1252 N 22nd St, Suite B, Laramie, WY 82072
P: 307.745.3704 F: 307.207.2050

Vijaya Koduri MD
American Academy of Pediatrics Member

PATIENT REGISTRATION FORM

Today's Date: _____ New Patient (circle one): | Y | N | Foster Child (circle one): | Y | N |

PATIENT INFORMATION

Patient's Legal First Name: _____ Patient's Legal Last Name: _____

Other or Preferred Name: _____

DOB: _____ Gender (circle one): | M | F |

Ethnicity (circle one): Hispanic or Latino | Y | N | Decline |
Race (circle one): | African American | American Indian or Native Alaskan | Asian |
| Native HI or Pacific Islander | Caucasian | Other | Decline |

Parent/Guardian's Name: _____ DOB: _____

Parent/Guardian's Name: _____ DOB: _____

IF 18 & OVER

I authorize Laramie Pediatrics to release information to my parents (circle one): | Y | N |

Patients phone number: _____ Patients email address: _____

Signature: _____

ACCOUNT INFORMATION

Address: _____ APT#: _____ City:_____ State:_____ ZIP Code: _____

Mom's/Primary Phone #: _____ Dad's/Secondary Phone #:_____

Primary Email: _____ Secondary Email: _____

Emergency Contact (other than parent/guardian):_____ Phone #:_____

Consent to Patient Portal: | Y | N | (Portal username will be primary phone number including dashes)

INSURANCE INFORMATION

Private Pay? (circle one): | Y | N |

Primary Insurance:
Insurance Co: _____
ID #: _____ Grp #: _____
Policy Holder: _____
Policy holder SSN #: _____ DOB: _____
Employer: _____

Secondary Insurance:
Insurance Co: _____
ID #: _____ Grp #: _____
Policy Holder: _____
Policy holder SSN #: _____ DOB: _____
Employer: _____

SOCIAL HISTORY

Parent:_____ Circle One: | Biological | Adoptive | Foster | Step |
Parent:_____ Circle One: | Biological | Adoptive | Foster | Step |
Sibling:_____ Circle One: | Biological | Adoptive | Foster | Step |
Sibling:_____ Circle One: | Biological | Adoptive | Foster | Step |
Sibling:_____ Circle One: | Biological | Adoptive | Foster | Step |
Other:_____ Circle One: | Biological | Adoptive | Foster | Step |

If Adopted/Foster/Step circled does child know?: | Y | N |

Do Parent's Reside at the same address: | Y | N |

If no, what is the name of parent who does not reside at the same address: _____

What is the living situation: | Joint Custody | Single Custody | Other |

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Laramie PEDIATRICS

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PATIENT MEDICAL HISTORY

Is your child currently on medication?	Y	N	Explain:_____
Is your child allergic to any medication or drugs?	Y	N	Explain:_____
Does your child have any serious chronic illness?	Y	N	Explain:_____
Has your child ever been hospitalized?	Y	N	Explain:_____
Has your child ever had any surgery?	Y	N	Explain:_____
Physical/Occupational/Speech Therapy?	Y	N	Explain:_____
Is your child in special or resource classes at school?	Y	N	Explain:_____
Does your child see any specialists?	Y	N	Explain:_____

If yes who & for what? _____

Has your child ever had:

Asthma, recurrent cough, bronchitis, or pneumonia?	Y	N	Explain:_____
Nasal allergies or eczema?	Y	N	Explain:_____
Frequent ear infections or sore throats	Y	N	Explain:_____
Problems with ears or hearing	Y	N	Explain:_____
Problems with eyes, vision, teeth	Y	N	Explain:_____
Frequent headaches or neurological problems	Y	N	Explain:_____
Frequent abdominal pain	Y	N	Explain:_____
Constipation requiring doctor visits	Y	N	Explain:_____
Bladder/kidney infection	Y	N	Explain:_____
Any heart problem or heart murmur	Y	N	Explain:_____
Anemia or bleeding problem	Y	N	Explain:_____
Thyroid or endocrine problem	Y	N	Explain:_____
Diabetes	Y	N	Explain:_____
ADHD	Y	N	Explain:_____
Mental Health (anxiety, depression)	Y	N	Explain:_____
Use of alcohol or drugs	Y	N	Explain:_____
Any other medical issues/problems?	Y	N	Explain:_____

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: _____
Genitourinary:	Y	N	Who: _____	Lipids:	Y	N	Who: _____
Hypertension:	Y	N	Who: _____	Psychiatry:	Y	N	Who: _____
Neurological Disorder:	Y	N	Who: _____	Skin:	Y	N	Who: _____
Stroke:	Y	N	Who: _____	Thyroid:	Y	N	Who: _____

I have completed this form entirely and certify that I am the patient or duly authorized agent of the patient authorized to furnish the information requested. I understand that even though I have some type of insurance coverage, I am responsible for payment of the service and any interest applied to the unpaid balance. I authorize payment of government benefits to Laramie Pediatrics, who accepts assignment. I authorize payment of medical benefits to Laramie Pediatrics for all services rendered by its providers and/or staff. I also authorize the release of any medical information to process any insurance claims.

