

SANSON PEDIATRICS

PATIENT REGISTRATION FORM

Patients Information

LAST NAME: _____ FIRST _____ MI _____

MOTHER'S NAME _____ FATHER'S NAME _____

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE NO. _____ OTHER NO. _____

SOCIAL SECURITY NO. _____ DOB: _____

MALE _____

FEMALE _____

Responsible/Insured party Information

LAST NAME: _____ FIRST _____ MI _____

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE NO. _____ OTHER NO. _____

SOCIAL SECURITY NO. _____ DOB: _____

EMPLOYER: _____ WORK PHONE NO. _____

CITY _____ STATE _____ ZIP _____

PLEASE SUBMIT YOUR INSURANCE CARD TO THE RECEPTIONIST

YOU MUST PRESENT YOUR CARD TO THE RECEPTIONIST AT THE TIME OF YOUR VISIT AND A PHOTO COPY WILL BE TAKEN TO INSURE PROPER BILLING OF YOUR CHILD'S CLAIM(S).

I HAVE READ THE BACK OF THIS REGISTRATION FORM AND HEREBY AGREE THE TERMS AND OFFICE POLICY OF SANSON PEDIATRICS. AS A COURTESY I UNDERSTAND SANSON PEDIATRICS WILL BILL MY INSURANCE COMPANY(IES) ON MY BEHALF, REALIZING I AM RESPONSIBLE TO PAY NON-COVERED SERVICES AND THAT PAYMENT IS DUE AT THE SCHEDULED OFFICE VISIT THE TIME SERVICES ARE RENDERED. I ALSO AUTHORIZE THE RELEASE OF PERTINENT MEDICAL INFORMATION TO MY INSURANCE CARRIER(S).

SIGNATURE OF RESPONSIBLE PARTY

DATE

REFERRED BY: _____

CHILDREN'S MEDICAL HISTORY FORM

LAST NAME _____ FIRST _____ MI _____
MALE _____ FEMALE _____ DOB _____ HOME PHONE NO. _____ ALLERGIES Y _____ N _____

BIRTH HISTORY

MEDICATIONS TAKEN DURING PREGNANCY (INCLUDE NON PRESCRIPTION)

- 1. _____
- 2. _____
- 3. _____

DID MOTHER DELIVER CLOSE TO DUE DATE? YES _____ NO _____

HOW MANY WEEKS OF GESTATION? _____

DID CHILD'S MOTHER HAVE A NORMAL PREGNANCY? YES _____ NO _____
____ VAGINAL ____ WITH FORCEPS ____ C-SECTION ____ OTHER

IF NO, PLEASE DESCRIBE COMPLICATIONS:

WAS CHILD SENT HOME WITH MOTHER AFTER DELIVERY? YES _____ NO _____

WAS YOUR CHILD PLACED IN THE NEWBORN INTENSIVE CARE UNIT? YES _____ NO _____
IF YES, HOW LONG?

NUTRITIONAL INFORMATION

CHILD'S DIET DURING FIRST YEAR:

____ BREAST ____ FORMULA ____ COWS MILK ____ BABY FOOD ____ OTHER: _____

ANY FEEDING PROBLEMS OR NUTRITIONAL OR CONCERNS: _____

DEVELOPMENTAL HISTORY

*PLEASE INDICATE AT WHAT AGE YOUR CHILD ACHIEVED THE FOLLOWING MILESTONES:

*MARK N/A FOR THOSE WHICH YOUR CHILD HAS NOT ACHIEVED YET

____ ROLLED OVER ____ STOOD ALONE ____ DRANK FROM CUP
____ SAT ALONE ____ WALKED ALONE ____ USED SPOON
____ CRAWLED ____ BABBLED ____ TOILET TRAINED
____ PULLED TO STAND ____ SAID FIRST WORD ____ DRESSED SELF

DO YOU BELIEVE YOUR CHILD IS BEHIND IN HIS/HERS MOTOR SKILLS? YES _____ NO _____
IF YES, PLEASE DESCRIBE _____

CURRENT PHYSICAL LIMITATIONS: _____

SPECIAL EQUIPMENT YOUR CHILD USES

*PLEASE CHECK ANY OF THE FOLLOWING THAT MAY APPLY TO YOUR CHILD.

