PATIENT REGISTRATION FORM

(Please Print)

How did you hear about us? ☐ Google ☐ Facebook ☐ Instagram ☐ Hospital

☐ PediaTrust Employee: _____ ☐ Insurance ☐ A Friend ☐ Other: _____

PATIENT INFORMATION

Patient's Last Name: First:	Patient's Cell Ph (if 12 yrs. or older):	Sex: ☐M ☐ F	Birth Date:

Siblings & Birth Dates:	Sibling Name	Nickname	Date of Birth	Patient Cell Ph. (if 12 yrs. or older)

Street address:	City:	State:	Zip Code:

Mother's Name:	Mother's Date of Birth:	Email:

Primary Number: _____ ☐ Home ☐ Cell ☐ Work	Alternate Number: _____ ☐ Home ☐ Cell ☐ Work

Father's Name:	Father's Date of Birth:	Email:

Primary Number: _____ ☐ Home ☐ Cell ☐ Work	Alternate Number: _____ ☐ Home ☐ Cell ☐ Work

If you provide your email, you will be included on occasional important practice announcements via email.

Emergency Contact Name: _____ Emergency Contact Number: _____

☐ Parent ☐ Relative ☐ Friend ☐ Home ☐ Cell ☐ Work

GUARANTOR/ SUBSCRIBER INFORMATION

(PERSON WHO HOLDS THE INSURANCE POLICY)

Guarantor Name:	Relationship to Patient:	Date of Birth:
Guarantor SSN:		

Address (if different from above):	Primary Contact Number (if different from above):

Insurance Company Name:	Insurance ID Number:	Insurance Group Number:	Employer:

Secondary Insurance Company Name (if applicable):	Secondary Insurance ID Number:	Secondary Insurance Group Number:

For Office Use Only:

Pt. Rep. Initials: _____

Date Information Confirmed and Changes Entered: _____

Revised September 2016

Todays Date:

GUARANTOR INFORMATION (PERSON RESPONSIBLE FOR BILL)

Guarantor Name:	Relation to Patient:
Email:	

If you provide your email, you will be included on occasional important practice announcements via email.

PATIENT INFORMATION (FILL IN ALL THAT APPLY)

Patient's Last Name:	First:	Middle:	Birth Date:

Ethnicity (please circle):	Not Hispanic or Latino	Hispanic or Latino	Other/Unknown
Race (please circle):	American Indian or Alaska Native	Asian	Black or African American
	Native Hawaiian or Other Pacific Islander	White	Other/Unknown
Preferred Language:			

2nd Patient's Last Name:	First:	Middle:	Birth Date:

Ethnicity (please circle):	Not Hispanic or Latino	Hispanic or Latino	Other/Unknown
Race (please circle):	American Indian or Alaska Native	Asian	Black or African American
	Native Hawaiian or Other Pacific Islander	White	Other/Unknown
Preferred Language:			

3rd Patient's Last Name:	First:	Middle:	Birth Date:

Ethnicity (please circle):	Not Hispanic or Latino	Hispanic or Latino	Other/Unknown
Race (please circle):	American Indian or Alaska Native	Asian	Black or African American
	Native Hawaiian or Other Pacific Islander	White	Other/Unknown
Preferred Language:			

4th Patient's Last Name:	First:	Middle:	Birth Date:

Ethnicity (please circle):	Not Hispanic or Latino	Hispanic or Latino	Other/Unknown
Race (please circle):	American Indian or Alaska Native	Asian	Black or African American
	Native Hawaiian or Other Pacific Islander	White	Other/Unknown
Preferred Language:			

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize PediaTrust or my insurance company to release any information required to process my claims.

Signature: *Date:*

For Office Use Only:

Pt. Rep. Initials: _____

Date Information Confirmed and Changes Entered: _____

Revised September 2016

Patient History Form

Last Name	First Name	MI	Date of Birth
Other doctors involved with patient's care:			
How many brother and sisters does patient have?		**Who does the patient live with?**	
Prefer appointment reminders by: ❑ Phone ❑ Text ❑ Email		**Best phone number to reach you:**	

REVIEW OF SYSTEMS

Has the patient had any of the following? If yes, circle C=CURRENT PROBLEM AND P=PAST PROBLEM (problem resolved).

