Patient Registration (*Registro de Paciente*)

HAPPY KIDS pediatrics

Name
Nombre: _____

Date of Birth *Fecha de Nac.*: ___/___/___ ○ **Male** / *Hombre* ○ **Female** / *Mujer* **Social Security #** *# de Seguro Social*: ___-___-___ **Phone** *Teléfono*: ___-___-___

Address *Domicilio*: _____ **City** *Ciudad*: _____ **State/Zip** *Estado/CP*: _____ _____

School *Escuela*: _____ **Referred by** *Referido por*: _____

Father/Guardian *Padre/Guardian*: _____ **DOB** *F. de Nac.*: ___/___/___ **SS #** *# de SS*: ___-___-___

Phone *Teléfono*: ___-___-___ **Mobile P.** *T. Móvil*: ___-___-___ **Employment** *Empleo*: _____

Mother/Guardian *Madre/Guardian*: _____ **DOB** *F. de Nac.*: ___/___/___ **SS #** *# de SS*: ___-___-___

Phone *Teléfono*: ___-___-___ **Mobile P.** *T. Móvil*: ___-___-___ **Employment** *Empleo*: _____

Emergency Contact *Para Emegencia, hablar*: _____ **Phone** *Teléfono*: ___-___-___

Closest Relative *Pariente Cercano*: _____ **Phone** *Teléfono*: ___-___-___

Person Responsible *Persona Responsable*: _____ **Relationship to Patient** *Parentesco al Paciente*: _____

Address *Domicilio*: _____ **Phone** *Teléfono*: ___-___-___

Payment required at time of Service-Unless prior arrangements have been made.
El pago se cobra en el momento que se rinde el servicio a menos que haya arreglo previo.

① **Insurance** *Aseguranza*: _____ **Effective Date** *Fecha de Vigencia.*: ___/___/___ **Address** Domicilio: _____

City *Ciudad*: _____ **State/Zip** *Estado/CP*: _____ _____ **Phone** *Teléfono*: ___-___-___

Subscriber's Name *Nombre del Asegurado*: _____ **ID #** *# de Identificación*: _____ **Group #** *# de Grupo*: _____

② **Insurance** *Aseguranza*: _____ **Effective Date** *Fecha de Vigencia.*: ___/___/___ **Address** Domicilio: _____

City *Ciudad*: _____ **State/Zip** *Estado/CP*: _____ _____ **Phone** *Teléfono*: ___-___-___

Subscriber's Name *Nombre del Asegurado*: _____ **ID #** *# de Identificación*: _____ **Group #** *# de Grupo*: _____

③ **Additional Coverage** *Covertura adicional*: _____

Authorization to Pay Benefits to Physician : I hereby authorize direct payment to be made to the above named corporation. I understand Happy Kids Pediatrics, P.C. will file an insurance claim on my behalf as a courtesy, nevertheless, I am financially responsible for the charges not covered by my insurance company. I also understand that if my account is notpaid by myself, or the insurance company after ninety (90) days from the date of service, it will be turned over to an independant collection agency and a $25.00 fee will be added to the account for processing charges.There will be a $25.00 service charge for any returned check. I hereby certify that I do not have other insurance carrier at this time.

Authorization to Release Information : I hereby authorize the aboveto Happy Kids Pediatrics, P.C. to release any information required in the course of my examination or treatment to insurance companies for payment. I hereby authorize any photocopies of this form to be valid as the original.

Se otorga el derecho de cobra servicios rendidod : Se reconoce que Happy Kids Pediatrics, P.C. cobrará los servicios rendidos alpaciente a la aseguranza y que en caso de que no se cubre el gasto a través de la aseguranza, se reconose responsabilidad personal para el individuo que firme. En caso de que no se pague el servicio dentro 90 dias se contratará una agencia de coleción y se añadirá un cobro de proceso de $25.00 a la cuenta. Se añadirá un cobro de $25.00 a la cuenta si bota su cheque por no tener suficient fondos. Se declara queno hay otra aseguranza que cubrirá la cita.

Se otoga el derecho de enviar información : Se le otorga a Happy Kids Pediatrics, P,C. el derecho de enviar información del exámen cuando sea necesario al cobrar las aseguranzas. Se otorga el derecho de presentar documentos y fotocopias, como si fuesen originales, cuando sea necesario.

