THE CHILDREN'S DOCTOR

Registration

PATIENT INFORMATION (Please Print) Date _____

Last Name _____ First Name _____ Date of Birth _____ Sex ____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ SS# _____

Preferred Pharmacy (Name and Location _____

Race _____ Preferred Language _____

Patient Place of Birth _____ Hospital _____

GUARANTOR INFORMATION ***(IF PATIENT IS UNDER 18 YEARS)*** ☐ N/A

Father's Name (or Legal Guardian) _____ DOB _____

Cell Phone _____ E-Mail Address _____

Preferred method of contact for results or x-rays ☐ Phone ☐ Email ☐ Text

SS# _____ DL# _____ Occupation _____

Employer _____ Address _____ Phone # _____

Mother's Name (or Legal Guardian) _____ DOB _____

Cell Phone _____ E-Mail Address _____

Preferred method of contact for results or x-rays ☐ Phone ☐ Email ☐ Text

SS# _____ DL# _____ Occupation _____

Employer _____ Address _____ Phone # _____

INSURANCE / PAYMENT INFORMATION

☐ Cash ☐ Credit Card ☐ Name of Insurance _____

ID# _____ Group/Plan # _____

Name of Insured (*if other than patient*) _____ Date of Birth _____

LOCAL / EMERGENCY CONTACT (NOT LIVING IN THE HOME)

Name _____ Relationship _____

Phone # _____ Cell # _____

Address _____ City _____ Zip _____

The Children's Doctor

Patient Name: _____ Date of Birth: _____

CONSENT TO TREAT / PROTECTED HEALTH INFORMATION RELEASE

The term "health care provider(s)" in this document means The Children's Doctor Professional Corporation, its agent and employees, members of the medical staff, their agents and employees, and other health care practitioners who provide care to patients.

I understand that as part of my health care, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plan for care including future treatment. I understand that this information serves as:

1. a basis for planning my care and treatment,
2. a means of communications among the many health professionals who contribute to my care,
3. a source of information for applying my diagnosis and surgical information to my bill,
4. a means by which a third-party payer can verify that services billed were actually provided, and
5. a tool for routine healthcare operations, such as assessing quality and reviewing the competence of healthcare professionals.

I understand that I have been provided with the Notice of Information Practices that provides more complete information of uses and disclosures. I understand that I have the right to review the notice before signing this consent. I understand that the organization reserves the right to change their notice and practices and before implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to restrict how my health information may be used or disclosed to carry out payment, treatment, or health care operations and that the organization is not required to agree to the restrictions requested. I understand that I have the right to revoke this consent in writing, except to the extent that the organization has already taken action on my behalf. I understand that I may be seen by a Physician Assistant who is under the supervision of a Physician.

Permission is hereby granted to all health care providers involved in my care to administer such examination, treatment, testing, and procedures as are deemed necessary in the course of my care.

Patient/Legal Guardian Signature: X_____ Date: _____

☐ I am requesting the following restriction to the use or disclosure of my health information:

_____

Patient/Legal Guardian Signature: _____ Date: _____

FINANCIAL RESPONSIBILITY / ASSIGNMENT OF BENEFITS

Information about me necessary to substantiate my insurance claims may be released by the health care provider involved in my care. For those health care providers who accept assignment, I hereby authorize any insurance carrier with whom I have a policy to pay directly to that provider any benefits of any policies of insurance to those health care providers who have rendered services to me and who accept such assignment. I agree to pay all charges that are not paid in full by assigned insurance. If such amounts due to the health care providers are not paid after reasonable notice, that account shall be deemed delinquent and a service charge shall be added to the amount due. In the event that I default on payment of my account, I agree to be responsible for collection fees and interest due on amounts in default, including court costs and reasonable attorney's fees. If the debt is assigned to a third party for collection, I agree to be responsible for collection fees and interest due on amounts in default.

Patient/Legal Guardian Signature: X_____ Date: _____

**If under 21 years of age, please read and sign the following:*

CALIFORNIA CHILD HEALTH & DISABILITY PREVENTION PROGRAM (CHDP) CONSENT

I hereby give my consent to receive the health screening tests and immunizations recommended by the CHDP Program. I hereby authorize release of information concerning the results of these screening tests to CHDP Program personnel. I also authorize release of the information to the location indicated below. I understand that information provided to CHDP Program personnel will be strictly confidential and will be used only to make the provision of health services easier and to permit statistical reporting on the results of screening.

X_____ _____

Parent/Legal Guardian/Emancipated Minor Signature Parent/Legal Guardian/Emancipated Minor Name

If you want your health screening tests released to school, or other health care provider, provide name and address.

