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

Dellrange PEDIATRICS

Holly Hink DNP, APRN, CPNP
Emily Baker DNP, APRN, FNP-C
American Academy of Pediatrics Member

PATIENT REGISTRATION FORM

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

PATIENT INFORMATION

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

Other or Preferred Name:_____ Date of Birth: _____ Gender: M | F

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

Parent/Guardian's Name: _____ Date of Birth: _____

Parent/Guardian's Name: _____ Date of Birth: _____

If 18 & Over*

I authorize DellRange Pediatrics to release information to my parents (circle one): YES | NO

Patient Phone Number: _____ Patient Email: _____

Patient Signature: _____

ACCOUNT INFORMATION

Patient Lives With: _____ Send Bills To: _____

Address: _____ Address: _____

APT/LOT#: _____ City: _____ APT/LOT#: _____ City: _____

State: _____ Zip Code: _____ State: _____ Zip Code: _____

Mom Primary Phone #: _____ Mom Secondary Phone #: _____

Dad Primary Phone #: _____ Dad Secondary Phone #: _____

Mom Email: _____ Dad Email: _____

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

Patient Portal

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

Preferred Pharmacy:

Pharmacy Name: _____ Location: _____

Insurance Information Private Pay? (circle one) YES | NO

Primary Insurance

Insurance Co. _____

ID#: _____ Group#: _____

Policy Holder: _____

SSN#: _____ DOB:_____

Employer: _____

Secondary Insurance

Insurance Co. _____

ID#: _____ Group#: _____

Policy Holder: _____

SSN#: _____ DOB:_____

Employer: _____

****The parent/guardian who brings the child for the appointment is ultimately responsible for any balance due for services rendered.****

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.

Parent or Guardian Signature: _____ Date: _____

Patient Signature (if over 18): _____ Date: _____

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

Sibling: _____ (circle one) Biological | Adoptive | Foster | Step

Other: _____ (circle one) Biological | Adoptive | Foster | Step

If adopted/foster/step are circled above, does this child know? (circle one) YES | NO

Do both parents reside at the same address as the patient? (circle one) YES | NO

What is the living situation? (circle one) Joint Custody | Single Custody | Other

What is the name of the parent who does not reside at the same address as the patient?

_____

Medication and Allergies

Current Medications: _____

Medication Allergies: _____

Non-Medication Allergies: _____

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

Patient Medical History

Is your child currently on any medications?	[ ] Y [ ] N Explain_____
Does your child have any serious or chronic illnesses?	[ ] Y [ ] N Explain_____
Has your child had any serious injuries or accidents?	[ ] Y [ ] N Explain_____
Has your child had any surgeries?	[ ] Y [ ] N Explain_____
Has your child ever been hospitalized?	[ ] Y [ ] N Explain_____
Is your child allergic to any medicine or drugs?	[ ] Y [ ] N Explain_____
Has your child had any reactions to immunizations?	[ ] Y [ ] N Explain_____

Does your child have or 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, 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_____
Bladder/kidney infection or bed-wetting (after 5 years)	[ ] 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_____

Any other medical or mental health issues/problems _____

_____

Does your child see any specialist? [ ] Y [ ] N If yes, who? _____

For what reason or diagnosis? _____

Has your child ever had Occupational Therapy, Physical Therapy, or Speech Therapy? [ ] Y [ ] N Explain _____

_____

Is your child in special or resource classes in school? [ ] Y [ ] N Explain_____

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 _____

_____

Parent/Guardian Signature: _____ Date: _____

Patient Signature (if over 18): _____ Date: _____

Office Policy

*****Please initial on each line*****

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

At DellRange 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	*3-12 years of age on 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) ***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 patient 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. 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 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 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. You also understand that you are ultimately responsible for the charges incurred by your child as their legal parent or guardian.**

Parent/Guardian Signature: _____ Date: _____

Patient Signature (if over 18): _____ Date: _____

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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 (Must be 18 to sign): _____ Date: _____

Parent/Guardian Name (Please Print): _____

Parent/Guardian 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.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name (Print Name): _____

Patient Signature (if over 18): _____ Date: _____

Patient Name (Print Name): _____