Victor Wilson, M.D.
PEDIATRIC PATIENT REGISTRATION

PATIENT INFORMATION

Patient Name _____ Social Security Number _____
Last First MI

Mailing Address _____ City _____ State _____ Zipcode _____

Date of Birth _____ Sex: M F Primary Phone # _____ Secondary Phone # _____

E-mail address _____

Race _____ Ethnicity _____ Language Preference _____

Pharmacy Preference _____

Who referred you to our office? _____

FATHER'S INFORMATION or Guardian

Name _____ Date of Birth _____ Social Security Number _____
Last First MI

Mailing Address _____ City _____ State _____ Zipcode _____

Best Telephone Contact Number _____

MOTHER'S INFORMATION or Guardian

Name _____ Date of Birth _____ Social Security Number _____
Last First MI

Mailing Address _____ City _____ State _____ Zipcode _____

Best Telephone Contact Number _____

PRIMARY INSURANCE INFORMATION

Name of Insurance _____ ID # _____ Group # _____

Subscriber's Name _____ Subscriber's Date of Birth _____

Subscriber's Social Security # _____ Relationship to Patient _____

SECONDARY INSURANCE INFORMATION

Name of Insurance _____ ID # _____ Group # _____

Subscriber's Name _____ Subscriber's Date of Birth _____

Subscriber's Social Security # _____ Relationship to Patient _____

RELEASE OF INFORMATION

I have been given and reviewed the Notice of Privacy Policy (on request). I understand that I am giving the following person(s) permission to bring my child to appointments. In order for the individuals to schedule appointments or receive medical and financial information it must be indicated below.

Name: _____ Telephone #: _____	Relationship:
Name: _____ Telephone #: _____	Relationship:
Name: _____ Telephone #: _____	Relationship:

Initial History Questionnaire

Child's Name _____

Birth Date _____ Gender F M

Form Completed by: _____ **Date form completed** _____

Family History: Please list all those living in the child's home

Name	Relationship to Child	Name	Relationship to Child

Are your child's parents: Married Unmarried Separated Divorced Other: _____

If anything besides Married, who has primary custody? Mother Father Joint

Is there smoking/vaping in the home?.....No Yes

Do you have: Guns in the home? No Yes If yes: Are they locked up? No Yes

Pets in the home? No Yes If yes, types and names: _____

_____

_____

Birth History Please circle and explain the answer

Birth weight _____ Birth Length _____ Birth Place _____

Was baby full term ….....No Yes Explain _____

Did mother have any illness with pregnancy?.....No Yes Explain _____

Did the baby go home with mother from hospital?.....No Yes Explain _____

Did baby have any problems right after birth?.....No Yes Explain _____

During pregnancy, did mother..... Smoke _____ Drink Alcohol _____ Use drugs or medications _____

Was the delivery Vaginal _____ Cesarean _____ If cesarean, why? _____

Was initial feeding Breast _____ Bottle _____

Was Hepatitis B Vaccine given in hospital? _____ If so, what was date given? _____

General

Do you consider your child to be in good health?..... Yes No Explain _____

Does your child take any medications?..... Yes No Explain _____

Is your child allergic to an medicines or drugs?..... Yes No Explain _____

Does your child have any serious illness or medical conditions?..... Yes No Explain _____

Has your child had any serious injuries or accidents?..... Yes No Explain _____

Has your child had any surgeries or been hospitalized?..... Yes No Explain _____

Development

Are you concerned about your child's ___ Physical Development? ___ Mental or emotional development? ___ Attention Span?

Explain _____

How is his/her behavior in school? _____ Failed or repeat any grade in school? _____

How is he/she doing in academic subjects? _____ Attends special school or classes? _____

Past History

Does your child have, or has he/she ever had:

Chickenpox..... Yes No Explain _____

Frequent ear infections, problems with ears or hearing..... Yes No Explain _____

Problems with eyes or vision..... Yes No Explain _____

Nasal Allergies..... Yes No Explain _____

Asthma, bronchitis, bronchiolitis, or pneumonia..... Yes No Explain _____

Any heart problem or heart murmur..... Yes No Explain _____

Anemia, bleeding problem, or blood transfusion..... Yes No Explain _____

Frequent abdominal pain..... Yes No Explain _____

Convulsions or other neurological problem..... Yes No Explain _____

Diabetes..... Yes No Explain _____

Thyroid or other endocrine problem..... Yes No Explain _____

Any other significant problem.....Yes No Explain _____

(For Girls) Has she started her menstrual periods?..... Yes No Explain _____

(For Girls) Are there any problems with her periods..... Yes No Explain _____

Initial History Questionnaire

Child's Name _____

Birth Date _____ Gender F M

Form Completed by: _____ **Date form completed** _____

Family History (Family History only as far back as child's Grandparent's)

Has any family member had the following?