School or Provider Name: _____ Address: _____

City, State, Zip: _____ Phone #: _____

Witness: _____ Title: _____ Date: _____

CHILD HEALTH HISTORY

HISTORY OF PREGNANCY WITH THIS CHILD:

Did you receive prenatal care? ☐Yes ☐No How many months was your pregnancy? _____ months
Where did you have the baby? _____

Did you have any illnesses or problems? (including sexually transmitted or other communicable diseases)	Yes	No	Did you use any non-prescribed drugs? (tobacco, alcohol, 'street drugs', over-the-counter drugs or home remedies)	Yes	No
Did you take any medications prescribed by your doctor? Which one? _____	Yes	No	Did the baby go home with you from the hospital?	Yes	No
Did you have a difficult/abnormal delivery/c-section?	Yes	No	Was more than one baby born?	Yes	No
Did the baby have any problems in the first week of life? If yes, what problems? _____	Yes	No	Did baby receive any shots for Hepatitis B?	Yes	No

CHILD'S MEDICAL HISTORY: ☐M ☐F Is this child adopted? ☐Yes ☐No Birth Weight: _____ lbs ____ oz Length: _____inches

Has your child ever had:

Measles, Chickenpox, Mumps, Rubella	Yes	No	Vomiting after eating/refusal to eat	Yes	No
Tuberculosis or a positive tuberculosis test	Yes	No	Muscle, joint, or bone problems	Yes	No
Tonsillitis/Sore throat	Yes	No	Skin problems	Yes	No
Problems with eyes or vision	Yes	No	Headaches or dizziness	Yes	No
Problems with ears or hearing	Yes	No	Convulsions, seizures, epilepsy	Yes	No
Difficulty breathing/snoring at night	Yes	No	Diabetes	Yes	No
Heart problems	Yes	No	Thyroid problems	Yes	No
Asthma, bronchitis, pneumonia	Yes	No	Allergies	Yes	No
Anemia, bleeding problems, blood transfusion	Yes	No	Problems with development or school performance	Yes	No
Stomachaches	Yes	No	Serious illness or accident	Yes	No
Diarrhea/soiling self with stool	Yes	No	Surgery or hospitalization	Yes	No
Bladder or kidney problems/wetting self or bed	Yes	No	**(Girls)** Has she started her period?	Yes	No
Constipation	Yes	No	**(Girls)** Are there problems with her period?	Yes	No

FAMILY HISTORY: Does anyone in the family have:
Mother **(M)**, Father **(F)**, Brother **(B)**, Sister **(S)**, Uncle **(U)**, Aunt **(A)**, Grandma **(GM)**, Grandpa **(GP)**

			Which family member?				Which family member?
Yes	No	Diabetes		Yes	No	High blood pressure	
Yes	No	Epilepsy or convulsions		Yes	No	Blood disorders	
Yes	No	Mental Retardation		Yes	No	Tuberculosis	
Yes	No	Cancer		Yes	No	Allergies	
Yes	No	Kidney or urinary disease		Yes	No	Eye disorder	
Yes	No	Bone or joint problems		Yes	No	Ear disorder	
Yes	No	Someone under 55 years died from heart problems		Yes	No	Lung/breathing problems or asthma	
Yes	No	Heart problems		Yes	No	Autism	

PARENT INFORMATION:

	Mother:	Father:
Age:	_____	_____
Height:	_____	_____
Occupation:	_____	_____

HOME INFORMATION: Number of people in home? _____
Do both parents live in the home? ☐Yes ☐No
Does anyone in the home smoke, use drugs, or drink alcohol? ☐Yes ☐No
Language(s) spoken in the home? _____
Do you live in a ☐House ☐Apartment ☐Mobile Home ☐Shelter ☐Homeless

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Patient's Name: _____ **Date of Birth:** _____

Signature: _____ Date: _____
Patient/legal guardian (if patient is younger than 18 years old)

Printed Name: _____ Relationship to Patient: _____

Reviewing Provider's Signature: _____ **Date:** _____

THE CHILDREN'S DOCTOR

Judith M. Bedoy M.D.
3975 Jackson St., Suite 207
Riverside, CA 92503
(951) 352-2092 · (951) 352-1913

Privacy Notice Acknowledgment

I understand that as part of my healthcare, this organization originates and maintains health records describing my/my child's health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my/my child's care and treatment.
- Means of communication among other health professionals who contribute to my/my child's care.
- A source of information for applying my/my child's diagnosis and surgical information to my bill.
- A means by which third party payer (insurance) can verify that services billed were actually provided.
- A tool for routine healthcare operations such as quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a notice of privacy practices (privacy notice), which provides a more complete description of information and disclosure. I understand that I have a right to review the notice before signing it. I understand that this organization has the right to change their notice and practice and that prior to implementation will mail a copy of the revised notice to the address that I have provided. I understand that I have the right to restrict as to how my information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this organization is not required to agree to the restrictions requested.

By signing below, I acknowledge receipt of this organization's privacy practice.

Signature: _____ Date: _____
Parent or Legal Guardian (if patient is younger than 18 years old)

Printed Name: _____ Relationship: _____

Patient Name: _____ DOB: _____

Judith M. Bedoy, MD
3975 Jackson St. Ste 207
Riverside, CA. 92503
951-352-2092 | 951-352-1913

THE CHILDREN'S DOCTOR

Agreement of Financial Responsibility

Thank you for choosing us as your health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are a contracted provider and are the designated Primary Care Provider (PCP), if applicable.

- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.

- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.

- If we have a contract with your insurance company we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.

- If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.

- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.

- Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

_____ _____

Signature of Patient /Responsible Party Date

_____ _____

Name of Patient/Responsible Party (please print) Relationship to Patient