Tuscany Children Clinic
www.TuscanyChildrenClinic.com
info@TuscanyChildrenClinic.com
2851 S Ave B Ste 19
Yuma, AZ 85364
Phone: (928) 366-1026
Fax: (928) 366-1028

PATIENT REGISTRATION FORM

PATIENT INFORMATION

PATIENT NAME _____ (Last) _____ (First) _____ (Middle) SSN _____

DOB _____ AGE _____ HEIGHT _____ WEIGHT _____

MAILING ADDRESS _____ CITY _____ ST _____ ZIP _____

HOME PHONE _____ CELL/WORK PHONE _____

EMPLOYER/SCHOOL _____ EMPLOYER PHONE _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

EMPLOYMENT TITLE _____ _____

EMERGENCY CONTACT _____ PHONE _____ RELATION _____

PHARMACY _____ REFERRING PHYSICIAN _____

EMAIL _____

PARENT/LEGAL GUARDIAN INFORMATION

PARENT/LEGAL GUARDIAN NAME _____ (Last) _____ (First) _____ (Middle) SSN _____

DOB _____ EMAIL _____

MAILING ADDRESS _____ CITY _____ ST _____ ZIP _____

HOME PHONE _____ CELL/WORK PHONE _____

EMPLOYER/SCHOOL _____ EMPLOYER PHONE _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

PRIMARY INSURANCE INFORMATION & RESPONSIBLE PARTY

NAME OF INSURANCE _____ ID # _____

GROUP/POLICY NUMBER _____ CO-PAY _____ DEDUCTIBLE _____

NAME OF INSURED _____

RELATION TO PATIENT _____ DOB _____ SS# _____

EMPLOYER _____ EMPLOYER PHONE _____

EMPLOYER ADDRESS _____ CITY _____ ST _____ ZIP _____

SECONDARY INSURANCE INFORMATION & RESPONSIBLE PARTY

NAME OF INSURANCE _____ ID # _____

GROUP/POLICY NUMBER _____ CO-PAY _____ DEDUCTIBLE _____

NAME OF INSURED _____

RELATION TO PATIENT _____ DOB _____ SS# _____

EMPLOYER _____ EMPLOYER PHONE _____

EMPLOYER ADDRESS _____ CITY _____ ST _____ ZIP _____

IF YOU DO NOT HAVE MEDICAL INSURANCE COVERAGE AND ARE PAYING FOR YOUR MEDICAL SERVICES YOU WILL BE EXPECTED TO PAY AT THE TIME OF SERVICE. PRIOR TO TREATMENT, PLEASE DISCUSS PAYMENT OPTIONS WITH OUR BILLING DEPARTMENT.

PATIENT'S NAME: ***DOB:***

LIFETIME AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize Tuscany Children Clinic to furnish information to insurance carriers concerning my illness(es) and treatment (s) and I hereby assign to the physician (s) all payments for medical services rendered to myself or my dependents. Initial Here: _____

I understand that should I agree to the medical services which are not covered benefit under my medical insurance plan (s) that I am responsible for all of those non-covered procedures or services.
Initial Here: _____

I authorize the release of my medical records from _____ to Tuscany Children Clinic for continuity of my medical treatment and/or care . Initial Here: _____

CONSENT TO TREATMENT

I authorize and consent Tuscany Children Clinic licensed healthcare providers to examine my person, perform any medical diagnostic studies, and give any medical treatment which is consistent with quality medical care
Initial Here: _____

CONSENT FOR IMMUNIZATIONS

I authorize and consent Tuscany Children Clinic licensed healthcare providers to provide all immunizations as needed to my child.

If applicable, list exceptions here: _____
_____
_____ Initial Here: _____

HIPPA

I _____ acknowledge that I have read a copy of the "Notice of Privacy Practices". My signature means that I agree and consent to allow Tuscany Children Clinic to use and disclose my protected health information to carry out treatment, payment, and healthcare operations.

If a minor (under 18 years): _____ _____
Consent for treatment (signature) Relation to Patient

I certify that the information I have reported with regard to my insurance coverage and personal information is correct.

Signature: _____ Date: _____

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QUESTIONS ABOUT YOUR CHILD

Your pediatrician would like to know your child as a person, and not only treat one specific problem. Many of the questions below may not have anything to do with today's visit, but they will help your pediatrician to know your child better. They may help to prevent other problems before they get worse. Your answers will remain confidential.

	No	Yes
1. Was the pregnancy of the child's mother more than 2-3 weeks shorter or longer than normal?	_____	_____
2. Did the child's mother have any serious problems during the pregnancy?	_____	_____
3. Did she smoke during the pregnancy?	_____	_____
4. Did she drink or use any street drugs before or after she learned that she was pregnant?	_____	_____
5. Was the pregnancy unplanned ("oops")?	_____	_____
6. Was the pregnancy vaginal ____ or C-section ____? What was the child's birth weight, if you remember it? _____	_____	_____
7. Did the child have any complication at birth and did he/she stay in the hospital longer than the mother?	_____	_____
8. Did the child have to be admitted to the hospital (not just seen in the emergency room) in the first month after birth or any time during childhood?	_____	_____
9. Did the child have any operations? If yes, what type, what year or how old? _____	_____	_____
10. Did the child have any serious chronic illness? If yes, which one, and starting at what age? _____	_____	_____
11. Did the child fall behind in the things that children do (sitting, standing, walking, talking, etc…) or in his/her intelligence?	_____	_____
12. Are you worried about the child not talking, hearing or seeing well?	_____	_____
13. Does the child wet the bed at night, if older than 4 years?	_____	_____
14. Does the child have trouble pooping (constipation)?	_____	_____
15. Does someone on either side of the family have asthma, convulsions, or other serious illness?	_____	_____
16. How many children are there in the family (total)? _____ Are they from different father or mothers?	_____	_____
17. Are the parents of the child separated or divorced?	_____	_____
18. Does the mother or the father of the child smoke?	_____	_____
19. Has the mother or the father of the child had any problem with drinking, drugs or violence? (ex. Father hitting mother)?	_____	_____

Name of Child	Date of Birth	Today's Date
_____	_____	_____