____ HEARING AIDS/HEARING DIFFICULTY ____ SPLINTS ____ G-TUBE
____ WEARS GLASSES/VISION PROBLEMS ____ BRACES ____ WHEELCHAIR
____ OTHER: _____

IMMUNIZATION'S

*PLEASE GIVE YOUR SHOT RECORD TO THE NURSE FOR REVIEW.

IS YOUR CHILD EXEMPT FROM IMMUNIZATIONS? YES ___ NO ___

DOES YOUR CHILD HAVE A SHOT RECORD? YES ___ NO ___

ARE YOUR CHILD'S IMMUNIZATIONS UP TO DATE? YES ___ NO ___

FAMILY HISTORY

* PLEASE CHECK ANY ILLNESS IN BLOOD RELATIVES OR CHILD THAT MAY APPLY.

- | | | |
|--|--|--|
| <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> BIRTH DEFECTS | <input type="checkbox"/> HIGH BLOOD PRESSURE |
| <input type="checkbox"/> DEAFNESS | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> DIABETES |
| <input type="checkbox"/> MENTAL ILLNESS | <input type="checkbox"/> EPILEPSY/SEIZURES | <input type="checkbox"/> MIGRAINE |
| <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> ASTHMA ALLERGIES | <input type="checkbox"/> GOUT |
| <input type="checkbox"/> ALCOHOLISM | <input type="checkbox"/> STROKE | <input type="checkbox"/> DRUG DEPENDENCE |
| <input type="checkbox"/> THYROID DISEASE | <input type="checkbox"/> BLEEDING TENDENCY | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> BREAST CANCER | <input type="checkbox"/> AIDS | <input type="checkbox"/> OTHER (PLEASE LIST) |

YOUR CHILD'S MEDICAL HISTORY

CURRENT DIAGNOSIS: _____

HOSPITALIZATIONS: YES ___ NO ___

IF YES, PLEASE DESCRIBE _____

SURGERIES: YES ___ NO ___

IF YES, PLEASE DESCRIBE _____

PSYCHOLOGICAL EVALUATION: YES ___ NO ___

IF YES, PLEASE DESCRIBE _____

BY: _____

CURRENT PHYSICIAN(S) OR SPECIALIST YOUR CHILD IS ACTIVELY SEEING

1. _____
2. _____
3. _____

MEDICATIONS PRESENTLY BEING USED

1. _____
2. _____
3. _____

ALLERGIES

*PLEASE LIST ALL ALLERGIES AND THE REACTION

NKDA TO DATE _____

1. _____ REACTION _____
2. _____ REACTION _____
3. _____ REACTION _____

EDUCATIONAL INFORMATION

PRESENT GRADE LEVEL: _____ SCHOOL CURRENTLY ATTENDING: _____
SPECIAL SERVICES RECEIVED IN SCHOOL: ___ OT ___ PT ___ SPEECH ___ IEP ___ SPECIAL ED ___ .

ADDITIONAL COMMENTS OR CONCERNS: _____

SOCIAL/EMOTIONAL

DOES YOUR CHILD INTERACT WELL WITH OTHERS? YES ___ NO ___

DOES YOUR CHILD HAVE TROUBLE MAKING FRIENDS? YES ___ NO ___

DOES YOUR CHILD HAVE FEARS OR COPING BEHAVIORS? YES ___ NO ___

DOES YOUR CHILD HAVE DIFFICULTIES CALMING HIMSELF/HERSELF WHEN UPSET? YES ___ NO ___

ADDITIONAL COMMENTS OR CONCERNS: _____

BEHAVIOR

*PLEASE CHECK ANY OF THE FOLLOWING THAT MAY APPLY TO YOUR CHILD.

