Pediatric Urology Associates, P.C.

Patient Registration Form

PATIENT INFORMATION **DATE** _____

Patient's Name: _____ Date of Birth: _____ Sex: M / F

Street Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Pediatrician: _____ Phone: _____ Fax: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Pharmacy Name: _____ Phone: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

PLEASE COMPLETE ALL FIELDS BELOW

PARENT / LEGAL GUARDIAN INFORMATION

***Mother's* Name:** _____
(or Legal Guardian)

Social Sec# _____ -_____-_____

DOB: _____ Cell Phone: _____

***Father's* Name:** _____
(or Legal Guardian)

Social Sec# _____ -_____-_____

DOB: _____ Cell Phone: _____

INSURANCE (PRIMARY)

Employer Name: _____ **Work Phone:** _____ **Ext.** _____

Employer Address: _____ **City:** _____ **State:** _____ **Zip:** _____

***Primary* Insurance Company Name:** _____ **Policy/ID#** _____

Group or Plan# _____ **Insured's Name (policy holder):** _____ **DOB:** _____

Claims Address: _____ City: _____ State: _____ Zip Code: _____

Phone# _____ **Patient's Relationship to Insured (circle one):** **SELF CHILD SPOUSE OTHER** _____

INSURANCE (SECONDARY)

Employer Name: _____ **Work Phone:** _____ **Ext.** _____

Employer Address: _____ **City:** _____ **State:** _____ **Zip:** _____

***Secondary* Insurance Company Name:** _____ **Policy/ID#** _____

Group or Plan# _____ **Insured's Name (policy holder):** _____ **DOB:** _____

Claims Address: _____ City: _____ State: _____ Zip Code: _____

Phone# _____ **Patient's Relationship to Insured (circle one):** **SELF CHILD SPOUSE OTHER** _____

Pediatric Urology Associates, P.C.

150 White Plains Road
Suite 306
Tarrytown, NY 10591
914.493.8628 fax: 914.493.8564

1200 High Ridge Road
3rd Floor
Stamford, CT 06905
203.359.4211 fax: 203.327.4211

745 64th Street
4th Floor
Brooklyn, NY 11220
718.283.7743 fax: 718.283.6603

1999 Marcus Avenue
Suite M18
New Hyde Park, NY 11042
516.466.6953 fax: 516.466.5608

Dear Parents,

This letter is to inform you of some important changes that directly affect how physicians and their staff must conduct their medical practices. The government has implemented new regulations called HIPAA, which directs how medical personnel and medical information must be handled.

These rules went into effect on April 14, 2003 and this may cause some inconvenience or delays in our daily operations.

We have attached a copy of our Privacy Policies. Please read it carefully, and feel free to ask any questions. After reading it, you will be asked to sign it, stating that you have read it and understand it. The signed statement will be placed in your records. If you do not wish to sign it, we will note it in your medical record. We must still comply with all of the policies outlined in this document whether or not you sign it.

To protect your privacy, we will require a written authorization prior to releasing any medical information to another physician, insurance carrier, family member or you. We will not be allowed to release information to anyone without your permission. Our form will provide a blanket release for family, insurance carriers, pharmacies or your primary care physician. Any additional individuals that you like to have authorized to receive information may be added to the original consent. Any future individuals that are not listed on the authorization form will require you to sign a new authorization form. We will accept a faxed authorization.

Please note that there are exceptions to this rule and they are defined in the Privacy Policy.

If you arrive to our office and we are currently assisting another patient, you will be asked to have a seat in the waiting area and we will call you when we have finished with the previous patient. This will protect the privacy of all of our patients, including you.

A few other topics:

Many managed care entities mandate that you have a referral for any visit to our office. It is your responsibility to have the referral to us prior to or at the time of appointment. If you do not have it, we will be forced to reschedule your appointment. THERE ARE NO EXCEPTIONS.

If you are requesting copies of your records to be mailed to another physician, a hospital or an attorney, you will be required to pay $0.75 per page for photocopying and mailing expenses. This is the fee that the New York State Health Department mandates for copies of records. Overnight courier, if requested, will be an extra charge.

Patient Consent for Use of PHI & Receipt of Privacy Notice

With my consent, Pediatric Urology Associates, P.C. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

I have received and have the right to review the Notice of Privacy Practices prior to signing this consent. By signing this form, I am consenting to Pediatric Urology Associates, P.C.'s use and disclosure of my PHI to carry out TPO.