SYSTEM	NO	YES		SYSTEM	NO	YES		SYSTEM	NO	YES		SYSTEM	NO	YES	
Birth History				**Cardiac**				**Neurologic**				**Ear, Nose, & Throat**			
Normal				High blood pressure		P	C	Seizures		P	C	Frequent ear infections		P	C
Prematurity				Heart defect		P	C	Weakness		P	C	Frequent sinus infections		P	C
Apnea/Bradycardia				Irregular heartbeat		P	C	Migraines/headaches		P	C	Deafness		P	C
Intubation				**Respiratory**				Developmental delay		P	C	Frequent hoarse voice		P	C
NEC				Chronic Cough		P	C	**Musculoskeletal**				Snores loudly		P	C
Gastrointestinal				Asthma		P	C	Joint pain		P	C	Recurrent congestion		P	C
Diarrhea		P	C	Pneumonia		P	C	Arthritis		P	C	Frequent mouth sores		P	C
Constipation		P	C	Tracheotomy		P	C	**Blood Disorders**				**Psychological**			
Soils in underwear		P	C	**Skin**				Easy bruise/bleed		P	C	ADHD/ADD		P	C
Blood in stool		P	C	Rash		P	C	**Ophthalmic**				Sensory integration		P	C
Heartburn		P	C	**Genitourinary**				Blindness		P	C	Depression		P	C
Trouble swallowing		P	C	Pain with urination		P	C	**Constitutional**				Anxiety disorders		P	C
Nausea		P	C	Kidney Disease		P	C	Chronic fatigue		P	C	**Any symptoms/diseases not listed above?**			
Vomiting		P	C	Frequent urine infection		P	C	Poor sleeper		P	C				
Abdominal Pain		P	C	**Endocrine/Metabolic**				Fever		P	C			P	C
Poor appetite		P	C	Diabetes		P	C	Weight loss		P	C			P	C
Passes a lot of gas		P	C	Thyroid Disorders		P	C	Cancer		P	C			P	C

PAST HISTORY

Please explain any YES answers in detailed description in the box provided.

Has the patient ever had any surgery or been hospitalized? **Has the patient had any problems with anesthesia? No ____ Yes _____ If yes, please list below:**	**❑ No ❑ Yes**	**Surgeries**	**Dates**	**Hospitalizations other than surgery**	**Dates**
Is the patient allergic to any medications or latex?	**❑ No ❑ Yes**	**If yes, what?**			
Is the patient allergic or intolerant of any food	**❑ No ❑ Yes**	**If yes, what food(s) and what reaction?**			

Is the patient currently taking any medications or drugs (including vitamins, herbs or other alternative medicines)?	**❑ No ❑ Yes**	**Medication**	**Dose**	**Times**	**Medication**	**Dose**	**Times**
Is the patient currently experiencing a lot of stress (school, moves, deaths, parent divorce)	**❑ No ❑ Yes**	**If yes, please explain**					

FAMILY HISTORY: Please indicate if the patient's parents, grandparents, aunts, uncles and/or siblings have had any of the following conditions:

Condition	Relationship to patient	Condition	Relationship to patient	Condition	Relationship to patient
Colon/ Rectal Cancer **❑ No ❑ Yes**		GERD **❑ No ❑ Yes**		Constipation **❑ No ❑ Yes**	
Intestinal Polyps **❑ No ❑ Yes**		Ulcerative Colitis **❑ No ❑ Yes**		Other:	
Celiac Disease **❑ No ❑ Yes**		Crohns Disease **❑ No ❑ Yes**		Other:	

Person Completing This Form/Relationship to Patient **Reviewed by Provider** **Date(s)**

CONSENT TO TREATMENT

I, the patient/parent/legal guardian, with my signature, authorize this practice, and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include, but shall not be limited to, preventative, diagnostic, therapeutic, rehabilitative, counseling, assessment or review of physical or mental status/function of the body, and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent encompasses contact and discussion with other health care professionals for care and treatment.

In consideration of any medical care provided to the patient, I hereby assign to the practice and providers associated with the practice all my rights, title and interest to any and all medical reimbursement under my insurance policy, subscription certificate or other health benefit indemnification agreement otherwise payable to me for those services rendered by the practice.

I understand that the practice participates in a health information exchange (the "Exchange") operated by Ann & Robert H. Lurie Children's Hospital of Chicago ("Lurie Children's") that facilitates the electronic sharing and exchange of medical and other individually identifiable health information regarding patients among all health care providers that participate in the Exchange, including Lurie Children's Affiliates. I understand that by participating in the Exchange, my/my child's electronic health record is accessible to all health care providers that participate in the Exchange.

