North Manhattan Pediatrics

PATIENT REGISTRATION

Date ___ / ___ /_____ ☐**New Patient** ☐**Change of Information**

Patient Registration		
Patient's Full Name		Nickname
Date of Birth	Sex ☐Male ☐Female	Social Security Number
Physical/Permanent Address		City/State/Zip
Mailing Address (If different from Physical Address)		
Home Phone	Cell Phone	Email Address

☐ **Mother/** ☐ Parent 1/ ☐ **Legal Guardian's Information**		☐**Same as Patient's Address**
Full Name	Date of Birth	Social Security Number
Physical/Permanent Address		City/State/Zip
Mailing Address (If different from Physical Address)		
Home Phone	Cell Phone	Email Address
Employers' Name and Address		
Work Phone Number/Ext.	Occupation	

☐ **Father/** ☐ Parent 2/ ☐ **Legal Guardian's Information**		☐**Same as Patient's Address**
Full Name	Date of Birth	Social Security Number
Physical/Permanent Address		City/State/Zip
Mailing Address (If different from Physical Address)		
Home Phone	Cell Phone	Email Address
Employer's Name and Address		
Work Phone Number/Ext.	Occupation	

Emergency Contact Information ☐ **Mother/Parent 1** ☐ **Father/Parent 2** ☐ **Guardian** ☐ **Other**			
If you checked **Guardian or Other**, please specify relationship:			
Full Name			Date of Birth
Home/Mailing Address			City/State/Zip
Home Phone	Cell Phone	Work Phone	Email Address

If parents are divorced who has legal custody of child? ☐ Mother/Parent 1 ☐ Father/Parent 2☐ Guardian ☐ Other _____
Whom may we thank for referring you? _____

I authorize, _____ (☐ myself/☐ the patient) to be evaluated by the attending physician on staff at North Manhattan Pediatrics. I understand that I will be informed of any medical treatment or procedures to properly treat myself, or the patient. Authorization is hereby granted for such treatment and procedures. My signature below will act as authorization for today and all future medical treatment, unless I rescind such authorization in writing. I also certify that all information above is correct and accurate.

Signature (Patient/Guardian) _____ **Date** ___/___/_____

2366 Adam Clayton Powell Jr. Boulevard, Front 1
New York, NY 10030-2220
Telephone: 212.234.1112
Facsimile: 646.688.2333
www.nmpeds.com
info@nmpeds.com

Patient Name _____ **Date of Birth** ___/___/_____

PRIMARY INSURANCE INFORMATION	
Primary Insurance Carrier Name	**Policy ID Number**
Primary Insurance Carrier Address	Primary Insurance Carrier Phone Number
Policy Holder's name ☐ Patient ☐ Responsible Party	Relationship to Patient
Employer/Group Name	Group Number
Primary Care Physician chosen (if applicable)	

SECONDARY INSURANCE INFORMATION	
Secondary Insurance Carrier Name	**Policy ID Number**
Secondary Insurance Carrier Address	Secondary Insurance Carrier Phone Number
Policy Holder's name ☐ Patient ☐ Responsible Party	Relationship to Patient
Employer/Group Name	Group Number
Primary Care Physician chosen (if applicable)	

IT IS IMPORTANT THAT YOU TAKE THIS TIME TO REVIEW OUR FINANCIAL POLICY

- All new patients must complete our patient forms prior to being seen. Established patients must provide the office with any insurance changes prior to being seen.
- Please be aware of your insurance benefits. Your insurance policy is a contract between you and your insurance carrier. It is your responsibility to be aware of your insurance company's provision for payment of office visits, well-child visits and immunizations, co-payments, deductibles, and co-insurance.
- If your insurance company requires you to choose a PCP, it is your responsibility to call and change the PCP to our physician prior to the visit.
- Unless a Financial Agreement has been made, self-pay payments are due at time of service. You may call our Office Manager at 212.234.1112 to arrange financial agreements if you are unable to pay at time of visit.
- For the convenience of our patients, we accept Cash, Debit Cards, Visa, MasterCard, Discover and American Express.
- All returned checks will be charged a $25 returned check fee. After two returned checks, we will no longer accept personal checks on your account.

Our Front Office is available during office hours to discuss our charges, insurance questions, the status of your account, and to help you with any billing or insurance questions.