Deafness.....Yes No Who _____
Nasal Allergies.....Yes No Who _____
Asthma.....Yes No Who _____
Tuberculosis..... Yes No Who _____
Heart Disease.....Yes No Who _____
High blood pressure.....Yes No Who _____
Autism.....Yes No Who _____
Mental illness or development problems..... Yes No Who _____
Liver.....Yes No Who _____
Kidney disease.....Yes No Who _____
Diabetes.....Yes No Who _____
Bed wetting (after 10 years old).....Yes No Who _____
Epilepsy or convulsions..... Yes No Who _____
Alcohol or drug abuse..... Yes No Who _____

Immune problems.....Yes No Who _____
HIV or AIDS.....Yes No Who _____
Cancer.....Yes No Who _____
Thyroid.....Yes No Who _____
High Cholesterol..... Yes No Who _____
High Cholesterol..... Yes No Who _____
Anemia or bleeding disorder.....Yes No Who _____

PLEASE READ CAREFULLY AND INITIAL EACH ITEM

_____ I understand the above release will stay in effect until a change is requested in writing. I understand both biological parents have access to full disclosure (even non-custodial parent) and both can authorize representatives unless parental rights have been terminated by court order. If those court orders exist, I must present copies for my child's file.

_____ I have reviewed and agreed to the Financial Policy, which states I am financially responsible for any balance not covered by my insurance carrier. I understand that my coverage is determined by an agreement I have made with my insurance carrier and that insurance denials do not reflect the opinions of Caring Pediatrics

_____ I have been provided the Medical Home Agreement and office policies. I understand that I may receive additional copies of any policy upon request.

_____ I understand that any previous unpaid balance and current charges, are due upon checking in.

_____ I understand that a fee may be assessed for missed appointments.

_____ I am aware that appointment wait times may vary.

I have read and I agree to Caring Pediatrics. I consent to the treatment of my child as well as the use of the disclosure of my child's Person Health Information. I attest the information I have provided is true and correct.

Signature of Parent/Legal Guardian: _____

Authorization for Medical Treatment
I, the undersigned, authorize Victor T. Wilson, M.D., P.C. (hereinafter "The Clinic") and its Medical Staff to administer to the patient any medical, diagnostic or therapeutic treatment as is necessary. I acknowledge that no guarantees have been made as the result of the treatment or examination. I further understand that the physician or provider may order an HIV Antibody (AIDS) test as part of diagnosis and treatment. I also understand that I have the right to consent or refuse consent to any proposed procedure or therapeutic course absent emergency or extraordinary circumstances.

Disclosure of Information
I understand that my medical records and billing information are made and retained by The Clinic, and are accessible to its personnel and medical staff. Employed personnel and physicians in attendance may use and disclose medical information for treatment, payment, and health care operations to any other physician or health care personnel involved in my course of care. Safeguards are in place to discourage improper access. The Clinic and its medical staff are authorized to disclose all or part of the patient's medical record to any insurance carrier, workers compensation carrier, or self-insurance employer group liable for any part of The Clinic's charges and to any health care provider who is or may become involved with patient's care. I further consent to release of information as necessary for payment and health care operations. Oklahoma law requires that The Clinic advise you that information authorized for disclosure may include information which may be considered a communicable or venereal disease, including, but not limited to: Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome (AIDS). By signing this agreement you are consenting to such disclosure.

Release of Responsibility
The Clinic is hereby released from any responsibility for any items or personal property brought onto The Clinic premises.

Financial Agreement and Assignment of Benefits
For services rendered to the patient, I assign and authorize payment to The Clinic of any health car insurance benefits including Major Medical Benefits. Physician or provider benefits otherwise payable to the insured are to be made payable to the physician responsible for my care. I understand that I am responsible for and guarantee payment of any health insurance deductibles and any remaining reasonable charges after Title XVIII payment. I fully understand this bill is subject to any charges and/or credits not available at the time care is rendered, as well as changes in the estimate insurance benefits, fees, and court costs related to collection of this account. I Also understand by signing, that the Financial Agreement and Assignment of Benefits will NOT expire even if patient is no longer being seen by The Clinic.

I hereby certify that I have read each of the above statements, and have had them explained to me to my satisfaction, and accept the terms herein. I further certify that I am the parent or guardian of the patient and am duly authorized to accept these terms in his or her behalf. A photocopy or digital image of this shall be considered the same as the original.

Patients Name: _____ **Date of Birth** _____

_____	_____	_____	_____
Parent or Guardian Signature	Date	Relationship	Witness

ACKNOWLEDGMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

A complete description of how the patient's medical information will be used and disclosed by The Clinic is in the Notice of Privacy Practices, which is available upon request.

_____	_____	_____	_____
Parent or Guardian Signature	Date	Relationship	Witness