I understand that by participating in the Exchange, the practice may disclose my/my child's electronic health information with the other exchange participants. I understand that such disclosure may also include the following highly confidential types of protected health information: HIV/AIDS related health information and/or records; Behavioral or mental health information and/or records; Information about sexually transmitted diseases; Pregnancy; Birth control; Drug/alcohol diagnosis, treatment, and/or referral information; Genetic testing information and/or records; Information about sexual assault/abuse; and Information about child abuse and neglect.

I understand that I may revoke my authorization to disclosures of information about me/my child through the exchanges by notifying the practice of such revocation in writing, but that no such revocation will affect any disclosures made prior to acceptance of such revocation by the practice and Ann & Robert H. Lurie Children's Hospital of Chicago.

By signing this form, I authorize the practice to electronically search for, use and disclose my/my child's demographic (including cellular phone number and email addresses), medical, billing, and other health-related information, including any highly confidential health information, to other health care providers that participate in the Exchange and request such information for purposes including but not limited to facilitating or providing treatment (both primary and specialty care), arranging for payment and collections purposes, or otherwise conducting or administering their health care operations.

I UNDERSTAND THAT MY AUTHORIZATION IS VALID FOR ONE (1) YEAR.

PATIENT NAME:
Patient/Parent/Legal Guardian Signature: **Date:**

_____ _____

_____

PediaTrust, LLC
Summary of our Notice of Privacy Practices

This summary of our Notice of Privacy Practices applies to patients and, as applicable, their parent(s), legal guardians or other authorized personal representatives.

Who Will Follow The Notice Of Privacy Practices:

This Notice describes the privacy practices of PediaTrust, LLC and all of its members.

Our Pledge Regarding Patient Information:

We understand that patient information about you is personal. We are committed to protecting the confidentiality of your patient information. Our complete Notice of Privacy Practices describes how we may use and disclose your patient information without your written authorization to provide treatment, obtain payment for services, conduct our health care operations, or for other purposes that are permitted or required by law. When required by law, we will obtain your authorization before using or disclosing any of your patient information. It also describes your rights to access and control your patient information. "Patient information" is information that may identify the patient and that relates to the patient's past, present or future physical or mental health or condition and related health care services or payment for such services.

This is a list of some of the types of uses and disclosures of protected health information (PHI) that may occur:

Treatment: We obtain health information, or PHI, about you to treat you. Your PHI is used by us and others to treat you. We may also send your PHI to another physician, facility, or counselor to which we refer you for treatment, care, procedures, or testing. We may also use your PHI to contact you to tell you about alternative treatments, or other health-related benefits we offer. If you have a friend or family member involved in your care, we may give them PHI about you.

Payment: We use your PHI to obtain payment for the services that we render. For example, we send PHI to Medicaid, Medicare, or your insurance plan to obtain payment for our services.

Health Care Operations: We use your PHI for our operations. For example, we may use your PHI in determining whether we are giving adequate treatment to our patients. From time-to-time, we may use your PHI to contact you to remind you of an appointment.

Legal Requirements: We may use and disclose your PHI as required or authorized by law. For example, we may use or disclose your PHI for the following reasons:

Public Health: We may disclose your health information to prevent or control disease, injury or disability, to report births and deaths, to report reactions to medicines or medical devices or to report suspected cases of abuse or neglect.

Health Oversight Activities: We may use and disclose your PHI to state agencies and federal government authorities when required to do so. We may use and disclose your health information in order to assist others in determining your eligibility for public benefit programs and to coordinate delivery of those programs.

Judicial and Administrative Proceedings: We may use and disclose your PHI in judicial and administrative proceedings.

Law Enforcement: We may use and disclose your PHI in order to comply with requests pursuant to a court order, warrant, subpoena, summons, or similar process. We may use and disclose PHI to locate someone who is missing, to identify a crime victim, to report a death, to report criminal activity at our offices, or in an emergency.

Avert a Serious Threat to Health or Safety: We may use or disclose your PHI to stop you or someone else from getting hurt.

Work-Related Injuries: We may use or disclose PHI to an employer if the employer is conducting medical workplace surveillance or to evaluate work-related injuries.

