



HUDSON HEIGHTS PEDIATRICS PATIENT REGISTRATION FORM

PATIENT INFORMATION

*Last Name: _____ *First Name: _____ *Middle Name: _____ *Birthdate: _____ *Sex: M / F

*Street Address/Apt. #: _____

City: _____ State: _____ Zip: _____

Patient Phone # (for patients aged 16+): _____ Consent to text? Y / N

Patient Email (for patients aged 16+): _____

(The patient portal is useful for seeing upcoming appointments, vaccine records, and posting **non-urgent** questions to the office)

Race _____ Ethnicity (please circle) Hispanic / Non-Hispanic / Other Language(s) spoken _____

With whom does the child live? (please circle) Both Parents / Mother / Father / Shared Custody / Grandparents / Legal Guardian / Other

If any information is the same as that listed above, you may write 'same' in the sections below.

PARENT 1 INFORMATION – (PRIMARY CONTACT PERSON)

*Parent's name _____ Sex: M / F *Birthdate _____

Parent's address _____

City _____ State _____ Zip _____

*Primary Phone # _____ cell / home / work *Email (for patient portal) _____

Secondary Phone # (if applicable) _____ cell / home / work

Occupation _____ Employer's name _____

Marital status: Single / Married / Divorced / Domestic Partner Spouse's/Partner's name _____

PARENT 2 INFORMATION

*Parent's name _____ Sex: M / F *Birthdate _____

Parent's address _____

City _____ State _____ Zip _____

*Primary Phone # _____ cell / home / work *Email (for patient portal) _____

Secondary Phone # (if applicable) _____ cell / home / work

Occupation _____ Employer's name _____

Marital status: Single / Married / Divorced / Domestic Partner Spouse's/Partner's name _____

IF PARENTS ARE DIVORCED OR SEPARATED:

Who has custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? **Y / N**

If yes, please explain below. **We will need a copy of any legal paperwork that supports this restriction.**

OTHER PEOPLE IN HOUSEHOLD (including siblings)

Name / Relationship / Sex / Age _____

Name / Relationship / Sex / Age _____

Name / Relationship / Sex / Age _____

EMERGENCY CONTACT INFORMATION (other than parents or guardians)

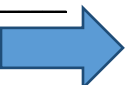
Name _____ Phone _____

Relationship _____

*PREFERRED PHARMACY

Name _____ Address _____

Phone _____ Fax _____



PLEASE READ AND SIGN ALL LINES

The provided insurance information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any charges not covered by my insurance carrier. I also authorize my medical provider or insurance company to release any information required to process my claims. A copy of this signature is to be used in place of the original.

Patient/Parent/Guardian Signature _____ Date _____

RECEIPT OF HIPAA OF PRIVACY PRACTICES ACKNOWLEDGEMENT

The Notice of Privacy Practices describes how Protected Health Information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

Hudson Heights Pediatrics is required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice which describes the health information privacy practices of our practice, its medical staff and affiliated health care providers that jointly perform payment activities and business operations with our practice. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

I have received the notice of Privacy Practices as is required by State and Federal Regulations

Patient/Parent/Guardian Signature _____ Date _____

PRESCRIPTION HISTORY PROGRAM

I authorize Hudson Heights Pediatrics to obtain my/my child's medication history.

Patient/Parent/Guardian Signature _____ Date _____

PRIMARY INSURANCE INFORMATION

Name of Policy Holder _____ Relationship to patient _____
SSN _____ Birthdate _____ Sex: M / F
Insurance carrier name _____ Policy number _____
Employer's name _____ Group number _____
Employer's address _____
City _____ State _____ Zip _____
Employer's phone _____

SECONDARY INSURANCE (IF ANY)

Name of Policy Holder _____ Relationship to patient _____
SSN _____ Birthdate _____ Sex: M / F
Insurance carrier name _____ Policy number _____
Employer's name _____ Group number _____
Employer's address _____
City _____ State _____ Zip _____
Employer's phone _____

Who is responsible for bills? (please circle) Both Parents / Mother / Father / Grandparents / Legal Guardian / Other



Welcome to Hudson Heights Pediatrics! We're glad you are joining the practice. In order to give your child the best possible care, we will need detailed information about your child's and family's medical history

FAMILY HEALTH HISTORY

| |
|---|
| <ul style="list-style-type: none">○ Asthma Who? _____○ Cancer Who? _____○ Chemical Dependency Who? _____○ Diabetes Who? _____○ Hearing Loss Who? _____○ Heart Disease Who? _____○ Hemophilia / Bleeding Who? _____○ High Blood Pressure Who? _____○ High Cholesterol Requiring Medication Who? _____○ Kidney Disease Who? _____○ Mental Disorders Who? _____○ Migraine Who? _____○ Seizures / Epilepsy Who? _____○ Sudden Death in Person < 40 yrs Who? _____○ Tuberculosis Who? _____○ Other _____ |
|---|

BIRTH HISTORY

Which pregnancy is this child? _____

Is your child adopted? Y / N *If so, please describe the following to the best of your knowledge.*

Did the mother have any health problems during the pregnancy? Y / N

If yes, please describe _____

Hospital / city of birth _____

Any previous miscarriage? Y / N If yes, reason? _____

Born by vaginal delivery or c/section? _____ If c/section, reason _____

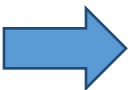
How many weeks gestation at birth? _____

Birth weight _____ APGAR score (if known) _____

Did the child leave the hospital with the mother? Y / N Length of hospital stay _____

If no, reason _____

Please list problems, if any, after birth (jaundice, feeding problems, infections, etc.) _____



CHILD'S HEALTH HISTORY

How would you describe your child's health generally? _____

Is he/she taking any medications on a regular basis (please list with dose/frequency)? _____

