fasttrack pediatrics

Registration Form

CHILDREN'S INFORMATION - PLEASE LIST ALL CHILDREN TO BE REGISTERED UNDER THIS ACCOUNT

Child's Legal Name Last: ______________ First: ______________ Preferred Language: ☐ English ☐ Spanish ☐ Other: ____________	DOB:	☐Male ☐Female	Ethnicity & Race *(Meaningful Use Data)* ☐ Hispanic ☐ Non-Hispanic Race: ______________
Child's Legal Name Last: ______________ First: ______________ Preferred Language: ☐ English ☐ Spanish ☐ Other: ____________	DOB:	☐Male ☐Female	Ethnicity & Race *(Meaningful Use Data)* ☐ Hispanic ☐ Non-Hispanic Race: ______________
Child's Legal Name Last: ______________ First: ______________ Preferred Language: ☐ English ☐ Spanish ☐ Other: ____________	DOB:	☐Male ☐Female	Ethnicity & Race *(Meaningful Use Data)* ☐ Hispanic ☐ Non-Hispanic Race: ______________
Child's Legal Name Last: ______________ First: ______________ Preferred Language: ☐ English ☐ Spanish ☐ Other: ____________	DOB:	☐Male ☐Female	Ethnicity & Race *(Meaningful Use Data)* ☐ Hispanic ☐ Non-Hispanic Race: ______________

PARENT/GUARDIAN INFORMATION

☐ Father ☐ Mother ☐ Other: ____________ Name: ______________ DOB: ________ Email: ______________	Address:	☐ Cell ☐ Home Primary Phone #:
☐ Father ☐ Mother ☐ Other: ____________ Name: ______________ DOB: ________ Email: ______________	Address:	☐ Cell ☐ Home Primary Phone #:

EMERGENCY CONTACTS

(LIST ADDITIONAL PERSONS WHO MAY BRING CHILDREN FOR APPOINTMENTS OR WHO WE ARE AUTHORIZED TO COMMUNICATE WITH FOR MEDICAL INFORMATION)

Name:	Relationship to child:	Phone # - ☐ Cell ☐ Home
Name:	Relationship to child:	Phone # - ☐ Cell ☐ Home
Name:	Relationship to child:	Phone # - ☐ Cell ☐ Home

INSURANCE INFORMATION - PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST

INSURANCE:	Subscriber:	DOB:
INSURANCE:	Subscriber:	DOB:

ASSIGNMENT OF INSURANCE BENEFITS/ CONSENT TO TREAT/ PRIVACY POLICY

✓ I understand that I am financially responsible for all professional charges that my children may incur.

✓ All copayments and non-covered charges are due at time of service. All costs not paid by insurance are due upon receipt of statement.

✓ I hereby authorize payment of medical benefits direct to Fasttrack Pediatrics I further authorize the release of any medical information necessary for processing the insurance claim. I understand that all costs not paid by insurance are my responsibility unless otherwise prohibited by state or federal regulations.

✓ Permission to Treat Minor (under age 18): In the event of an emergency and I cannot be contacted, I give my permission to Fasttrack Pediatrics to treat my child in their office as required by the events of that emergency situation.

✓ Acknowledgement of receipt of HIPAA Notice of Privacy Practices: I have received or have been given the opportunity to receive a copy of HIPAA Notice of Privacy Practices for Fasttrack Pediatrics

______________________________ ______________________________ ____________

Parent/Guardian Signature (Patient Signature if 18 or older) Printed Name Date

FEB 2019

FINANCIAL POLICY

Fasttrack Pediatrics is dedicated to providing excellent care and understanding overall-service to every patient at every visit. In the interest of avoiding misunderstandings that may arise due to any financial matters, please take note of our financial policy.

Our office participates in most major health plans, but please remember:

- It is your responsibility to verify that **Fasttrack Pediatrics** is a participating health care provider in your health plan. This should be done prior to making an appointment.
- It is your responsibility to know your benefits and to understand that if services rendered are applied to your deductible or considered non-covered services, you will be responsible for payment.
- Co-pays are due at the time of service.
- Insurance cards must be brought to each visit so that we can ensure that we are billing the most current insurance plan.

Cancellation/No Show Policy & Late Arrival Policy

- **We** strive to accommodate as many same day appointments as possible in order to provide the best possible care to all our patients. Therefore, if you need to cancel an appointment, please provide 24 hours notice so we can offer the time to another patient. If sufficient notice is not provided, you could be considered a "no show."
- We ask that every patient arrives 10 minutes prior to their scheduled appointment to allow time for the check-in process. If you miss your appointment, we may have to reschedule you to accommodate all other patients on the schedule.
- Repeat violators of these policies could be dismissed from our practice.

By signing this form, I acknowledge that I have read and understood the above policies.

_____

Printed Name

_____ _____

Signature *Date*

HIPAA Acknowledgment

I acknowledge that I have received or have been given the opportunity to receive a copy of the HIPAA Notice of Policy Practices for **Fasttrack Pediatrics**

_____ _____

Signature *Date*

This acknowledgment will be scanned into the patient's permanent electronic medical record.

FASTTRACK PEDIATRICS

Patient Medical History Form

Date	Child's Name	Nickname	DOB	M F

Previous Physician/Office	Request for Records Transfer Complete Y N	Date of Last Physical

Mother's Name	Occupation	Age	Father's Name	Occupation	Age

Birth History

Birth weight _____ Preg # _____ Mom's age _____
Was the baby born on time?_____ Early?_____ Late? _____
If early, how many weeks gestation? _____
Did mother have any illness or problems with her pregnancy? ☐ Y ☐ N
Explain _____

During pregnancy, did mother:
Smoke ☐ Y ☐ N Drink alcohol ☐ Y ☐ N
Use drugs or medications ☐ Y ☐ N
What _____ When _____

Was the delivery ☐ Vaginal? ☐ Cesarean?
If Cesarean, why? _____
Did your baby have any problems right after birth? ☐ Y ☐ N
Explain _____

Was initial feeding ☐ Breast Milk? ☐ Formula?
Did your baby go home with mother from the hospital? ☐ Y ☐ N
Explain _____

Current and Past History

Is your child currently on any medication?	☐ Y ☐ N	Explain _____
Does your child have any serious or chronic illnesses?	☐ Y ☐ N	Explain _____
Has your child had serious injuries or accidents?	☐ Y ☐ N	Explain _____
Has your child had any surgery?	☐ 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 requiring doctor visits	☐ Y ☐ N	Explain _____
Bladder/kidney infection or bed-wetting (after 5 years old)	☐ 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	☐ Y ☐ N	Explain _____
Mental health issues (anxiety, depression)	☐ Y ☐ N	Explain _____
Use of alcohol or drugs	☐ Y ☐ N	Explain _____

Any other medical or mental health issues/problems _____

Does your child see any specialists? ☐ Y ☐ N If yes, Who?_____
For what reason or diagnosis? _____

Has your child ever received Occupational Therapy, Physical Therapy, 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 above? _____

Household Information

Please List All Those Living in the Child's Home

Name	Relationship to Child	DOB

Child Care: _____

Smokers in household? ☐ Y ☐ N Pets in household? ☐ Y ☐ N

Are there siblings not listed? If so, please list their names and ages and where they live. _____

_____

If mother and father are not living together or if child does not live with parents, what is the child's custody status? _____

_____

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home? _____

_____

Family Medical History (Parents, Siblings, Grandparents, Aunts & Uncles)

Have Any Family Members Had The following:

Alcohol/Drug Abuse	☐ Y ☐ N	Who_____	Comments_____	
Allergies	☐ Y ☐ N	Who_____	Comments_____	
Anesthesia Risk	☐ Y ☐ N	Who_____	Comments_____	
Arthritis	☐ Y ☐ N	Who_____	Comments_____	
Blood Disease	☐ Y ☐ N	Who_____	Comments_____	
Cancer	☐ Y ☐ N	Who_____	Comments_____	
Diabetes	☐ Y ☐ N	Who_____	Comments_____	
Genetic	☐ Y ☐ N	Who_____	Comments_____	
Gastroenteritis	☐ Y ☐ N	Who_____	Comments_____	
Genitourinary	☐ Y ☐ N	Who_____	Comments_____	
Heart	☐ Y ☐ N	Who_____	Comments_____	
Hypertension	☐ Y ☐ N	Who_____	Comments_____	
Lipids	☐ Y ☐ N	Who_____	Comments_____	
Neurologic Diagnosis	☐ Y ☐ N	Who_____	Comments_____	
Psychiatry	☐ Y ☐ N	Who_____	Comments_____	
Ophthalmology	☐ Y ☐ N	Who_____	Comments_____	
Respiratory	☐ Y ☐ N	Who_____	Comments_____	
Skin	☐ Y ☐ N	Who_____	Comments_____	
Stroke	☐ Y ☐ N	Who_____	Comments_____	
Thyroid	☐ Y ☐ N	Who_____	Comments_____	
Negative Family History	☐ Y ☐ N	Who_____	Comments_____	

Additional Family History/Comments _____

_____

_____

Initial Review (initials/date):

Screening Checklist for Contraindications to Vaccines for Children and Teens

PATIENT NAME _____

DATE OF BIRTH ____ / ____ / ____
month day year

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Is the child sick today?	☐	☐	☐
2. Does the child have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3. Has the child had a serious reaction to a vaccine in the past?	☐	☐	☐
4. Has the child had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?	☐	☐	☐
5. If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	☐	☐	☐
6. If your child is a baby, have you ever been told he or she has had intussusception?	☐	☐	☐
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	☐	☐	☐
8. Does the child or a family member have cancer, leukemia, HIV/AIDS, or any other immune system problems?	☐	☐	☐
9. In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	☐	☐	☐
10. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
11. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐	☐	☐
12. Has the child received vaccinations in the past 4 weeks?	☐	☐	☐

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

Did you bring your immunization record card with you? yes ☐ no ☐

It is important to have a personal record of your child's vaccinations. If you don't have one, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep it in a safe place and bring it with you every time you seek medical care for your child. Your child will need this document to enter day care or school, for employment, or for international travel.

immunization action coalition
IAC
immunize.org

Technical content reviewed by the Centers for Disease Control and Prevention

Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org

www.immunize.org/catg.d/p4060.pdf • Item #P4060 (9/17)

Cuestionario de contraindicaciones para vacunación de niños y adolescentes

NOMBRE DEL PACIENTE _____

FECHA DE NACIMIENTO ____/____/____
mes día año

A los padres/tutores: Las siguientes preguntas nos ayudarán a determinar cuáles vacunas le podremos administrar a su hijo hoy. Si responde "sí" a alguna pregunta, no necesariamente significa que no se debe vacunar a su hijo. Simplemente quiere decir que hay que hacerle más preguntas. Si alguna pregunta no está clara, solicítele a su proveedor de atención médica que se la explique.

