sgh PEDIATRICS

PATIENT REGISTRATION
(Please print)

Patient's First Name | Middle Name | Last Name | DOB

Race/Ethnicity | Male or Female Sex | Primary Phone Number

Address : (Street, City, State, Zip Code)

Parent Information

Mother's Name: | DOB | Email Address

Mother's Cell Number | Mother's Home Number | Mother's Work Number

Address (if different)

Employer | Occupation | Employer address

Father's Name: | DOB | Email Address

Father's Cell Number | Father's Home Number | Father's Work Number

Address (if different)

Employer | Occupation | Employer address

Sibling names and Dates of Birth:

Referral to our Practice

Who can we thank for referring you to our practice?

SGH Pediatrics * 800 W. Arbrook Blvd. Ste 250 * Arlington, TX 76015 *
Phone 817-375-5755 Fax 817-375-5788

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Patient Name: _____ DOB: _____

Primary Pharmacy: _____

Birth History

_____

Hospital of birth | Number of weeks pregnant | Type of delivery

_____

Problems or complications around birth? | Did you baby go home with you?

_____

Birth weight | Feeding (breast, bottle, or both) | If bottle, formula you are using

Child History

_____

Any known Allergies?

_____

Is your child on any mediations? If yes, please list them

_____

Has your child ever had surgery? If so, give age and type

_____

Has your child ever been hospitalized? If so, age and what for

Family History

List below any of the patients immediate relatives (mother, father, siblings, grandparents, aunts, uncles, cousins) who have had any of the following illnesses:

Condition	No	Yes	Family Member
Allergies			
Anemia			
Asthma, Emphysema, TB			
Birth Defects			
Blood Disease			
Cancer (Specify)			
Drug/Alcohol Use			
Ear/Ear Disorder			
Heart Disease			
Infections (Frequent or severe)			
Kidney/Liver Disease			
Learning Problems			
Mental Illness/Retardation			
Metabolic/Genetic Disease			
Nerve Disorder (Epilepsy, C.P.)			
Rheumatic Fever			
Sickle Cell Trait			
Thyroid Disease			
Other			

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Patient Name: _____ Date: _____

Consent for treatment and understanding of financial responsibility

The patient agrees to general medical treatment by SGH Pediatrics and understand and consents to the review and use of his/her medical records by SGH Pediatrics. All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments.
However, it is understood and agreed to, that the patient is responsible for all fees, including remainder of deductibles, regardless of insurance coverage. It is customary to pay for services when rendered, unless other arrangements have been made in advance. ***SGH Pediatrics does not accept Medicaid. ***

I hereby authorize SGH Pediatrics to furnish information concerning my medical condition and treatment thereof to insurance carries. I also assign insurance benefits paid on my behalf by any and all insurance companies that cover the expenses I incur as the result of any diagnostic services or treatment provided to me by SGH Pediatrics. I further agree that the authorization to release information assignment of beneifts shall remain in effect unless and until it is revoked in writing by me.

_____

Parent/Guardian Signature Relationship to patient Date

Consent for care ~ Parent substitute

I, _____. Give permission for:
Parent's Name

_____	_____
Name	**Relationship to child**
_____	_____
Name	**Relationship to child**
_____	_____
Name	**Relationship to child**
_____	_____
Name	**Relationship to child**
_____	_____
Name	**Relationship to child**

To bring my child, _____, for his/her appointments.
Child's name
Please give them any instructions and/or prescription that may be needed.

In case of emergency, I can be reached at _____.
Contact Number

HIPAA ACKOWLEDGEMENT:

1. I hereby acknowledge that I have been presented with a copy of SGH Pediatrics notice of privacy practices.
2. I hereby acknowledge that I have been presented with a copy of the SGH Pediatrics Office Protocol Handout and understand my responsibilities.

_____

Parent/Guardian Signature Relationship to patient Date

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Phone 817-375-5755 Fax 817-375-5788

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Authorization to release protected health information
To: SGH Pediatrics

Patient Name: _____ DOB: _____

I, the undersigned, authorize the release of or request access to the information specified below from the medical record(s) of the above named patient(s), which is called "Protected Health Information" under a federal health privacy law, as described below:

The Protected Health Information will be used for the following purposes:
____ Continuation of care ____ Insurance Application _____ billing records
____ History & Physical ____ Transfer of Care ____ Other (description) _____

Specific Description of the Information to be used or disclosed (including service date(s):
____All Medical records ____Newborn Records (Hospital Name) _____
_____ Shot record only _____Other _____

Persons or Class of Persons Authorized to Make the Use of Disclosure: SGH Pediatrics

The above information may be released (FROM) _____
Specify Name of title of individual or the name of the organization from which records are to be released and the appropriate address.

_____
Doctor, Hospital, Insurance Company, Self, etc. Phone Number

_____
Address (Street, City, State, Zip Code)

I understand that if the person or entity that receives this information is not a health plan or healthcare provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law.
I understand that I may revoke this authorization at any time by notifying SGH pediatrics in writing. However, if I chose to do so, I understand that my revocation will not affect any action taken by SGH Pediatrics before receiving my revocation. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in the health plan, or eligibility for benefits.

_____
Parent/Guardian Signature Relationship to patient Date

Office Representative Initials: _____ Date Completed: _____

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Notice of Privacy Practices

To our patients. This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Commitment to your Privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.
We realize that these laws are complicated, but we must provide you with the following important information.

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use and disclose your health information:
1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings is response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities as required by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For business associates to resolve payment issues for services rendered.