Patient Registration Information

Today's Date ______/_______/________

Last Name ____ First Name ________________________

Gender: Male or Female Date of Birth: ______/______/_________

Address ____
Street City State Zip

Home Phone # ______________________________ Alternate # ______________________________

Pediatrician: ____________________________________ Hospital born in ____________________

Emergency Contact-

Contact's Name __________________________ Relation _________ Phone # __________________

Mother's Information (or Legal Guardian)

Last Name ____ First Name ________________________

Address ____
Street City State Zip

Date of Birth : _____/_____/_____ Phone # __________________ Alternate # ____________________

Employer: ____________________________________ Occupation: _________________________

Address ____
Street City State Zip

Father's Information (or Legal Guardian)

Last Name ____ First Name ________________________

Address ____
Street City State Zip

Date of Birth : _____/_____/_____ Phone # __________________ Alternate # ____________________

Employer: ____________________________________ Occupation: _________________________

Address ____
Street City State Zip

Primary Insurance Information

Insurance ___________________________ ID # /Group _________________ Phone # _____________

Subscriber's

Name ____ Relationship to Patient __________________

Insurance Address ____
Street City State Zip

Secondary Insurance Information

Insurance ___________________________ ID # /Group _________________ Phone # _____________

Subscriber's

Name ____ Relationship to Patient ________________

Consent for Treatment

I authorize Children's Specialists Medical Group of Sacramento, Inc. (CSMGS) to administer treatment with the Pediatrics Surgeons.

Release of Medical Records Information

I authorize CSMGS to release any medical information necessary to process and secure payments of charges from my insurance carrier or it's intermediaries in behalf of myself or my dependent.

Protected Health Information

Children's Specialist Medical Group of Sacramento, Inc. (CSMGS) may use and disclose my Protected Health Information (PHI) to carry out Treatment, Payment and Healthcare Operations (TPO).

Children's Specialist Medical Group of Sacramento, Inc. may call or mail to my home, or other designated location, and leave an informational message referencing appointments, inquiring as to insurance information, assisting in referrals, accessing information for the purpose of any TPO.

Please refer to CSMGS's Notice of Privacy Practices for an in depth description of this stature. I have the right to review the Notice of Privacy Practices prior to signing this consent. A Notice of Privacy Practices may be obtained by forwarding a written request to:

Children's Specialist Medical Group of Sacramento, Inc, Privacy Officer
5301 F Street, Suite 313
Sacramento, CA 95819

CSMGS, Inc. reserves the right to revise its Notice of Privacy Practices at anytime.

Assignment of Benefits

I authorize my insurance carrier, or its intermediaries, to make payment directly to CSMGS for medical services rendered. I understand that I am financially responsible for all charges not paid by my insurance carrier.

CSMGS will bill the insurance carrier as a courtesy to help maximize allowable benefits. In order to achieve these goals, we need your assistance and understanding of our financial policy as follows:

1. Your insurance is a contract between you and your insurance company. We encourage you to contact your insurance carrier regarding any issues.
2. Referral and/or authorizations from your pediatrician is likely necessary.
3. Eligibility must be current for the month of the given medical service.
4. Not all services are covered benefits of your insurance policy. Some insurance companies arbitrarily select services they will not cover, thereby rendering these service charges as the insured's financial responsibility.

If temporary financial problems are affecting timely payment on you account, we ask that you contact us promptly to work out a payment plan that satisfies both parties. Please call our Patient Accounting Department at (916) 736-6470 with any questions you may have about the above information or any uncertainty regarding your insurance coverage. Please do not hesitate to ask; we are here to help.

I have read, understand & consent to the above on behalf of myself or the patient:

____

Parent's, Guardian's or Patient's Signature   Date

Pediatric Surgery Medical History Report

Patient's Name: ___________________________________ DOB: ____/____/____ Today's Date: ____/____/____
Last Name, First Name

Child's Past Medical History – Please mark ALL that apply

Birth History
Pregnancy: __Uncomplicated __Complications________________________________
Delivery: __Full Term __Pre-Term (weeks premature_____)
Birth Weight: _____lbs____oz

Newborn History
Did your child remain hospitalized over 24 hours after birth? __No __Yes, how long?_________

Hospitalized for:

__Prematurity __Feeding Problems __Breathing Problems (req'd Oxygen or Breathing Machine)
__Heart Problems, defects __ASD __VSD __PDA Other_________________________
__Neurologic Problem: __Cerebral Palsy Other_________________________
__Infections, what kind? ____

Previous Medical History
Does your child have any known syndrome? __No __Yes, please circle syndrome name-
Down Turner's VATER's Other__________________

Is your child allergic to any medications? __No ___ Yes, please complete on back of page

Does your child take any medications regularly? __No ___ Yes, please complete on back of page

Has your child been hospitalized for any illness or injury? __No ___ Yes, please complete on back of page

Has your child had any previous surgeries? __No ___ Yes, please complete on back of page

Has your child or anyone in your family experienced any difficulty with anesthesia? __No __Yes
Is there a family history of bleeding problems? __No __Yes
Are your child's immunizations up to date? __No __Yes

Does your child have any other medical problems or special needs not listed above?

Please Circle:

General	Recent weight loss	Y N	Heart	Murmurs?	Y N
	Fevers	Y N		Racing Heart?	Y N
	Night sweats	Y N		Chest pain?	Y N
Head	Runny Nose	Y N	GI	Diarrhea?	Y N
	Earaches	Y N		Constipation?	Y N
	Sore throat	Y N		Vomiting?	Y N
	Nose bleeds	Y N		Blood in stool?	Y N
Lungs	Coughing	Y N	Urinary	Painful Urination?	Y N
	Asthma	Y N		Blood in Urine?	Y N
	Shortness of Breath	Y N		Urinary Infection?	Y N
Neurologic	Seizures	Y N	Heme	Easy Bruising?	Y N
	Head Injury?	Y N		Bleeding Gums?	Y N
	Difficulty walking?	Y N		Swollen joints?	Y N

Name of Medication child is allergic and type of reaction to the medication:

Please List Child's Medications:

Medication	Dose
Medication	Dose
Medication	Dose
Medication	Dose
Medication	Dose
Medication	Dose

Hospitalizations:

Illness/Injury	Hospital	Date
Illness/Injury	Hospital	Date
Illness/Injury	Hospital	Date
Illness/Injury	Hospital	Date

Surgery(ies):

Surgery	Hospital	Date
Surgery	Hospital	Date
Surgery	Hospital	Date

Completed / Updated by:

______________________________ Date(s): ______________________
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____
____

Reviewed by:

______________________________ Date(s): ______________________

Physician's signature

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