BEST ANGELS PEDIATRICS

7950 Cherry Ave. STE 105. Fontana, CA 92336. Phone: (909) 434-1657 Fax: (909) 231-6231

PATIENT'S REGISTRATION FORM

New Patient: yes / no Change of Address/ Insurance: yes / no **Date** _____/____/_____

PATIENT'S INFORMATION:

1st Child's Name: Last _____ First _____ M.I. _____ **D.O.B**____/_____/_____

Gender: M____ F____ SSN: _____-_____-_____ Race _____ Ethnicity _____Religion_____

2nd Child's Name: Last _____ First _____ M.I. _____ **D.O.B**____/_____/_____

Gender: M____ F____ SSN: _____-_____-_____ Race _____ Ethnicity _____Religion_____

3rd Child's Name: Last _____ First _____ M.I. _____ **D.O.B**____/_____/_____

Gender: M____ F____ SSN: _____-_____-_____ Race _____ Ethnicity _____Religion_____

Patient's Address_____ City_____ State _____Zip _____

Cell phone: (_____) _____ Home phone: (_____) _____ Preferred Phone: Cell / Home

E-mail:_____ Preferred Language: _____

Hearing Impairment: Yes __ No __ Submit Vaccines Records to CA vaccines registry (CAIR)? Yes__ No__

PARENTS/ GUARANTOR INFORMATION:

Mother's Name Last _____ First _____D.O.B _____ SSN _____-_____-_____

Home Address (same as patient___) _____ City_____ State _____Zip _____

Cellphone (_____) _____ Home phone (_____) _____ Work phone (_____) _____

Occupation _____ Work Address _____ City_____ State _____Zip _____

Father's Name Last _____ First _____D.O.B _____ SSN _____-_____-_____

Home Address (same as patient___) _____ City_____ State _____Zip _____

Cellphone (_____) _____ Home phone (_____) _____ Work phone (_____) _____

Occupation _____ Work Address _____ City _____ Zip _____

PRIMARY INSURANCE INFORMATION: **Primary Subscriber**: Mother _____ Father _____ Other _____

Name: Last _____ **First** _____ D.O.B _____ SSN _____-_____-_____

Health Plan _____ **Insurance ID#** _____ Group# _____

Address (same as patient___) _____City_____ State _____Zip _____

SECONDARY INSURANCE INFORMATION:

Name: Last _____ **First** _____ D.O.B _____ SSN _____-_____-_____

Health Plan _____ **Insurance ID#** _____ Group# _____

Address (same as patient___) _____City_____ State _____Zip _____

EMERGENCY CONTACT INFORMATION: (Other than Parents/ Legal Guardian)

Name _____ Relationship to patient _____

Address _____ City_____ State _____Zip _____

Cellphone (_____) _____ Home phone (_____) _____ Work phone (_____) _____

Completed by: _____ Mother / Father/ Foster parent / legal guardian / other _____

BEST ANGELS PEDIATRCIS

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CONSENT TO TREAT A MINOR/CHILD

Today's Date: _____/_____/_____

1st Patient's/Child's Name: _____ **Date of Birth**_____/_____/_____
Last. First . M.I.

2nd Patient's/Child's Name: _____ **Date of Birth**_____/_____/_____
Last. First . M.I.

3rd Patient's/Child's Name: _____**Date of Birth**_____/_____/_____
Last. First . M.I.

I, _____, the parent/legal guardian of the child/minor named in this document, give the permission to the health care provider to administer such examination, treatment, testing, vaccinations, medical plan and procedures as are deemed necessary in the course of the child/minor care.

AKNOWLEDGMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICE (HIPPA):
I understand and have been provided with a notice of privacy practices (privacy notice), which provides a more complete description of information and disclosures. I understand that I have a right to review the notice before signing it. I understand that I have the right to revoke this consent in writing, except to the extent that the healthcare provider has already taken action on my behalf.
I, the parent/legal guardian of the patient named in this document, have received a copy of this office's Notice of Privacy Practice.

SUBMISSSION OF VACCINES INFO TO CA IMMUNIZATION REGISTRY (CAIR)
I, the parent/legal guardian of this patient give permission to Best Angels Pediatrics to submit vaccines records to CA Registry (CAIR).

FINANCIAL RESPONSIBILITY:
Information about me necessary to substantiate my insurance claims may be used by the healthcare provider involved in my care. I hereby authorize any insurance carrier with whom I have a policy to pay directly to the healthcare provider any benefits of any policies of insurances to the healthcare provider who has rendered the service to me and who accept such assignment. I agree to pay all charges that are not paid in full by assigned insurance. If such amounts due to the healthcare provider are not paid after reasonable notice, that account shall be deemed delinquent and a service charge fees shall be added to the amount due. In the event that I default on payment of my account, I agree to be responsible for the collection fees and interest due on amounts in default, including court costs and reasonable attorney's fees. If the debt is assigned to a third party for collection, I agree to be responsible for collection fees and interest due on amount in default.

