



Pediatric New Patient Registration

PATIENT INFORMATION

Last Name:	First Name:	Midde Initial:	Preferred Name:
Date of Birth:	Age:	Sex Assigned at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number:
Home Address:		City:	State:
Mailing Address (if different):		City:	State:
Phone:			
Home Phone: _____ Message Phone: _____			
Cell Phone: _____ Email: _____			
Student Status: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Not a student			

PARENT / GUARDIAN INFORMATION

Mother's Name:	Date of Birth:	Phone:
Father's Name:	Date of Birth:	Phone:
Patient's Legal Guardian or Representative if different than above: If patient has a legal guardian or representative, please provide that information (proof required legal guardian, representative, or medical power of attorney, etc.).		
Legal Guardian or Representative Name: _____		Date of Birth: _____
Social Security #: _____		Phone: _____
Name of person patient primarily lives with: _____		
Relationship to patient: _____		
Phone: _____		

RESPONSIBLE PARTY WHO HAS FINANCIAL RESPONSIBILITY FOR THE PATIENT

Responsible Party Name:	Date of Birth:	SSN:
Phone Number:	Address:	

City:	State:	Zip:	Employer:
Occupation:	Business Address:	Phone:	

INSURANCE INFORMATION

Name of Primary Insurance:

Group #:	Policy #:
Policyholder (PH) Name:	PH Date of Birth:
PH Social Security #:	PH Relationship to Patient:

Name of Secondary Insurance (if applicable):

Group #:	Policy #:
Policyholder (PH) Name:	PH Date of Birth:
PH Social Security #:	PH Relationship to Patient:

EMERGENCY CONTACT FOR PATIENT

Name:	Relationship:	Phone:
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Preferred Pharmacy:

Advance Directive Completed? Yes No **POLST Completed?** Yes No **Organ Donor?** Yes No

Signature of Patient or Parent / Guardian of Minor Child: _____

Date: _____

ADDITIONAL PATIENT INFORMATION

Patient Name:	Date of Birth:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other	Name of partner / spouse (if applicable):
Employer:	Occupation:
Business Address:	Phone:
*Patient's Race: <input type="checkbox"/> American Indian / Alaska Native <input type="checkbox"/> Black / African American <input type="checkbox"/> Other <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Declined	
*Patient's Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Declined	
*Patient's Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____	

**The collection of this information is legal and authorized under Title VI of the Civil Rights Act of 1964. The purpose of gathering this information is to improve the overall quality of healthcare offered. The information gathered is helpful in measuring trends, identifying disparity gaps in healthcare, and implementing targeted intervention toward specific populations that may be at a higher risk for certain illnesses. This information will never be used to profile patients or discriminate against patients in any way.*

REQUEST FOR CONFIDENTIAL COMMUNICATIONS REGARDING MEDICAL INFORMATION

I request that Saint Moscati communicate with me confidentially about medical matters in the following manner:

Patient's Preferred Method of Contact: Phone Email**

Would you like the clinic to leave medical information for you in a voicemail? Yes No

Would you like to be enrolled in the Patient Portal to access your health file? Yes No

Would you like to receive Text notifications for appointment reminders? Yes No

Saint Moscati may disclose my protected health information (PHI) to the following person(s)

(Please note: If you want to allow us to disclose PHI to your spouse/child/etc, his/her name MUST be listed below):

SIGNATURE BLOCK

Consent to Obtain Medication History from Pharmacies through e-Prescribing:

I hereby give my consent to Saint Moscati, including its licensed practitioners and employees, to access, use and disclose my protected health information to any pharmacies I currently use or will use in the future for the purpose of transmitting prescriptions to them for my treatment. I consent to the disclosure of my prescription medication information by any provider, mental health provider, pharmacy, insurer or prescription benefits manager, specifically including any state or federal health program to Saint Moscati and pharmacies for the purpose of my treatment. My consent includes the re-disclosure of protected health information maintained by a drug or alcohol treatment program.

Signature of Patient or Legal Representative

Date

Relationship to Patient

Assignment of Insurance Benefits/Release of Information

I authorize Saint Moscati to release any information including the records of any treatment or examination rendered during the period of such care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly Saint Moscati benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for the payment of all services rendered on my behalf for myself or my dependents. I authorize the use of my signature on all my insurance submissions.

Signature of Patient or Parent/Guardian of Minor Child: _____

Date: _____

Medicare Authorization
IF YOU ARE COVERED BY MEDICARE, PLEASE SIGN AND DATE BELOW

I request payment of authorized Medicare benefits be made either to me or on my behalf to Juan Luis Castillo, FNP-C/Saint Moscati for any services furnished to me by SM. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the health care provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services, Co-Insurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature of Beneficiary: _____
Date: _____

**Patient Acknowledgment of Receipt of Notice of Privacy Practices, Patient Rights & Responsibilities
Office Policies and Financial Policy**

Your name and signature below indicate that you have received a copy of the Saint Moscati Notice of Privacy Practices and Patient Rights & Responsibilities on the date indicated. If you have any questions regarding the information in Saint Moscati's Notice of Privacy Practices, please do not hesitate to contact the Practice Administrator as indicated on the notice. Your signature also indicates that you have received a copy of the Saint Moscati's Financial Policy. By my signature I agree to the terms outlined in the financial policies. Please contact Clinic Manager if you have any questions.

