AGC Pediatrics, LLC

Patient Registration Form (18 YEARS OR OLDER)

Today's Date _____/_____/_____ **MRN** _____

PATIENT INFORMATION

Name _____ DOB _____/_____/_____

Address _____ Phone Number ( )_____

City _____ Zip _____ Work Number ( ) _____

Employer Name _____ E-mail Address _____

INSURANCE INFORMATION

Who has legal responsibility for the Health Insurance coverage for you?
If you are responsible for your own Health Insurance, skip to the box below this one. If one of your parents is responsible please fill out below.

Name _____ Relationship _____

Address _____ City/State/Zip _____

Phone # _____ DOB _____

Employer _____

Primary Insurance Information: **Insurance Co.** _____

Subscriber _____ **Subscriber's DOB** _____/ _____ /_____
(This will be who carries the Insurance on you)

Phone: _____ **Member ID:** _____ **Group #:** _____

Secondary Insurance _____ **Subscriber Name:**_____

Member ID: _____ **Group #:** _____

EMERGENCY CONTACT

Name _____ Relationship _____

Phone Number ( ) _____ Work Number ( )_____

AUTHORIZTION FOR TREATMENT AND RELEASE OF INFORMTION

_____ initial I _____ authorize AGC Pediatrics to contact me by telephone with medical information pertain to my care.

_____ initial I authorize AGC Pediatrics or whomever they designate to evaluate and treat me and to release to my insurance company any information acquired in the course of my examination or treatment, and to receive all payments for such examination or treatment. AGC has my permission to release any diagnostic studies, reports, etc. to a specialist involved in my care.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____ initial I acknowledge that I have received the Notice of Privacy Practice, which explains how my health information will be handled in various situations.

GENERAL HEALTH INFORMATION

General History

Do you consider yourself to be in good health? Yes No DK
Explain _____

Do you have any serious illnesses or medical conditions? Yes No DK
Explain _____

Have you had any surgery or been hospitalized? Yes No DK
Explain _____

Are you allergic to any medications? Yes No DK
Explain _____

Past Medical History

Do you or have or have you had:

Chickenpox	Yes	No	DK	HIV	Yes	No	DK
Problems with ear or hearing	Yes	No	DK	Chemotherapy	Yes	No	DK
Heart problems	Yes	No	DK	Cancer	Yes	No	DK
Blood transfusion	Yes	No	DK	Obesity	Yes	No	DK
Organ Transplant	Yes	No	DK	Diabetes	Yes	No	DK
Abdominal pain (Frequent)	Yes	No	DK	High blood pressure	Yes	No	DK
Frequent ear infections	Yes	No	DK	Dental decay	Yes	No	DK
Allergies (other than Medication)	Yes	No	DK	History of family Violence	Yes	No	DK
Anemia or Bleeding problems	Yes	No	DK	Pregnancy	Yes	No	DK
Malignancy/bone morrow transplant	Yes	No	DK	Tobacco use	Yes	No	DK
Recurrent Urinary Tract Infection	Yes	No	DK				
Congenital cataracts/retinoblastoma	Yes	No	DK	**For girls:**			
Metabolic / Genetic disorders	Yes	No	DK	Problem with periods	Yes	No	DK
Bed-wetting (after 5 years old)	Yes	No	DK	Has had first period	Yes	No	DK
Thyroid or endocrine problems	Yes	No	DK	Age at first period	Age _____		
Developmental delay	Yes	No	DK				
History of injures/Fractures/Concussions	Yes	No	DK	**For boys:**			
Use of alcohol or drugs	Yes	No	DK	Testicular/ Scrotum pain	Yes	No	DK
History of family violence	Yes	No	DK	Testicular / Scrotum swelling	Yes	No	DK
Sexually transmitted infections	Yes	No	DK				
Asthma, bronchitis, bronchiolitis, or pneumonia	Yes	No	DK				
Kidney disease or urologic malformations	Yes	No	DK				
Sleep problems (snoring)	Yes	No	DK				
Chronic or recurrent Skin problems	Yes	No	DK				
Frequent headaches	Yes	No	DK				
ADD/ADHD/ mood problems/ depression	Yes	No	DK				

My signature below indicates I am the patient listed on the front page and that I have provided accurate information to the best of my knowledge and I understand and agree to all the provisions as stated.

Patient Signature _____ Date _____