- | | |
|--|---|
| <input type="checkbox"/> CRIES OFTEN | <input type="checkbox"/> FREQUENT TEMPER TANTRUMS |
| <input type="checkbox"/> TROUBLE FOLLOWING DIRECTIONS | <input type="checkbox"/> ANXIOUS |
| <input type="checkbox"/> TROUBLE WITH CHANGES IN ROUTINE | <input type="checkbox"/> AVOIDS TOUCH FROM OTHERS |
| <input type="checkbox"/> CLUMSY | <input type="checkbox"/> DISLIKES HAIR BRUSHING |
| <input type="checkbox"/> WEAK MUSCLES | <input type="checkbox"/> DISLIKES TOOTH BRUSHING |
| <input type="checkbox"/> PICKY EATER | <input type="checkbox"/> SEEMS TO BE "ON THE GO" |
| <input type="checkbox"/> MOUTHS OBJECTS | <input type="checkbox"/> ROCKS SELF |
| <input type="checkbox"/> POOR ATTENTION SPAN | <input type="checkbox"/> SENSITIVE TO LIGHT AND/ OR SOUND |

ADDITIONAL COMMENTS OR CONCERNS: _____

ADDITIONAL COMMENTS/INFORMATION

*PLEASE NOTE HERE, ANY INFORMATION OR QUESTIONS, YOU MAY HAVE FOR DR. SANSON OR TRACEY.

THANK YOU FOR TAKING THE TIME TO FILL OUT YOUR CHILD'S MEDICAL HISTORY FORM. THIS INFORMATION WILL HELP US BECOME MORE FAMILIAR WITH YOUR CHILD SO THAT WE CAN PROVIDE THE BEST CARE POSSIBLE TO YOU AND YOUR CHILD. BY SIGNING BELOW YOU HEREBY AGREE THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF YOUR KNOWLEDGE.

SIGNATURE OF PARENT OR LEGAL GUARDIAN DATE

WHOM MAY WE THANK FOR REFERRING YOU: _____

Sanson Pediatrics, PC
203 S. Candy Lane, Suite 6B
Cottonwood, AZ 86326
928-649-1559
Fax 928-649-1427

Consent for Treatment & Financial Responsibility

Patient Name: _____
Last First Middle

Patient's Date of Birth: _____

I hereby consent to the medical care recommended by my health care providers at Sanson Pediatrics, PC, Jayne A. Sanson-Jaraczewski, MD, PC and/or Tracey J. Fender, PNP. I authorize payment for all medical benefits for services performed by Jayne A. Sanson-Jaraczewski, MD, PC and/or Tracey J. Fender, PNP to Jayne A. Sanson-Jaraczewski, MD, PC, and/or Tracey J. Fender, PNP. I understand that I am fully responsible for any charges and that payment is expected at the time services are rendered.

If my insurance is billed or if I am covered under AHCCCS or Medicare, I authorize the release of any information necessary for Sanson Pediatrics, PC to secure payment from my insurance.

I understand that as a courtesy, Sanson Pediatrics, PC will bill my insurance company(ies) on my behalf, realizing I am responsible to pay for any co-pay, co-insurance, unsatisfied deductible, or non-covered services and that payment is due at the time services are rendered.

I understand that verification of insurance is required at the time of service in order for Sanson Pediatrics, PC to bill my insurance company(ies). **Verification of insurance is defined as the ability to confirm at the time of service, a patient is eligible on the insurance policy and has specific medical coverage and benefits pertaining to the reason for the office visit on the same day services are rendered.** If verification of insurance is not provided or is unable to be obtained for any reason, I understand that I am responsible for payment in full at the time of service based on Sanson Pediatrics, PC applicable charges.

I understand that I am responsible to determine, before a Well Child Exam, whether or not my insurance pays for immunizations. If it does not cover immunizations, they may be covered under the Vaccines for Children Program. In order for the Vaccines for Children Program to cover the cost of the immunizations, I am responsible for informing the nurse that my insurance does not cover immunizations before the immunizations are given. If I fail to do this, I will be responsible for payment of those immunizations.