Parent/Guardian *Padre/Madre/Guardian*: _____ **Signature** *Firma*: _____ **Date** *Fecha.*: ___/___/___

Health History

HAPPY KIDS pediatrics

Name of Patient		Name of Person Completing Form	
Date / /	Relationship to Patient		
Sex ○ Male ○ Female	Race	Social Security # / /	DOB / /

• • • PLEASE LIST ALL PEOPLE IN HOUSEHOLD • • •

	Name	DOB	Occupation	Education
Father:				
Mother:				
Other:				
Other:				
Other:				
Other:				

Have there recently been any major changes or stresses in the child's life? ○ Yes ○ No

If YES, please explain: _____

_____

Does the child regularly go to a baby-sitter, pre-school or day care? ○ Yes ○ No

Is your child exposed to cigarette smoke? ○ Yes ○ No

• • • BIRTH HISTORY • • •

Birth weight: _____ Length: _____ Place: _____

During the pregnancy did the mother: (If Yes, please explain.)

Have any Medical Problems? ○ Yes ○ No _____

Smoke or Drink? ○ Yes ○ No _____

Use any Medication? ○ Yes ○ No _____

Use Alcohol or Drugs? ○ Yes ○ No _____

Have Problems with Labor/Delivery? ○ Yes ○ No _____

How long did the baby stay in the hospital after birth? _____

• • • PAST MEDICAL HISTORY • • •

Is the child's general health: ○ Good ○ Fair ○ Poor

Does the child have any allergies? ○ Yes ○ No _____

Is the child taking any medication? ○ Yes ○ No _____

Please list any hospitalizations, operations, serious ilnesses or accidents. (with dates)

_____ Date: _____

_____ Date: _____

Has the child had any problems with the following? If YES, please explain.

Eyes/Vision	○ Yes ○ No	_____	Skin	○ Yes ○ No	_____
Feet	○ Yes ○ No	_____	Lungs	○ Yes ○ No	_____
Digestion/Nutrition	○ Yes ○ No	_____	Teeth	○ Yes ○ No	_____
Ears/Hearing	○ Yes ○ No	_____	Heart	○ Yes ○ No	_____
Urine/Kidney	○ Yes ○ No	_____	Seizures	○ Yes ○ No	_____
Joints	○ Yes ○ No	_____	Repeated Infections	○ Yes ○ No	_____

• • • FAMILY HISTORY • • •

Have any of the child's brothers or sisters died? If YES, give age and cause. ◯ Yes ◯ No

---

Have any of the child's blood relatives had the following diseases? If YES, please list family member.

Heart disease	◯ Yes	◯ No	_____
Tuberculosis	◯ Yes	◯ No	_____
High Blood Pressure	◯ Yes	◯ No	_____
Kidney Disease	◯ Yes	◯ No	_____
Allergies/Asthma	◯ Yes	◯ No	_____
Cancer	◯ Yes	◯ No	_____
Diabetes	◯ Yes	◯ No	_____
Mental/Emotional Problems	◯ Yes	◯ No	_____
Sickle Cell	◯ Yes	◯ No	_____
Seizures	◯ Yes	◯ No	_____

• • • DEVELOPEMENT • • •

Do you have any concerns about the following? If YES, please explain.

Developement	◯ Yes	◯ No	_____
Behavior	◯ Yes	◯ No	_____
Eating Habits	◯ Yes	◯ No	_____
Sleeping Habitts	◯ Yes	◯ No	_____
School Experience	◯ Yes	◯ No	_____
Bathroom/Toilet Habits	◯ Yes	◯ No	_____
Discipline	◯ Yes	◯ No	_____
Other (explain)	◯ Yes	◯ No	_____

• • • • • • • • • • • IMMUNIZATIONS WILL BE COPIED ON IMMUNIZATION RECORD BY OFFICE STAFF • • • • • • • • • • •

• • • This Section is for Teenagers and is to Completed by the Teenager • • •

Do you:

Use Tabacco?	◯ Yes	◯ No
Drink Beer or other Alcoholic Beverages?	◯ Yes	◯ No
Use any kind of drugs?	◯ Yes	◯ No

(For Females) How old were you when you had your first period? _____

Are you sexually active?	◯ Yes	◯ No
If YES, do you use birth control?	◯ Yes	◯ No
Have you ever been pregnant or fathered a child?	◯ Yes	◯ No

Do you have any concerns about the following? If YES, please explain.

