Patient Name_____Date of Birth_____

Past Medical History (>1 years old) <PLEASE FILL IN ENTIRE BUBBLE WITH INK>

Any complications at birth or neonatal period? O No O Yes

Was your child full term at birth? O Yes 37-40 weeks gestation O No <37 weeks gestation

Was your child adopted? O No O Yes

Any previous wheezing, chronic cough, asthma or use of albuterol?
O None O Yes asthma O Yes wheezing O Yes chronic cough O Yes albuterol use

Any developmental delay or missed milestones during childhood? O No O Yes

Any significant past medical history? O None O Yes specialist visits O Yes other

Social History

Parents O Married O Divorced O Other

Does anyone smoke at home or regularly expose child to tobacco smoke? O No O Yes

Guns in home? O No guns O Yes locked O Yes but not locked

Do you have a pool? O No pool O Yes fenced O Yes but not fenced

Pets at home? O No O Yes

Family History

Does your child's father have? O Healthy O Asthma O Cancer O Diabetes O Heart Problems
O Allergies O ADHD O Depression/Anxiety O High Cholesterol O Seizures O Other

Does your child's mother have? O Healthy O Asthma O Cancer O Diabetes O Heart Problems
O Allergies O ADHD O Depression/Anxiety O High Cholesterol O Seizures O Other

Does your child's siblings have (leave blank if only child)? O Healthy O Asthma O Cancer O Diabetes
O Heart Problems O Allergies O ADHD O Depression/Anxiety O High Cholesterol
O Seizures O Other

Surgical History

Any surgeries? O None O Yes

Hospitalization

Any hospitalizations? O None O Yes

Desert Shores Pediatrics
Patient Registration

Patient Name: _____DOB: ___/____/____ Gender: M F Other

Race: (check all that apply)
- ◯ White
- ◯ Asian
- ◯ Native Hawaiian/Pacific Islander
- ◯ American Indian/Alaska Native
- ◯ Black/African American

Ethnicity:
- ◯ Hispanic/Latino
- ◯ Non-Hispanic/Latino
- ◯ Declined to report

Language: (Primary)
- ◯ English
- ◯ Spanish
- ◯ Other:_____

Address: _____
City:_____State:_____Zip:_____
E-mail:_____
Desert Shores Patient Portal (24/7 access to patient health records): Yes, Enable OR No Thanks
Cell Phone Number:_____ Home Phone (if different): _____

MOTHER STEP-MOTHER LEGAL GUARDIAN
Please circle one

Name:_____
Cell #: _____
Work #:_____
Date of Birth:_____/_____/_____
SS#_____
Employer:_____

FATHER STEP-FATHER LEGAL GUARDIAN
Please circle one

Name:_____
Cell #:_____
Work #: _____
Date of Birth:_____/_____/_____
SS#_____
Employer:_____

If patient lives at two different addresses, please provide second address.
This address is for: Mother Father Other:_____
Address:_____
City:_____ State:_____ Zip:_____
E-mail:_____

Primary Insurance:
Policy Holder: _____
Insurance:_____

Secondary Insurance:
Policy Holder:_____
Insurance:_____

Emergency Contact:_____ Phone:_____
Relationship:_____

How did you hear about our practice (if OB/GYN, please list name):_____

Consent to treat:
I, acting as a guardian to the above patient, herby give consent for the above patient to receive medical evaluation and treatment by the provider's at Desert Shores Pediatrics. I assign all benefits and payments from my insurance company to be paid directly to Desert Shores Pediatrics. I understand that if for any reason my insurance company does not make payments, I am responsible for all services.

Signature:_____ Date:_____

OFFICE POLICIES

We make every attempt to ensure that all services are compatible with your special insurance requirements. However, all policies have different benefits. The insurance company informs all participants that it is ultimately their responsibility to know and understand their policy. We do not have the capability to know each individual policy as it varies per patient. We cannot guarantee that all services will be covered. It is your responsibility to verify benefits and coverage information prior to having any services rendered.

Insurance companies require that we submit all claims within a specified time limit. We do our best to follow all guidelines set forth by your insurance company. However, if your insurance changes and you fail to inform us, we may be unable to bill the appropriate company within these time limits. A denial from the previous insurance company is the only way we know that the insurance has changed. Denials are generally not generated until after the filing deadline. If you do not notify us and your insurance company decides not to pay, you will be held responsible for payment of these services. Please notify us of any changes to your insurance, address or phone number immediately; ultimately, you will be responsible for this bill.

You will be responsible for payment of all services if any of the following circumstances apply:

- If you do NOT have insurance.
- If you are with an insurance company that we are NOT contracted with or
- If your insurance company denies your claim for any reason that is not resolvable.

PAYMENT (COINSURANCE/DEDUCTIBLE OR COPAY) IS EXPECTED ANY TIME A SERVICE IS PROVIDED UNLESS PRIOR FINANCIAL ARRANGEMENTS HAVE BEEN MADE. WE ACCEPT CASH, CHECKS AND MAJOR CREDIT CARDS.

- A charge of $25.00 will be made for personal checks drawn on insufficient funds.
- There will be a charge for missed appointment or appointments not cancelled 24 hours in advance.

Based on American Academy of Pediatrics Bright Start Guidelines, DSP recommends ANNUAL well child checks for all children 2 years and older. Preventative care is of utmost importance to your child's health. Therefore, if your child has not been seen for wellness care in over 2 years, the patient will come under review by the practice. We may be unable to refill medications, fill out requested forms, or fulfill other parental requests.

Neither patients, caregivers, nor their visitors are allowed to take pictures or videotape using their cell phones and/or other electronic devices to protect the privacy and confidentiality of our patients.