Patient Name (Printed): _____ **Date:** _____

Signature of Patient or Parent/Guardian of Minor Child: _____

Relationship to (if not patient): _____

No-Call, No-Show Cancellation Policy

We value your time and strive to provide the best possible care to all our patients. To ensure we can accommodate everyone efficiently, we have the following policy regarding missed appointments:

- A **\$25 fee** will be charged for any **missed appointment** if you do not give at least a **24-hour notice** prior to cancellation of your appointment.
- Each patient is allowed **up to 4 missed appointments** within a **12-month period**.
 - **1st Missed Appointment:** \$25 fee applied.
 - **2nd Missed Appointment:** \$25 fee applied.
 - **3rd Missed Appointment:** \$25 fee + written warning.
 - **4th Missed Appointment:** Discharge from the practice.

Please note:

- Cancellations must be made **at least 24 hours in advance** to avoid the fee.
- Missed appointments will be reviewed on a case-by-case basis.

Signature of Patient or Parent/Guardian of Minor Child: _____
Date: _____

Consent for Treatment

I (or my legal guardian/parent) authorize Saint Moscati to provide medical care reasonable by current best practice guidelines and standards.

Signature of Patient or Parent/Guardian of Minor Child: _____

Date: _____

Patient Social Media Policy

At Saint Moscati Community Health Care, we prioritize patient privacy and respect for our staff. By engaging with our clinic on social media, you agree to the following:

- **Privacy:** Do not share confidential medical information about yourself or others. Do not take photos, videos, or recordings without permission.
- **Respect:** Offensive, false, or threatening comments about the clinic, staff, or patients will not be tolerated.
- **Reviews:** You may leave honest reviews, but do not disclose specific medical details or post misleading information.
- **Use of Branding:** Unauthorized use of the clinic's name, logo, or images is prohibited.
- **Consequences:** Violations may result in service restrictions or legal action.

Signature of Patient or Parent/Guardian of Minor Child: _____

Date: _____

Narcotic (Opioid) Prescription Policy – Patient Acknowledgment

Saint Moscati is committed to safe and responsible pain management. As part of our dedication to fighting the opioid crisis and preventing addiction, we have adopted the following prescribing policy:

We only prescribe narcotic (opioid) medications for **short-term use in the following cases:**

- Pain experienced after a **severe, acute injury**.

These prescriptions will be **limited in dose and duration** to support safe recovery. We **do not** prescribe opioids for chronic pain or long-term use. We will work with you to manage pain using safer alternatives such as non-narcotic medications, therapy, and specialist referrals when appropriate. If you have any questions, we encourage you to discuss them with your provider.

Patient Acknowledgment: I have read and understand Saint Moscati's narcotic prescription policy.

Signature of Patient or Parent/Guardian of Minor Child: _____

Date: _____



PRIMARY CARE PEDIATRIC HEALTH HISTORY

Patient Name:	Date of Birth:	Age:	Date:
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Previous Primary Care Provider:	Last Visit:
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CURRENT HEALTH

Present Health Concerns:

MEDICATIONS: Please list ALL medications including Vitamins, herbs, home remedies

Medication Name	Strength (mg)	Directions	Reason for Taking

ALLERGIES: or reactions to medications, environmental, animals, food, vaccines, etc.

Allergy	Symptoms or Reaction

PHARMACY

Please list pharmacy:

DENTAL: Has the patient been seen by a dentist? Yes No If yes, date of last visit:

Name of Dental Provider:	How often are they seen:
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Has the patient had dental sealants: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	If yes, when:
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EYE EXAM

Has the patient had an eye exam? Yes No If yes, when:

BLOODWORK

Has the patient had bloodwork done? Yes No If yes, when:

IMMUNIZATIONS: Please bring the patients immunization records with you

Up to date? Yes No Unsure Reactions to past vaccines (if any):

ADOLESCENT HEALTH QUESTIONNAIRE (for ages 12 and older) Please have the **PATIENT** answer the following questions.

Do you use tobacco or nicotine? Yes No Previously What type:

*In the **last 12 months**, did you:*

Drink any alcohol (more than a few sips)? No Yes

Smoke any marijuana or hashish? No Yes

Use anything else to get high? No Yes

Have or do you EVER:

Have you ever ridden in a car driven by someone (including yourself) who was "high" or had been using alcohol or drugs?
 No Yes

Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in? No Yes

Do you ever use alcohol or drugs while you are by yourself or alone? No Yes

Do you ever forget things you did while using alcohol or drugs? No Yes

Do your family or friends ever tell you that you should cut down on your drinking or drug use? No Yes

Have you ever gotten into trouble while you were using alcohol or drugs? No Yes

During the past 2 weeks, have you been bothered by little interest or pleasure in doing things? No Yes

During the past 2 weeks, have you been bothered by feeling down, depressed, or hopeless? No Yes

MEDICAL HISTORY

Please describe any major medical problems (Asthma, Seizures, Heart Problems, Diabetes, etc.):

Child's School:	Grade:
Are there any pets in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list:	
Does anyone in the home smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No Who? <input type="checkbox"/> Inside <input type="checkbox"/> Outside <input type="checkbox"/> Car	
Please list any sports played or hobbies:	

FAMILY MEDICAL HISTORY

Please list any family member with any of the following conditions:

1. Cancer:
2. Birth Defects:
3. Stroke:
4. Mental Illness:
5. Hypertension:
6. Heart Disease:
7. Diabetes:
8. Asthma:
9. Arthritis:
10. Osteoporosis:
11. Migraines:
12. Other medical conditions: