Denver Pediatrics, PC

Patient Registration

Date___________________

PATIENT INFORMATION

Legal Name ____
Last First Middle Initial

Street Address ___________________________________Apt/Unit #__________

City ______________________ State ________ Zip Code ________

Birth Date ____________Age __________ SS# ____________________

Home Phone ____________________ Sex _______Male _______ Female _______

Responsible Party: Name ______________ DOB: ______SS# ______________

Preferred Pharmacy: Name ________________ Phone: ______________

Siblings ____________________ Siblings ____________________

Siblings ____________________Siblings ____________________

Mother's Name __________________DOB: ________ S.S.#: ____________

Father's Name __________________DOB: ________S. S.#: ____________

INSURANCE INFORMATION

Primary Insurance ________________________Type (HMO/PPO, etc) ________

Insured's Name ________________Relationship to insured ______________

ID# ________________Group __________ Insured's Date of Birth __________

Claims Address ______________________ Phone: ________________

Secondary Insurance ______________________ Type (HMO/PPO, etc) ________

Insured's Name ________________ Relationship to insured ______________

ID # ________________Group __________Insured's Date of Birth __________

Claims Address ______________________Phone ________________

ADDITIONAL INFORMATION

Emergency Contact ____________________Relationship to Patient __________

Home Phone ______________Work Phone ______________ Cell ______________

Whom may we thank for referring you? ________________________________

MEDICAL INFORMATION AUTHORIZATION: I authorize release of any medical information necessary to process my/my child's claim

Signed ________________________ Date________________

Medical Information Authorization: I authorize medical benefits to the names provider/s. I understand that I am financially responsible for charges not covered by this authorization. I agree to pay all non-covered fees incurred within 30 days or my account may incur interest at the rate of 18% ANNUAL PERCENTAGE RATE. I further agree to pay all costs including actual attorney fees incurred for collection of my account.

____

Responsible Party/Parent or Legal Guardian Name Date

Denver Pediatrics

Pediatric Patient Questionnaire Completed By:

Childs Name: ____ **Birth Date**: ____________________________

Please circle Y or N or N/A
Reason for today's visit: ____

Previous Doctor: ______________________________

Pregnancy and Birth Information

Mother's age at pregnancy: ________________________________
Any illness during pregnancy: Y________ N___________
Smoking. Alcohol, Street Drugs used during Pregnancy: Y: _______ N: __________
Was baby On Time: ________ Early: ________ Late: ___________
Type of Delivery: ________________ Birth Weight: ____________
Problems with baby at birth: Y________ N: __________
Jaundice: Y ____ N ____ Other problems: ____________________
Problems soon after birth: __________________________________

Childs Past Medical History

Allergic reaction to medicines: Y_________N: __________
Allergic reaction to Food: Y ________ N: __________
Allergic reaction to animals: Y ________ N: __________
Allergic reaction to insect bites: Y_________N: __________
Medications taken on a regular basis: _________________________
____
Immunizations up to date: Y: _______ N: __________
Do you have a shot record: Y: _______ N: __________
Hospitalizations: Y________ N: __________

- Where: _______________________________________
- When: ____
- Why: ____

List serious injuries: _____________________________________
____

Family History

List all blood relatives of your child who have had the following (Use abbreviations)
(F) Father (M) Mother (B) Brother (S) Sister
(MM) Mothers Mother (FM) Fathers Mother
(MF) Mothers Father (FF) Fathers Father
(A) Aunt (U) Uncle (C) Cousin

Anemia/Blood Disorder: ___________________
Asthma: _________________________________
Mental Retardation: _______________________
Drug problems: ___________________________
Alcoholism: ______________________________
Cancer: _________________________________
Aids: ___________________________________
Cystic Fibrosis: ___________________________
Muscular Dystrophy: _______________________
Arthritis: ________________________________
Epilepsy/Seizures: _________________________
Heart Disease: ____________________________
High Blood Pressure: _______________________
Cholesterol Problems: ______________________
Migraines: _______________________________
Sudden Infant Death: _______________________
Birth Defects: _____________________________
Early Deafness: ____________________________
Diabetes: _________________________________

Childhood Diseases

Chicken Pox	Y__ N__	Mumps	Y__ N__	German Measles	Y__ N__	Measles	Y__ N__
Whooping Cough	Y__ N__	Rheumatic Fever	Y__ N__	Scarlet Fever	Y__ N__	Ear Infection	Y__ N__
Strep Throat	Y__ N__	Asthma/Wheezing	Y__ N__	Eczema/Hives	Y__ N__	Seizures	Y__ N__
Anemia	Y__ N__	Hepatitis	Y__ N__	Hearing Problems	Y__ N__	Bleeding Problems	Y__ N__
Urinary infection	Y__ N__	Vision Problems	Y__ N__	Blood Transfusions	Y__ N__	Joint Problems	Y__ N__

Other Unlisted Problems: ____

Feeding and Nutrition

Food Allergies Y__ N__ Appetite Good ___ Poor ___ Colic or feeding problems first 3 months Y__ N__
Brest Feeding Y__ N__ Number of Months _______ Formula Y__ N__ Current Brand ______________________
Vitamins Y__ N__ Brand ____________________ Fluoride Y__ N__ Special Diet ________________________

Development and Behavior

APPROPRIATE AGE AT WHICH CHILD: Sat Alone: _________ Walked __________ Used Sentences ___________
Toilet Trained ______ Grades In school ____________________________

Problems in School: Y _________ N:____________ Learning Problems: Y _____________ N: _________
Behavior Problems: Y _________ N: ____________ Bed Wetting: Y _____________ N: _________
Sleeping Problems: Y _________ N: ____________ Lives at Home: Y _____________ N: _________
Use of Illegal Drugs: Y _________ N: ____________ Type of Drugs: _______________________________

Family Profile

Parents Married: Y__ N __ Separated: Y__ N __ Divorced: Y__ N __
Fathers Age: ________________ Mothers Age: ______________ Fathers Health: __________________________
Mothers Health: _____________ List Siblings: ____
____

Denver Pediatrics
Gita Sikand, M.D., FAAP/Dr. Susan Spoerke, M.D., FAAP
9141 Grant Street, Suite 100
Thornton, CO 80229

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

PATIENT NAME ____

BIRTHDATE ____________________________ **SS #:** ____________________

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination, tests results, diagnosis, and treatment and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many healthcare professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:
- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

☐ I request the following restrictions to the use or disclosure of my/my child's health information:

____

____

PATIENT: ____

OFFICE USE ONLY

☐ **ACCEPTED**

____
Signature **Title** **Date**

☐ **DENIED**

GITA S. SIKAND, M.D.

Fellow American Academy of Pediatrics   Diplomat of the American Board of Pediatrics

PARENTAL PRE-AUTHORIZATION FOR MEDICAL CARE TO CHILDREN

For families who are ongoing patients of DENVER PEDIATRICS it may be more convenient to have prior authorization for medical care delivered directly to minors without a parent having to be present for treatment. Please review the following authorization form for treatment and complete the information if you want to authorize such treatment in advance.

AUTHORIZATION

I request and authorize Denver Pediatrics and its personnel to deliver medical care to my children listed below:

PLEASE PRINT

CHILD'S NAME	DATE OF BIRTH
CHILD'S NAME	DATE OF BIRTH
CHILD'S NAME	DATE OF BIRTH
CHILD'S NAME	DATE OF BIRTH

I authorize the following person(s) to bring my children in for medical care in my absence:

NAME	RELATIONSHIP
NAME	RELATIONSHIP
NAME	RELATIONSHIP

NOTE: If there is any special parental or custodial relationship custody of one parent only, legal custody/guardianship with non-parents, etc. please explain on space below with your signature and telephone number where you can be contacted.

____

____

SIGNATURE   DATE

PRIVACY PRACTICES ACKNOWLEDGEMENT

DENVER PEDIATRICS
9141 Grant St., Suite 100
Thornton, CO 80229

PRIVACY PRACTICE ACKNOWLEDGEMENT

DENVER PEDIATRICS
9141 GRANT STREET, SUITE 100
THORNTON, CO 80229
303-920-9000
303-920-4000 Fax

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Parent/Legal Guardian Name: ____
Parent Legal Guardian Signature: _____________________________________

For Child's Name: ____
Date of Birth: ____

For Child's Name: ____
Date of Birth: ____

For Child's Name: ____
Date of Birth: ____

For Child's Name: ____
Date of Birth: ____

****PLEASE BRING THIS FORM IN WITH YOU ON DAY OF APPOINTMENT****