With my consent, Pediatric Urology Associates P.C., may communicate via mail, e-mail or telephone with my home or other designated location and leave a message in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, patient statements and any other information pertaining to my clinical care, including laboratory results among others.

I have the right to request that Pediatric Urology Associates P.C., restrict how it uses or disclosed my PHI to carry out TPO in the following listed individuals. However, the practice is not required to agree to any requested restrictions, but if it does it is bound by this agreement.

Name_____ Restriction_____

Name_____ Restriction_____

Name_____ Restriction_____

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Pediatric Urology Associates, P.C. may decline to provide treatment to me.

X_____ X_____
Printed Name of Parent or Legal Guardian Patient's Name

X_____ X_____
Signature of Parent or Legal Guardian Date

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

X_____ X_____
Printed Name of Parent or Legal Guardian Patient's Name

X_____ X_____ X_____
Signature of Parent or Legal Guardian Date Relation to Patient

PEDIATRIC UROLOGY ASSOCIATES, P.C.

Patient Name: _____ Nickname: _____ Date of Birth: _____

- Have any of the patient's siblings been seen by our practice before? ☐ Yes. Name: _____ ☐ No
- Was your child ever seen by any doctor in our practice? ☐ Yes. Name of Doctor: _____ ☐ No
- Why is your child being seen today? _____
- Has your child had any test performed recently? _____

Current Medication(s), including OTC products:		**Allergies:** ☐ Yes ☐ No	
Name:	***Dosage:***	***If yes, list below:***	***Type of reaction:***
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MEDICAL HISTORY:

Any past or current diagnosis: _____

_____

SURGICAL HISTORY:		**HOSPITALIZATIONS:**	
Date (month/year)	***Type of surgery***	***Date (month/year)***	***Reason for hospitalization***
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY HISTORY: PLEASE CHECK ALL THAT APPLY

Mother:	☐ deceased ☐ no problem ☐ kidney problems ☐ urine reflux ☐ UTIs ☐ kidney stone ☐ voiding problems ☐ bleeding problems ☐ anesthesia problem ☐ heart arrhythmias ☐ Other: _____
Father:	☐ deceased ☐ no problem ☐ kidney problems ☐ urine reflux ☐ UTIs ☐ kidney stone ☐ voiding problems ☐ bleeding problems ☐ anesthesia problem ☐ heart arrhythmias ☐ testicular problem ☐ penile problem ☐ Other: _____

PEDIATRIC UROLOGY ASSOCIATES, P.C.

FAMILY HISTORY: PLEASE CHECK ALL THAT APPLY

Siblings: ☐ deceased ☐ no problem ☐ kidney problems ☐ urine reflux ☐ UTIs
☐ kidney stone ☐ voiding problems ☐ bleeding problems ☐ anesthesia problem
☐ heart arrhythmias

SOCIAL HISTORY: Parents married ☐ Yes ☐ No/not applicable
Parents divorced ☐ Yes ☐ No/not applicable

Does your child have a history of any of the signs/symptoms listed below? PLEASE CHECK ALL THAT APPLY:

FEMALE – Genitourinary: ☐ blood in urine ☐ painful urination ☐ vaginal pain

MALE – Genitourinary: ☐ blood in urine ☐ painful urination ☐ testicular pain

General: ☐ premature delivery ☐ anesthesia problem ☐ weight loss ☐ weight gain
☐ fever ☐ chills

Ophthalmology: ☐ disturbed vision ☐ corrective lenses

ENT/Respiratory: ☐ nose bleeds ☐ asthma ☐ ear infections ☐ ear tubes ☐ snoring

Cardiology: ☐ palpitations ☐ murmurs ☐ heart surgery

Gastroenterology: ☐ constipation ☐ abdominal pain ☐ nausea and vomiting ☐ encopresis

Musculoskeletal: ☐ brace ☐ wheelchair ☐ back pain ☐ gait disturbance ☐ low muscle tone

Dermatology: ☐ skin rash ☐ eczema

Endocrinology: ☐ growth problems ☐ excessive thirst ☐ thyroid problems
☐ menses, age of onset: _____

Hematologic/Lymphatic: ☐ bleeding issues ☐ easy to bruise ☐ sickle cell anemia ☐ swollen glands

Neurology: ☐ weakness ☐ numbness ☐ seizures ☐ spina bifida ☐ headaches ☐ vp shunt

Psychology: ☐ depression ☐ sleep disturbance ☐ ADD/ADHD ☐ developmental delay
☐ autism/spectrum

OTHER MEDICAL CONDITION(s) NOT LISTED ABOVE:

_____

_____