release at any time by providing written notice of your revocation and submitting it to the Contact Person listed below.

Please understand that revocation of this release will not affect any action **DellRange Pediatrics** took in reliance on this release before receiving your revocation.

Consent to Release: I hereby authorize **DellRange Pediatrics** and staff to use my testimonial, photos, videos, audio and any information contained herein in its media/public relations efforts. I understand and approve the disclosure of the testimonial, photo, video, audio information to the media and other individuals and entities that may be involved in the media/public relations efforts of **DellRange Pediatrics.**

I understand that I am providing the testimonial, photo, video, or audio information to **DellRange Pediatrics** and that my treating healthcare provider will not be providing any protected information to the media or the public, including private health information in my medical records, the confidentiality of which may be protected by federal and state statutes and regulations, including the Health Insurance Portability and Accountability Act (HIPPA).

I waive the right of prior approval and hereby release **DellRange Pediatrics** from any and all claims for damages of any kind based on the use of my testimonial, picture, video, audio, or information in the testimonial.

By signing below, I agree and acknowledge that I have read and understood the above Release and agree to all terms described. I am of legal age and freely sign this Consent to Release my Patient Testimonial and other media I provided to the doctor.

Patient Signature: _____ Date: _____

Patient Name (Print Name): _____