Patient Signature:_____ **Date:**_____

OFFICE POLICY

PLEASE INITIAL ON EACH LINE

_____**(Initial) Well Check-ups are Required**

At Laramie Pediatrics, we feel strongly about children having routine well check-ups. Per American Academy of Pediatrics, children should receive health care at the following ages:

Newborn period	6 months of age	24 months of age
2 weeks of age	9 months of age	30 months of age
1 month of age	12 months of age	3-21 yrs of age --- on a yearly basis
2 months of age	15 months of age	
4 months of age	18 months of age	

We expect our parents to follow these guidelines so that we may continue to provide quality healthcare to our patients.

_____**(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 Laramie Pediatrics. Although there can be emergency situations that are out of control resulting in our running behind schedule, we pledge to provide quality care with minimal wait times to the best of our ability. In order to respect your time, we make the following requests:

1. Arrive early or on time for your, appointments. We may have to reschedule or squeeze you in whenever there is space, if you arrive more than 10 minutes late.
2. If you plan on having an additional child seen during an appointment, please notify us in advance so that we can provide sufficient time with you.
3. We will provide you with all of the time you need, but you must tell us when making the appointment ALL of the reasons you would like your child to be seen. This prevents us from running out of time and having to schedule another appointment to address other concerns.
4. If you are running late, call the office. We may be able to accommodate you with advanced 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 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 number 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, do not hesitate to ask.

_____**(Initial) Medicaid Only**

If your child has Wyoming Medicaid, and is also covered under private health 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. You also understand that you are ultimately responsible for the charges incurred by your child as their legal parent or guardian.

Patient Signature:_____ **Date:**_____

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HIPPA 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.

Immunizations will be sent to schools, public health, and other Dr. 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 (print)

_____ _____
Patient Signature (Patient must sign if 18 or over) Date

_____ _____
Parent/Guardian name (Please Print) Parent/Guardian Signature

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

_____Parent _____Guardian _____Power of Attorney Other:_____

Please Note: 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 due to one of the following:

_____ An emergency prevented us from obtaining the acknowledgment.

_____ A communication barrier prevented us from obtaining acknowledgment

_____ The individual was unwilling to sign.

_____ Other:_____

_____ _____
Staff member signature Date

THIS ACKNOWLEDGEMENT WILL BE SCANNED INTO THE PATIENT'S PERMANENT ELECTRONIC MEDICAL RECORD

Laramie Pediatrics
1252 N 22nd St, Suite B, Laramie, WY 82072
Office Phone: 307.745.3704
Fax: 307.207.2050
Email: fdlaramie@laramiekids.com

Authorization to Release Medical Information

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

I authorize the release of the following protected health information:

- ☐ Office Notes/Current Immunization Record
- ☐ Other (Specify) _____

The purpose for this request to release medical information:

- ☐ Medical Care/Treatment
- ☐ Insurance
- ☐ Other (Specify) _____

Please provide information from previous Clinic/Provider

Name: _____

Phone Number: _____ Fax Number: _____

Address: _____

City, State, Zip Code: _____

I understand that:

- By signing this form, I am authorizing the use of disclosure of protected health information as indicated above.
- I may refuse to sign this authorization, which will not affect my treatment or payment for health care.
- I may revoke this authorization at any time for the information I have requested is release by providing written notice of revocation as specifies in the Notice of Privacy Practices.
- If the receiving party is not subject to medical records privacy laws, the information may be redisclosed by the recipient and may no longer be protected by federal or state law. Dellrange Pediatrics shall not be held liable for any consequences resulting from re-disclosure.
- Alcohol or substance abuse, mental health, or psychiatry notes may have additional compliance requirements that must be met before the information can be released.
- A copy of this signed form will be provided to me.

_____ _____

Parent – Representative Signature Date

If the patient(s) listed above is a minor or is unavailable and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following.

_____ _____