Is your child allergic to any medications? Y / N

If yes, what medicine and what type of reaction? _____

Has your child ever been admitted to the hospital? Y / N

if yes, date, reason, duration: _____

Has your child ever had surgery? Y / N

if yes, type, date and outcome: _____

Has your child had any major injuries? Y / N

if yes, date / description: _____

Has your child ever had any of the following illnesses or conditions? Please circle 'yes' or 'no' and provide dates / comments.

| | | | <i>if yes, date</i> | | | | <i>if yes, date</i> |
|----------------------|---|---|---------------------|----------------------------|---|---|---------------------|
| Asthma | Y | N | _____ | Colitis | Y | N | _____ |
| Allergies (food) | Y | N | _____ | Chronic diarrhea | Y | N | _____ |
| Allergies (seasonal) | Y | N | _____ | Lactose intolerance | Y | N | _____ |
| Eczema | Y | N | _____ | Appendicitis | Y | N | _____ |
| Other skin problem | Y | N | _____ | Hepatitis | Y | N | _____ |
| Chickenpox | Y | N | _____ | Hernia | Y | N | _____ |
| Scarlet fever | Y | N | _____ | Celiac disease | Y | N | _____ |
| Pneumonia | Y | N | _____ | Ulcers | Y | N | _____ |
| Tuberculosis | Y | N | _____ | Urine infections | Y | N | _____ |
| Lyme Disease | Y | N | _____ | Kidney stones | Y | N | _____ |
| Rheumatic fever | Y | N | _____ | Bleeding / bruising | Y | N | _____ |
| Kawasaki Disease | Y | N | _____ | Sickle cell disease | Y | N | _____ |
| Sinus problems | Y | N | _____ | Anemia | Y | N | _____ |
| Vision problem | Y | N | _____ | Cancer / leukemia | Y | N | _____ |
| Hearing problem | Y | N | _____ | Bone / joint problems | Y | N | _____ |
| Ear infections | Y | N | _____ | Developmental / behavioral | | | |
| Headaches | Y | N | _____ | problems | Y | N | _____ |
| Head trauma | Y | N | _____ | ADHD | Y | N | _____ |
| Seizure / epilepsy | Y | N | _____ | Thyroid problem | Y | N | _____ |
| Hives / urticaria | Y | N | _____ | Diabetes | Y | N | _____ |
| Heart murmur | Y | N | _____ | Growth problem | Y | N | _____ |
| Heart defect | Y | N | _____ | Other problems | | | _____ |
| High blood pressure | Y | N | _____ | | | | _____ |
| Reflux / heartburn | Y | N | _____ | | | | _____ |

Please use this space to elaborate on any concerns not listed above.

Thank you, and we're looking forward to getting to know you and your children.

Joseph Richter, MD
 Jessica Wang, MD
 Cathy-Marie Hamlet, MD



Office Policies

Cancellation/Missed Appointment Policy:

If you are unable to make your appointment it must be canceled 24 hours in advance. If you must cancel your appointment less than 24 hours before its scheduled time or fail to show up for your appointment there will be a \$20 cancellation fee. **You are responsible for payment of the fee.**

Late Policy:

Hudson Heights Pediatrics strongly enforces our 20 minute rule. **If you arrive 20 minutes or more late for your Well Child or Follow-Up Appointment you will be re-scheduled.** The reason for this rule is to attempt to keep as close to schedule as possible. If you are late for an appointment, your time runs into the next scheduled appointment and so on. Other patients who have arrived on time will be forced to wait. Please be courteous to those who are scheduled after your visit.

We know that your time is valuable, but emergencies do occur. We ask for your understanding while waiting in the office. All visits are given the necessary time.

Forms Policy:

Our office receives a great deal of forms, all of which must be reviewed and signed by a doctor. Please get all school, daycare, and camp forms to our office as early as possible! **Our doctors can only complete a form if your child has been seen for a wellness visit in the past 12 months.** Forms will be completed within seven days to ten days after we receive them in the office.

There is a \$5 fee for forms. The only exception to the \$5 fee are WIC forms, which will be completed either during your appointment or within 24-hours of your request.

Otherwise, if you need your form expedited, we can have it ready for you in 24 hours for a \$20 fee. *If you send us a form, please contact us to ensure that we have received it.

Vaccine Policy:

In the interest of the safety of our patient base, we require all families to adhere to the minimum guidelines issued by the New York City Department of Health and Mental Hygiene regarding School Admission Immunization Requirements. We believe it is important for children and adults to get vaccinated to help protect communities by slowing or stopping disease outbreaks. While all patients must receive full vaccinations, any concerns can be discussed with a doctor. Our suggested vaccine schedule is available on our website. **If you are unable to commit to completing vaccines within one year of when they are required, we cannot continue to care for your children in this practice.**

Code of Conduct:

We strive to make Hudson Heights Pediatrics a welcoming environment for all of our patients and caregivers. Upon arriving in our office, please check in with reception. If the area is busy, please be as understanding as possible. The waiting area is equipped with books and toys to entertain the children while they are waiting to be seen. While you are waiting, we ask that you please:

1. Be respectful in your interactions with the staff and other caregivers
2. If you need to make a call, please speak in hushed tones so as not to disturb others
3. Supervise your children while they are playing
4. Bring any interpersonal issues to the attention of the staff that are sitting at reception so that we can address your needs

Please note, we do not tolerate sustained raised voices, verbal threats, and physical acts of aggression, and will be forced to notify our security. While the receptionists will try their very best to answer all of your queries, if you are unsatisfied with your service in the office we have a practice manager who you can ask to speak to at any time.

Please sign to acknowledge that you have read and consent to these policies

Patient/Parent/Guardian Signature _____ Date _____