NEW JERSEY BRAIN AND SPINE

New Jersey Brain and Spine

PEDIATRIC REGISTRATION FORM

Patient Name: Last _____ First _____ MI _____
D.O.B _____ Social Security # _____ Sex: (M) (F)
Patient lives with: Mother ____ Father ____ Other: _____
Language: English, Spanish or Other: _____
Ethnicity: Hispanic, African American, Caucasian, Asian or Other: _____

Mother/Guardian: _____D.O.B._____ Social Security # _____
Address: _____City: _____ State: _____Zip Code: _____
Home Phone: _____ Cellular Phone: _____
Work Phone: _____Employer: _____
Email: _____
Father/Guardian: _____D.O.B._____ Social Security # _____
Address: _____City: _____ State: _____Zip Code: _____
Home Phone: _____ Cellular Phone: _____
Work Phone: _____Employer: _____
Email: _____

Primary Insurance: _____
Policy Holder: _____ SS#: _____
DOB: _____ Address (if different from above): _____
Relationship to Patient: _____ ID#: _____ Group#: _____
Secondary Insurance: _____
Policy Holder: _____ SS#: _____
DOB: _____ Address (if different from above): _____
Relationship to Patient: _____ ID#: _____ Group#: _____

Emergency Contact Person (other than parents): _____ Phone: _____
Referring Doctor: _____ Phone: _____
Primary Doctor/Pediatrician: _____ Phone: _____

MEDICAL CARE CANNOT BE GIVEN UNLESS MY CHILD IS ACCOMPANIED BY ONE OF THE FOLLOWING:

_____

Parent/Guardian signature: _____Relationship: _____ Date: _____

AUTHORIZATION OF TREATMENT AND ASSIGNMENT OF BENEFITS

I authorize New Jersey Brain and Spine to treat my child. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to New Jersey Brain and Spine for the medical and surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments, deductibles and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original.

Parent/Guardian signature: _____ Relationship: _____ Date _____

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*** PLEASE FILL OUT THIS FORM COMPLETELY ****

What problem(s) is your child currently experiencing (what are we seeing your child for)?

_____

Check if patient has now or has had the following illness or problems:

( ) Trauma (broken bones, loss of consciousness,etc)	( ) Anemia or blood disorder
( ) Stomach or Intestinal problems	( ) Diabetes
( ) Growth problems	( ) Asthma
( ) Seizures	( ) Heart problems
( ) Cancer	( ) Emotional/behavioral problems
( ) Neurological problems	

Any past surgeries? Please explain:

_____

_____

Please list any medications or supplements your child is currently taking:

_____

Are all immunizations up to date? _____

ALLERGIES (list or indicate none if applicable): _____

FAMILY HISTORY _____ Bleeding _____ Problems with anesthesia _____ Cancer or blood disorder _____ Heart disease or liver disease Please explain: _____

_____

BIRTH HISTORY Type of delivery: _____ Vaginal _____ C-Section Baby Was: _____ Full Term _____ Premature

Birth weight: _____ Was he/she on a ventilator? _____No_____ Yes If so, how long? _____

Other complications:

_____

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NEW JERSEY BRAIN AND SPINE NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGMENT FORM

Our Notice of Privacy Practices ("Notice") provides information about: 1) the privacy rights of our patients; and 2) how we may use and disclose protected health information about our patients. Federal regulations require that we give our patients or their authorized representatives our Notice before signing this acknowledgment. By signing this form, you are only acknowledging that you have been provided our Notice.

Signature of Patient or Authorized Representative _____ Date _____

Print Name of Patient/Authorized Representative _____

NEW JERSEY BRAIN AND SPINE AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO FAMILY AND FRIENDS

I authorize the practice to discuss appointment dates, times, location, medical history, diagnosis, treatment, prognosis, financial, insurance and billing information with those listed below. I understand that my or my child's healthcare provider will use his/her judgment in sharing this information in order to foster continuity of care. The release of copies of medical records will require a signed HIPAA-compliant authorization. This permission will be considered on-going until I indicate otherwise in writing. PHI may be released to the following individuals:

1._____

2. _____

3. _____

4. _____

___ Yes ___No **The practice staff have my permission to share my or my child's personal health information with family members or others who are in the room with me/us during the appointment.**

The practice staff has my permission to leave messages concerning treatment (i.e., Lab Results) on my:
(Please check all that apply)

__ Home Voice Mail or Answering Machine Home Phone number: _____
__ Cell phone Cell phone number: _____
__ Work Voice Mail Work phone number: _____

__ NO INFORMATION: I do not authorize the release of any verbal information (other than appointment reminders to the number(s) that I have provided).

_____ _____
Print Name of Patient Print Name of Authorized Representative*

_____ _____
Patient/Authorized Representative* Signature Date Signed

* To act on the Patient's behalf: Parent/legal guardian or Power of Attorney *Evidence of authority must be provided and on file with the practice.