OFFICE FINANCIAL POLICY:

- PAYMENTS/CO-PAYS: The patient is expected to present an insurance card at each visit. All co-payments, deductibles, co-insurance and past due balances are due and payable at the time of service. The patient/parent is expected to inform the office with any change of health plan/insurance or contact information at each visit.
- SELF-PAY ACCOUNTS: Self-pay accounts are patients covered by insurance plans in which the provider does not participate, patients without an insurance card on file, or patients who do not have any insurance coverage. The parents shall pay in full at the time of service.
- NON-PARTICIPATING INSURANCE PLANS: we will file to these insurance plans as a non-assigned claim as a courtesy to our patients. The parents shall pay in full at the time of service. The insurance company may or may not reimburse the parent on non-assigned claims.
- PATIENT REFUNDS: The following criteria must be met prior to issuing a patient refund: there are no outstanding insurance claims on the family's account, and there are no outstanding patient balances on the family's account.
- CHILD CUSTODY CASES: The custodial parent is responsible for co-payments at the time of service for participating instances and for all past due balances. If the non-custodial parent carries the insurance, the office will bill that insurance company. It is the parents' obligation to work out an agreement and insure payment to our office.
- AFTER HOURS: a fee may apply to any medical services rendered after hours including medical consult over the phone.
- CHECKS: we do NOT accept checks.
- FORMS FEE: a fee may be applied for School physical forms / sport physical forms / special letter/ vaccines records/ and medical records.

MISSING APPOINTMENT: *$25.00 fee may be applied for missed appointment, unless canceled or rescheduled 24 hours in advance.*

By signing this document, I agree/ give permission on all items listed in this document.

Name: _____

Relationship To Patient (Circle one): Mother , Father , Foster Parent , Legal Guardian , Other: _____

Signature _____

Witness (Name and Signature) _____ Title _____ Date _____

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Patients Name: _____ Date of Birth: _____ Relationship to Patient _____

Please Circle Yes or No, explain where required. N/A - Not Applicable

PREGNANCY & BIRTH:

Mothers Health During Pregnancy? _____
Medications During Pregnancy? YES or NO
Hospital Name: _____
Gestation Weeks _____
Type of Delivery? C-Section Vaginal
Birth Weight _____
Newborn Hearing Test : PASSED FAILED
HEP B Vaccine given at birth? YES NO
Complications? YES NO Breech? YES NO
Problems with baby during birth: _____
Jaundice? YES NO
Smoking, Alcohol, Street drugs, during pregnancy? YES NO
Other problems during Pregnancy? _____

CHILD'S PAST MEDICAL HISTORY

Allergies to Medicine? YES NO / Food? YES NO
Any Surgeries? YES NO
Immunizations up to date? YES NO
Hospitalization (when, where, why)? _____
Serious Injuries (when, where)? _____

Asthma	YES	NO	Vision Problems	YES	NO
Allergic Rhinitis	YES	NO	Hearing Problems	YES	NO
Ear Infection	YES	NO	Joint Problems	YES	NO
Eczema/Hives	YES	NO	Skin Problems	YES	NO
Autism	YES	NO	Developmental Problems	YES	NO
Seizures	YES	NO	Heart Problems	YES	NO
UTI / Genital Urinary	YES	NO	Abdominal Problems	YES	NO
Speech Delay	YES	NO	ADD/ADHD/Psychiatric	YES	NO
Blood Disorder	YES	NO	Depression	YES	NO
Neurological / CP	YES	NO	Kidney Problem	YES	NO

NUTRITION

Appetite usually good? YES NO
Colic or feeding problems during first 3 months? YES NO
Breast fed? YES NO /Formula YES NO Brand:_____
Drinks Milk? YES NO
Eats Fruit? YES NO
Eats Vegetables? YES NO

SOCIAL HISTORY

Language Spoken at home: English Spanish Other:_____
Child Lives with:
Mother_____ Father_____ Both_____ Grandmother_____
Aunt _____ Guardian _____ Father/Mother Involved YES
NO Smokers at home? YES NO / Pets? YES NO

DEVELOPMENT & BEHAVIOR

Age at which child:
Sat Alone _____
Walked _____
Used Sentences / Speech _____
Teeth _____

SCHOOL AGE CHILD

Grade in school _____ Likes School YES NO
Problems in school? YES
NO Learning Problems? YES
NO Behavior Problems? YES
NO Bad Habits?
YES NO
Bedwetting? YES NO / Sleeping well YES NO
Smoking? YES NO
Use street or illegal drugs? YES NO
Any Hobbies or sports? _____

FAMILY MEDICAL HISTORY

List all blood relatives of your child who have had the following problems:

Allergies: _____
Asthma: _____
Allergic Rhinitis: _____
Eczema: _____
Blood Disorder: _____
Mental Illness: _____
Drug Problem: _____
Cancer: _____
Arthritis/Hip Disorder: _____
Epilepsy/Seizures: _____
Heart Disease/Cholesterol Problem: _____
High Blood Pressure: _____
Migraine: _____
Deafness: _____
Diabetes: _____
Stomach Problems: _____
Thyroid Problems: _____
Vision Problems: _____

Explain other concerns:

List of Medications:

Signature: _____ Date: _____