	sí	no	no sé
1. ¿El niño está enfermo hoy?	☐	☐	☐
2. ¿El niño es alérgico a algún medicamento, alimento, componente de vacunas o al látex?	☐	☐	☐
3. ¿El niño ha tenido alguna reacción seria a una vacuna en el pasado?	☐	☐	☐
4. ¿El niño ha tenido algún problema de salud como enfermedad de pulmonar, cardíaca, renal o metabólica (como diabetes), asma o un trastorno de la sangre? ¿Está en terapia de aspirina a largo plazo?	☐	☐	☐
5. Si el niño que va a ser vacunado tiene entre 2 y 4 años de edad, ¿le ha dicho algún proveedor de atención médica que el niño tuvo sibilancias o asma en los últimos 12 meses?	☐	☐	☐
6. Si el niño es un bebé, ¿le han dicho alguna vez que tuvo intususcepción?	☐	☐	☐
7. ¿El niño, uno de sus hermanos o padres, ha tenido convulsiones; el niño ha tenido problemas cerebrales o algún otro problema del sistema nervioso?	☐	☐	☐
8. ¿El niño o un miembro de su familia tiene cáncer, leucemia, VIH/SIDA o cualquier otro problema del sistema inmunitario?	☐	☐	☐
9. ¿En los últimos 3 meses, el niño ha tomado medicamentos que afecten el sistema inmunitario, como prednisona, otros esteroides o medicamentos contra el cáncer; medicamentos para el tratamiento de la artritis reumatoide, la enfermedad de Crohn o la psoriasis, o tuvo tratamientos de radiación?	☐	☐	☐
10. Durante el año pasado, ¿el niño recibió una transfusión de sangre o de productos sanguíneos, o se le administró inmunoglobulina o gammaglobulina o algún medicamento antiviral?	☐	☐	☐
11. ¿La niña/adolescente está embarazada o hay alguna posibilidad de que quede embarazada durante el próximo mes?	☐	☐	☐
12. ¿Se le aplicó alguna vacuna al niño en las últimas 4 semanas?	☐	☐	☐

FORMA LLENADA POR _____ FECHA _____

FORMA REVISADA POR _____ FECHA _____

¿Trajo su cartilla de vacunación consigo? **sí** ☐ **no** ☐

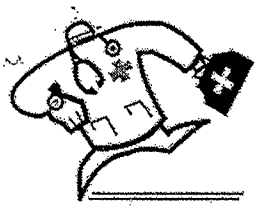
Es importante que tenga un registro personal de las vacunas de su hijo. Si no lo tiene, pídale al proveedor de atención médica de su hijo que le dé uno con todas las vacunas de su hijo. Guárdelo en un lugar seguro y llévelo con usted todas las veces que busque atención médica para su hijo. Su hijo necesitará este documento para ingresar a la guardería o a la escuela, para obtener empleos o para viajar al extranjero.

immunization action coalition
IAC
immunize.org

"Screening Checklist for Contraindications to Vaccines for Children and Teens"

Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org

www.immunize.org/catg.d/p4060-01.pdf • Item #P4060-01 Spanish (9/17)



Office use only. Patient MRN: _____

CONSENT FOR TREATMENT

I give my permission for **FASTTRACK PEDIATRICS** to treat my child, _____ (Please Print), according to the standards of care defined by the American Association of Pediatrics (AAP) and the realm of medical necessity as deemed appropriate by the treating Provider.

_____
Print Name

_____ _____
Signature of Parent/Guardian Date

OPTIONAL: AUTHORIZATION FOR TREATMENT WHEN PARENT/GUARDIAN IS NOT PRESENT WITH CHILD (ie. Nanny, Grandparent, Step-Parent, and/or teen by themselves)

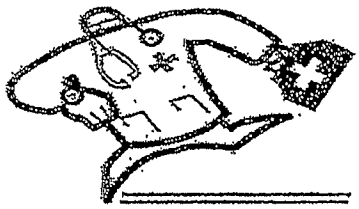
I,_____ (Please Print), do hereby consent and authorize **FASTTRACK PEDIATRICS** and its Providers and Staff to examine and/or treat my child in my absence. I affirm that I have the legal right to consent to this. I understand that this consent is legal and binding until specifically revoked by myself or another person who has the legal right to sign or revoke this authorization. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of examinations and/or treatments.

I give the Providers and Staff permission to treat my child in my absence with whatever treatment plan they deem necessary and appropriate. I understand that I will be contacted for a verbal consent if treatment plan includes vaccines, and the best number to reach me for this is: _____.

_____ _____
Signature Date

THIS ACKNOWLEDGEMENT WILL BE SCANNED INTO THE PATIENT'S PERMANENT ELECTRONIC MEDICAL RECORD.

fasttrack pediatrics



Please fill in Patients Information and at least phone number of your preferred Pharmacy.

Patient's Name: _____ **DOB:** _____

Pharmacy Name: _____

Address: _____

_____

_____

Phone Number: _____

PARENT/ GUARDIAN EMAIL: _____