Patient Name: _____ Date: _____

Airway Pediatrics
Office (509) 418.2799
Fax (509) 461.5287

10408 West Sunset Highway #3
Spokane, Washington 99224
Contact@Airwaypediatrics.com

Patient Registration Form

PATIENT INFORMATION:

Patient Name: _____

Sex: _____ DOB: _____ Age: _____ Race: _____

Address: _____

City / State: _____ Zip: _____

Phone: ( ) _____

Please *List all doctors this patient has seen in the last 3 years - please estimate the month / year last seen*

Doctor	**Month/Year**
1. _____	_____
2. _____	_____

Emergency Contact: Name: _____ Phone #: ( ) _____
Relationship to child: _____

INSURANCE INFORMATION: *(Please have insurance card available for front staff to copy)*

Primary Ins: _____ Primary Ins Phone #: _____

Address to Send Claims: _____

Policy ID #: _____Group #: _____ Effective Date: _____ Co-pay Amt: _____

Policy Holder's Name: _____ DOB: _____ Sex: _____

Address: _____

Social Security # _____ Relationship to Policy Holder: _____

Secondary Ins: _____ Secondary Ins Phone #: _____

Address to Send Claims: _____

Policy ID #: _____Group #: _____ Effective Date: _____ Co-pay Amt: _____

Policy Holder's Name: _____ DOB: _____ Sex: _____

Address: _____

Social Security # _____ Relationship to Policy Holder: _____

If your child has more than two insurances, please add them here: _____

PARENT 1

Parent Name: _____

DOB: _____ SSN#: _____

Address: *(if different than child)* _____

City / State: _____ Zip: _____

Phone: ( ) _____ Occupation: _____ Work Phone: ( ) _____

Relationship to Patient. Circle One: MOTHER FATHER STEPPARENT LEGAL GUARDIAN

Is this parent/legal guardian the Guarantor/Responsible Party for your child's insurance? YES NO

PARENT 2

Parent Name: _____

DOB: _____ SSN#: _____

Address: (*if different than child)* _____

City / State: _____ Zip: _____

Phone: ( ) _____ Occupation: _____ Work Phone: ( )_____

Relationship to Patient. Circle One: MOTHER FATHER STEPPARENT LEGAL GUARDIAN

Is this parent/legal guardian the Guarantor/Responsible Party for your child's insurance? YES NO

PHARMACY INFORMATION:

Name: _____ Location/City: _____

Phone #: ( ) _____

SURGICAL HISTORY:

(Type of surgery, hospitalizations, or major illness. Date, Location, and Doctor)

_____

_____

_____

FAMILY HISTORY

Please circle if your child's immediate family has a history of:
*Immediate family includes Mother / Father / Siblings.

ANESTHESIA ISSUES	GI DISORDER	AUTOIMMUNE DISORDER	THYROID / ENDOCRINE DISORDER
CARDIOVASCULAR DISEASE	ASTHMA / ALLERGIES	DIABETES	CANCER

Other family history we should know about?

_____

_____

_____

MEDICATION HISORTY

MEDICATION	CURRENT DOSAGE	PRESCRIBING PROVIDER

CHILDS MEDICAL HISORY

Please circle which applies to your child. Or check the box if none. ☐ **NO KNOW ISSUES**

ADHD	BIRTH COMPLICATIONS	DEPRESSION	GERD (reflux)	INSOMNIA
ANEMIA	BIPOLAR	DIABETES	HYPERLIPIDEMIA	SEIZURE DISORDERS
ARTHRITIS	BLEEDING DISORDER	DRUG / ALCHOHOL ABUSE	HYPERTENSION	SHORTNESS OF BREATH
ASTHMA	CANCER	HEART DISEASE	HYPOTHYROIDISM	SINUS CONDITION
AUTISM	CHEST PAIN	HEART MURMUR	INFECTION PROPLEMS	STROKE
KIDNEY PROBLEM	PREMATURE DELIVERY	IRRITABLE BOWEL SYNDROME	MIGRAINES / HEADACHES	TREMORS

OTHER CONDITIONS: _____

ALLERGIES

Please circle which allergies your child has:

ADHESIVE TAPE	ANESTHESIA	CODEINE
FOOD / OTHER	IODINE / SHELLFISH / CONTRAST DYE	LATEX
PENICILLIN	SULFA DRUGS	**NO KNOWN ALLERGIES**

Allergy details: _____

REGISTER ADDITIONAL CHILDREN (under the same Guarantor):

NAME	DATE OF BIRTH	GENDER

Assignment and Release

I give permission to Airway Pediatrics to release any information required to process all claims regarding my child / patient. I hereby authorize my insurance benefits be paid directly to Airway Pediatrics, and that I am financially responsible for all non-covered services. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

_____

Parent / Legal Guardian Name

_____ _____

Parent / Legal Guardian Signature **Date**