Coroners, Medical Examiners, and Funeral Directors: We may use or disclose PHI to a coroner or medical examiner in some situations.

Armed Forces: We may use or disclose the PHI of Armed Forces personnel to the military for proper execution of a military mission. We may also use and disclose PHI to the Department of Veterans Affairs to determine eligibility for benefits.

National Security and Intelligence: We may use or disclose PHI to maintain the safety of the President or other protected officials. We may use or disclose PHI for the conduct of national intelligence activities.

Correctional Institutions and Custodial Situations: We may use or disclose PHI to correctional institutions or law enforcement custodians for the safety of individuals at the correctional institution, those that are responsible for transporting inmates, and others.

Research: You will need to sign an Authorization form before we use or disclosure PHI for research purposes except in limited situations.

Fundraising: We do not currently, but if in the future we begin fundraising or marketing activities for which we would access PHI, we need your authorization to do so.

Immunizations: If we obtain and document your verbal or written agreement to do so, we may release proof of immunization to a school where you are a student or prospective student.

Illinois law: Illinois law also has certain requirements that govern the use or disclosure of your PHI. In order for us to release information about mental health treatment, genetic information, your AIDS/HIV status, and alcohol or drug abuse treatment, you will be required to sign an Authorization form unless state law allows us to make the specific type of use or disclosure without your authorization.

Your Rights Regarding Patient Information About You:

You have the following rights regarding patient information we maintain about you:

- Right to receive a copy of our complete Notice of Privacy Practices
- Right to inspect and copy patient information in your medical or billing records
- Right to request an amendment of patient information in your medical or billing records
- Right to an accounting of certain disclosures made by us
- Right to communicate with us via alternative means or have communications sent to alternative locations
- Right to request restrictions on how we use or disclose your patient information
- Right to receive an accounting of disclosures we have made of your PHI.
- Right to revoke an authorization given to us

Although you have these rights, we may deny your requests if they do not meet certain requirements.

We are required to obtain your written Authorization when we use or disclose your PHI in ways not described in this Notice.

If you feel that your privacy rights have been violated, you may file a complaint with us by calling our Privacy Officer at 224.330.6300. We will not retaliate against you for filing a complaint. You may also file a complaint with the Secretary of Health and Human Services in Washington, DC if you feel your privacy rights have been violated.

If you have any questions about this Notice, your privacy rights described above or believe your privacy rights have been violated, please contact PediaTrust, LLC or you may file a complaint with the Director of the Office for Civil Rights of the U.S. Department of Health and Human Services.

I have read the above summary of Privacy Notice for PediaTrust, LLC and I agree to the terms listed above.

Print Name _____ **Signature:**_____ **Date:** _____
Parent or Legal Guardian

Child _____ **DOB:** _____ **Child** _____ **DOB:** _____

Child _____ **DOB:** _____ **Child** _____**DOB:** _____

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We understand that patient information about you is personal. We are committed to protecting the confidentiality of your patient information. Our complete Notice of Privacy Practices describes how we may use and disclose your patient information without your written authorization to provide treatment, obtain payment for services, conduct our health care operations, or for other purposes that are permitted or required by law. When required by law, we will obtain your authorization before using or disclosing any of your patient information. It also describes your rights to access and control your patient information. "Patient information" is information that may identify the patient and that relates to the patient's past, present or future physical or mental health or condition and related health care services or payment for such services.

This is a list of some of the types of uses and disclosures of protected health information (PHI) that may occur:

Treatment: We obtain health information, or PHI, about you to treat you. Your PHI is used by us and others to treat you. We may also send your PHI to another physician, facility, or counselor to which we refer you for treatment, care, procedures, or testing. We may also use your PHI to contact you to tell you about alternative treatments, or other health-related benefits we offer. If you have a friend or family member involved in your care, we may give them PHI about you.

Payment: We use your PHI to obtain payment for the services that we render. For example, we send PHI to Medicaid, Medicare, or your insurance plan to obtain payment for our services.

Health Care Operations: We use your PHI for our operations. For example, we may use your PHI in determining whether we are giving adequate treatment to our patients. From time-to-time, we may use your PHI to contact you to remind you of an appointment.

Legal Requirements: We may use and disclose your PHI as required or authorized by law. For example, we may use or disclose your PHI for the following reasons:

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Health Oversight Activities: We may use and disclose your PHI to state agencies and federal government authorities when required to do so. We may use and disclose your health information in order to assist others in determining your eligibility for public benefit programs and to coordinate delivery of those programs.