Safety Issues	◯ Yes	◯ No	_____
Substance Use (drugs, alcohol, tabacco)	◯ Yes	◯ No	_____
Sexually transmitted Diseases	◯ Yes	◯ No	_____
Family Planning	◯ Yes	◯ No	_____
Other (explain)	◯ Yes	◯ No	_____

Notes:

Reviewed By _____ Date _____

Immunization Refusal

I, ________________________________ (parent or gaurdian) refuse immunization given to ___________________________ , DOB _______________ , who is a minor.

ALTERNATIVES INCLUDE: Give Immunization

RISK: I understand that if the child is not immunized that they are at risk of contracting a disease that may lame or cripple for life or may be fatal.

PATIENTS CONSENT: I have read and fully understood this consent form. I comprehend that I should ***not sign*** this form ***if*** all items or questions have not been explained or answered to my satisfaction or if I do not understand any of the terms or words contained in this consent form. I have no further questions.

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF NOT GIVING IMMUNIZATIONS OR ANY QUESTIONS CONCERNING THEM, ASK YOUR PHYSICIAN BEFORE SIGNING THIS FORM.

- -

____

WITNESS **DATE**

____

PARENT or GAURDIAN **DATE**

HAPPY KIDS pediatrics P.C.

1311 E Thomas Rd.
PHOENIX, AZ 85014
Phone (602) 322-1315
Fax (602) 322-1316

2033 E Warner Rd., #109
TEMPE, AZ 85284
Phone (480) 820-5525
Fax (480) 831-6755

135 S Power Rd., #101
MESA, AZ 85206
Phone (480) 214-0051
Fax (480) 214-0055

1345 E Main St., #103
MESA, AZ 85203
Phone (480) 223-0290
Fax (480) 223-0295

10238 E Hampton Ave., #204
MESA, AZ 85209
Phone (480) 776-3790
Fax (480) 776-3788

Patient Eligibility Screening Record

Vaccines for Children Program

This record must be kept in the health care provider's office to reflect the current status of all children 18 years of age or younger declared eligible to receive immunizations through the VFC program. The record may be completed by the parent, guardian, individual of record or by the health care provider. This same record may be used for all subsequent visits as long as the child's VFC eligibility status has not changed. Provider verification of responses is not required, but is necessary to retain this record on file for a minimum of three years.

(Please print or type)

Date: _____

Child: _____
Last name First name M.I.

Date of Birth: _____

Parent/Gaurdian/
Individual of Record: _____

Provider: _____

This child qualifies for vaccination through the VFC program because he/she (check only one box):

(0) ◯ is enrolled in KidsCare; or
(1) ◯ is enrolled in AHCCCS; or
(2) ◯ does not have health insurance; or
(3) ◯ is an American Indian or Alaskan Native; or
(4) ◯ has health insurance that does not pay for vaccines

◯ Check here if this child has health insurance that pays for vaccines.
These children do not qualify for VFC.

Please be advised, if your insurance does not cover immunizations and you do not let us know at the time of the visit, it is your responsibility to pay the cost involved. We cannot make Vaccines For Children Program retroactive and you are only eligible for Vaccine For Children Program at the time of the visit. If you are unsure if immunizations and well check-ups are covered, please contact your insurance company.

Thank You

_____
Signature Date

HAPPY KIDS pediatrics P.C.

1311 E Thomas Rd.
PHOENIX, AZ 85014
Phone (602) 322-1315
Fax (602) 322-1316

2033 E Warner Rd., #109
TEMPE, AZ 85284
Phone (480) 820-5525
Fax (480) 831-6755

135 S Power Rd., #101
MESA, AZ 85206
Phone (480) 214-0051
Fax (480) 214-0055

1345 E Main St., #103
MESA, AZ 85203
Phone (480) 223-0290
Fax (480) 223-0295

10238 E Hampton Ave., #204
MESA, AZ 85209
Phone (480) 776-3790
Fax (480) 776-3788

Medical Authorization

I, _____ mother/father of _____
DOB: _____ give permission to _____
to bring my son/daughter to the doctor and make any healthcare decision needed for my son's/daighter's care.

(Valid for 6 months only.)

- -

_____

SIGNATURE **DATE**