I, the undersigned certify that I (or my dependent) have insurance coverage with the above and assign directly to North Manhattan Pediatrics, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges (including co-pay, deductible, and co-insurance), whether or not paid by my insurance. I have read and understand the Financial Policy and agree to the terms listed above. I hereby authorize North Manhattan Pediatrics to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I also certify that all information above is correct and accurate.

_____ _____ ___/___/_____

Responsible Party Name and Signature **Relationship to Patient** **Date**

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, hereby acknowledge that North Manhattan Pediatrics has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me/the patient may be used and disclosed, and how I can access this information.

I understand that if I have a questions or complaints I may contact: Privacy Contact, **Dr. Jerome Abellana Cariaso, M.D.** at (212) 234-1112.

I also understand that I am entitled to receive updates upon request if North Manhattan Pediatrics, amends or changes its Notice of Privacy Practices in a material way.

Patient Name _____

☐ **Patient/☐ Parent/☐ Guardian Signature** _____

Relationship to Patient _____ **Date** ___/___/_____

THIS SECTION IS TO BE COMPLETED BY NORTH MANHATTAN PEDIATRICS, IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

☐ Notice of Privacy Practices Given – Patient Declined to Sign
☐ Other (specify): _____

_____ ___/___/_____
Name and Title of Employee Date

It is our policy not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. When returning calls and an answering machine picks up, we do not leave a message unless it is an appointment reminder. Information also will not be left with an unauthorized person who may answer the phone.

I authorize the staff of NORTH MANHATTAN PEDIATRICS, to leave medical information pertaining to the patients care by the following methods and will assume responsibility to notify them whenever this information changes:
☐ Home Telephone/Answering Machine/Fax ☐ Work Telephone/Voice Mail/Fax ☐ Cell phone/Voice Mail

Please list names of authorized people we may leave messages with: (i.e. spouse, boyfriend, girlfriend, parent, grandparent, etc.)

_____
Name Relationship

_____
Name Relationship

Who if anyone other than the responsible party has permission to be involved in your child's medical treatment including bringing them in for visits?

_____
Name Relationship

_____
Name Relationship

_____
Name Relationship

PATIENT NAME _____ **DATE OF BIRTH** ____/____/_____

BIRTH HISTORY:

Gestational Age _____ Birth weight _____ Birth length _____ Birth Hospital_____
Complications:
_____
_____

HOSPITALIZATION:

Where: _____ Date: _____ Reason: _____
Where: _____ Date: _____ Reason: _____
Where: _____ Date: _____ Reason: _____

ALLERGIES (please check specific type of allergy, as well as indicating name and reaction): ☐ None

☐ Drug ☐ Environmental or Food ☐ Allergen Name: _____ Reaction: _____
☐ Drug ☐ Environmental or Food ☐ Allergen Name: _____ Reaction: _____
☐ Drug ☐ Environmental or Food ☐ Allergen Name: _____ Reaction: _____
☐ Drug ☐ Environmental or Food ☐ Allergen Name: _____ Reaction: _____

FAMILY HISTORY (please check all that apply and indicate relation to patient):

☐ Anemia Relation: _____
☐ Asthma Relation: _____
☐ Cancer Relation: _____
☐ Diabetes Relation: _____
☐ High Cholesterol Relation: _____
☐ High Blood Pressure Relation: _____
☐ Stroke Relation: _____
☐ Tuberculosis Relation: _____
☐ Heart Disease- before 50 yrs old Relation: _____
☐ Other _____ Relation: _____

☐ Allergies Relation: _____
☐ Alcohol Abuse Relation: _____
☐ Drug Abuse Relation: _____

☐ Seizures Relation: _____
☐ Thyroid Relation: _____

PAST HISTORY (please check all that apply):

☐ Chickenpox When: _____
☐ Frequent ear infections Explain: _____
☐ Problems with ears or hearing Explain: _____
☐ Problems with eyes or vision Explain: _____
☐ Asthma, bronchitis, bronchiolitis, or pneumonia Explain: _____
☐ Any heart problem or heart murmur Explain: _____
☐ Anemia or bleeding problem Explain: _____
☐ Frequent abdominal pain Explain: _____
☐ Bladder or kidney infection Explain: _____
☐ Any chronic or recurrent skin problem (acne, eczema, etc) Explain: _____
☐Frequent headaches Explain: _____
☐ Seizures or other neurological problem Explain: _____
☐Thyroid or other endocrine problem Explain: _____
☐ Any other significant problem Explain:_____

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