Judicial and Administrative Proceedings: We may use and disclose your PHI in judicial and administrative proceedings.

Law Enforcement: We may use and disclose your PHI in order to comply with requests pursuant to a court order, warrant, subpoena, summons, or similar process. We may use and disclose PHI to locate someone who is missing, to identify a crime victim, to report a death, to report criminal activity at our offices, or in an emergency.

Avert a Serious Threat to Health or Safety: We may use or disclose your PHI to stop you or someone else from getting hurt.

Work-Related Injuries: We may use or disclose PHI to an employer if the employer is conducting medical workplace surveillance or to evaluate work-related injuries.

Coroners, Medical Examiners, and Funeral Directors: We may use or disclose PHI to a coroner or medical examiner in some situations.

Armed Forces: We may use or disclose the PHI of Armed Forces personnel to the military for proper execution of a military mission. We may also use and disclose PHI to the Department of Veterans Affairs to determine eligibility for benefits.

National Security and Intelligence: We may use or disclose PHI to maintain the safety of the President or other protected officials. We may use or disclose PHI for the conduct of national intelligence activities.

Correctional Institutions and Custodial Situations: We may use or disclose PHI to correctional institutions or law enforcement custodians for the safety of individuals at the correctional institution, those that are responsible for transporting inmates, and others.

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Illinois law: Illinois law also has certain requirements that govern the use or disclosure of your PHI. In order for us to release information about mental health treatment, genetic information, your AIDS/HIV status, and alcohol or drug abuse treatment, you will be required to sign an Authorization form unless state law allows us to make the specific type of use or disclosure without your authorization.

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- Right to request an amendment of patient information in your medical or billing records
- Right to an accounting of certain disclosures made by us
- Right to communicate with us via alternative means or have communications sent to alternative locations
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- Right to receive an accounting of disclosures we have made of your PHI.
- Right to revoke an authorization given to us

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We are required to obtain your written Authorization when we use or disclose your PHI in ways not described in this Notice.

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If you have any questions about this Notice, your privacy rights described above or believe your privacy rights have been violated, please contact PediaTrust, LLC or you may file a complaint with the Director of the Office for Civil Rights of the U.S. Department of Health and Human Services.

I have read the above summary of Privacy Notice for PediaTrust, LLC and I agree to the terms listed above.

Print Name _____ **Signature:**_____ **Date:** _____

Patient ***(18 Years of age +)***

PediaTrust, LLC

Authorization for Release of Patient Health Information Date: _____

Patient Name: _____
Patient Date of Birth: _____
Address: _____
City / State / ZIP: _____
Telephone #: _____

I hereby authorize the protected health information regarding the above named person to be released to:

Person/Institution: _____
Address: _____
City/State/ZIP: _____
Fax: _____

If record is needed because you are leaving the practice, what is your reason for leaving?

☐ "Aged out" ☐ Moving out of area ☐ Unhappy with practice or physician

The type of information to be used or disclosed is as follows:

☐ GROWTH CHART ☐ ENTIRE HEALTH RECORD
☐ IMMUNIZATION RECORD ☐ OTHER (please specify)_____

Include the following sensitive information:

	Behavioral or mental health information and/or records *(the patient 12 or over must authorize this release)*
	Birth control *(the patient 12 or over must authorize this release)*
☐	Drug/alcohol diagnosis, treatment, and/or referral information *(the patient 12 or over must authorize this release)*
	HIV/AIDS related health information and/or records *(the patient 12 or over must authorize this release)*
	Information about sexually transmitted disease *(the patient 12 or over must authorize this release)*
	Pregnancy *(the patient 12 or over must authorize this release)*

☐ Genetic testing information and/or records
☐ Information about sexual assault/abuse
☐ Information about child abuse and neglect
☐ Domestic abuse of an adult with a disability

By my signature, I hereby authorize PediaTrust, LLC to use or disclose my health information in the manner indicated above.

Parent/Legal Guardian Signature:_____ Date:_____

Patient Signature:_____Date:_____
(If 12 yrs. or older and items in box checked for release)

Authorized individual to pick up records *(Photo ID will be required)*: _____

For Office Use Only:
Records reviewed by Provider: _____
Records Transfer Fees: _____ Amount Paid: _____