At times, you may send or bring in pictures of your children and family. We love to display these photos but we need your permission to do so. You can opt out at any time. Please initial: Yes_____ No _____

We may ask to take a photo of your child to be included in their confidential medical record to be used for identification, security or clinical purposes only. We need permission to do so. Please initial: Yes_____ No_____

Our staff will be happy to answer any questions you may have in reference to our office policies.
We appreciate our Desert Shores Pediatrics patients and families.

_____/ _____

Signature Date

Patient Name:_____

OFFICE POLICIES

Please initial to acknowledge:

_____ Any appointment NOT scheduled in our normal office hours of Monday through Friday 8:00 am to 5:00 pm is subject to an additional $15.00 **after-hours** charge that will be billed to your insurance. If insurance does not cover this charge, you will be held responsible for payment.

_____ If you have multiple concerns, chronic conditions to discuss, or an acute illness that you would like addressed during a well care visit we are happy to accommodate these concerns! If these services are rendered together at the same visit, it may result in both the standard well visit charge plus an additional office/sick visit charge. We take the comprehensive care of our patients very seriously. It may require a return visit to address these ongoing and chronic conditions so that the proper time and care can be given. Coverage for these services, if rendered together, varies greatly among insurance companies. Please check with your insurance company regarding how they pay for these services on your behalf. You will be financially responsible for any services not covered by your insurance.

_____/_____

Signature Date

Patient Name:_____

Phone Calls, Texting and Leaving Messages

What is the best number we can call for appointment reminders? _____ Cell_____ Home_____

Is it ok to text your cell phone for appointment reminders? Yes_____ No_____

What is the best number we can call to give lab and/or test results (if different than above):_____

Is it ok to leave a detailed message regarding confidential information (i.e. lab and test results): Yes_____ No_____

Temporary Authorization to Consent to Treat a Child

◯ Not applicable at this time; I do not give authorization for anyone else to consent to routine medical care.

I (We) _____

Name(s) of parent or legal guardian

Designate _____

Must be 18 years or older: step-parent, grandparent, sibling, nanny, aunt, friend, etc.

The above stated person(s) are designated the power to consent for medical care for the following child(ren) in our absence. This may include in-house labs, therapeutic injections/medications, or vaccinations depending on the type of visit and treatment necessary. Additionally, protected patient health information may be shared with the proxy to facilitate informed decision making:

_____ _____

Child's Name & Date of Birth Child's Name & Date of Birth

_____ _____

Child's Name & Date of Birth Child's Name & Date of Birth

- **Parent or legal guardian may revoke this at any time by providing written notice of revocation.**
- **Parent or legal guardian understands that authorization cannot be revoked retroactively for treatment already provided.**

X_____ _____

Parent or Legal Guardian Signature Date

Patient Consent for Use and
Disclosure of Protected Health Information

As parent/ guardian of _____, I understand that as part of my child's health care, Desert Shores Pediatrics originates and maintains health records. These records describe history, symptoms, examination and test results, diagnoses, treatment, and any plan for future care or treatment.

I have been provided with a Notice of Information Practices that describes use and disclosures of my child's Protected Health Information (medical records). I understand that I have the right to review the notice prior to signing this consent.

With my consent, Desert Shores Pediatrics may call (including leaving voice mail messages), mail, text or email regarding items that assist the practice in carrying out treatment, payment, and health care operations, such as appointment reminders, laboratory results, and insurance items.

I understand that Desert Shores Pediatrics has the right to change its notice and practices and, prior to implementation, will mail a copy of any revised notice to the address that I have provided.

I understand that I have the right to request restrictions as to how my child's health information may be used or disclosed to carry out treatment, payment, or health care operations and that Desert Shores Pediatrics is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that Desert Shores Pediatrics has already taken action. If I do not sign this consent or revoke it, Desert Shores Pediatrics may decline to provide treatment to my child.

I fully understand and I consent to Desert Shores Pediatrics use and disclosure of my child's Protected Health Information to carry out treatment, payment, and healthcare operations.

_____ _____ _____

Parent/Guardian Date

Authorization for Disclosure of Health Information

Patient Name:_____ Date of Birth:____/____/____ Sex: M F

Address:_____City:_____State:_____Zip:_____

- I authorize the release of my child's health information from **previous doctor's office/hospital:**

Practice Name:_____ Phone:_____Fax:_____

Address:_____City:_____State:_____Zip:_____

- **PLEASE SEND ONLY THE FOLLOWING, AS APPLICABLE:**

  - ✓ Patient Summary Page
  - ✓ Last 2 Wellness Visits
  - ✓ Growth Charts
  - ✓ Immunization Record
  - ✓ Labs and Diagnostic Imaging Reports
  - ✓ Most Recent Specialist(s) Visit Report(s)

  - **NEWBORN HOSPITAL RECORDS**: H&P, Discharge summary, pertinent labs/imaging/specialist notes
    PLEASE DO NOT SEND NURSING NOTES OR VITAL CHARTS
  - **Other (as written in):**

- I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

- This information may be disclosed to:

Name:	Desert Shores Pediatrics
Address:	6285 S. Higley Rd. Gilbert, Arizona 85298
Fax:	480-460-5858

For the purpose of: Medical Care

- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

- If I fail to specify an expiration date, event or condition, this authorization will expire in sixty days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not to sign this form in order to assure treatment. I understand that I may inspect or copy the information to be disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

_____ _____ _____

Signature of Patient or Legal Representative | Relationship to Patient | Date

Please Note: This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written and informed release of the individual to whom is pertains or as permitted by state law (ORC-3701.243) and federal law 42 CFR, part II.