Signature of Parent or Legal Guardian

Date

SANSON PEDIATRICS
Jayne Sanson-Jaraczewski, MD, PC
203 S. Candy Lane, Ste. 6B, Cottonwood, AZ 86326 (928) 649-1559

PARENTS PLEASE READ AND SIGN

ADMINISTRATIVE POLICIES AND PROCEDURES "LATE FOR APPOINTMENT POLICY"

The purpose of this policy is to provide the best health care possible for your child and our other patients. We appreciate your trust in choosing our office for the medical care of your child and do our best to accommodate requests for appointment times. As such, appointments are times specifically set aside for your child. We understand that unplanned things can happen, but we would also like for you to be mindful that other patients are scheduled to see the doctor and are entitled to the same quality care. We ask that if you anticipate being late for your appointment, please call and let us know. Depending on the circumstances, your appointment may need to be rescheduled. If your child's medical condition requires immediate attention, he/she will be seen. If you are **less than 15 minutes late** and your child does not require immediate medical attention, we will make every effort to accommodate you for this visit, but we may need to ask you to reschedule. If you are **15 minutes late or more** and your child does not require immediate medical attention, you will most likely be rescheduled for a later date. If there are extenuating circumstances or if the doctor is available, you may possibly be seen.

Patient Name

Signature of Parent or Legal Guardian

Date

NOTICE OF PRIVACY PRACTICES

IMPORTANT: This notice describes how health information about your child may be used and disclosed and how you can get access to this information. Under the new healthcare Federal privacy law, The Health Insurance Portability and Accountability Act of 1996 (HIPPA), we are required to protect the privacy of your child's information, provide this notice about how we handle information, follow the privacy practices described in this notice and obtain written acknowledgement from you (as parent / guardian) that you have received this information.

Your child's privacy is important to us. We promise to respect your child's privacy rights and comply with all applicable privacy laws.

Your Child's Privacy Rights:

Although your child's medical record is the physical property of Sanson Pediatrics, PC, the information belongs to you as the parent / legal guardian. Thus you have right to:

Ask that we limit how we use and disclose your child's health information. You can request, in writing, a restriction of your child's health information. You may not be able to limit the uses and disclosures required by law.

Choose how we send your child's health information to you, i.e. only to work address, only by fax instead of by mail, and we must agree to your request if we can reasonably do so.

See and receive copies of your child's health information. This request must be in writing and we will charge a nominal fee for the copy.

Receive a list of instances in which we have disclosed your child's health information for purposes other than treatment, payment, or related administrative purposes other than when you explicitly authorized it. There may be restrictions that apply.

Amend your child's health information. If you feel the health information is incomplete or incorrect, you have the right to request, in writing, that we amend your child's health information. You must provide the reason for the request. If we are not able to meet your request, we will send you our reason in writing and you can request a review.

Request a paper copy of this Notice at any time.

Revoke your authorization to use or disclose your child's health information except to the extent action has already been taken on it.

Examples of How We Will Use and Disclose Your Child's Health Information:

Treatment: We use your child's information to best determine the best course of treatment, how your child responds to that treatment and the quality of that care. Information may be mailed, faxed, auto-faxed and e-mailed as appropriate.

Payment: A bill sent to you or your insurance company will contain information that identifies your child, i.e. your child's diagnosis, procedures, and supplies used to care for your child.

Healthcare Operations: Health information may be used and disclosed to assess care during a visit and to carry out routine business function.

Appointment Reminders and Call Backs: Health information may be used and disclosed to contact you for your child's appointment reminder or to follow-up after a visit.

Treatment Options and Health-Related Benefits: Health information may be used and disclosed when discussing with you possible treatment options, alternatives, and health-related benefits for your child.

As Required by Law: Health information may be used and disclosed when required to do so by federal, state, or local law, including for child abuse or neglect reporting or specific government functions.

Business Associates: Health information may be used and disclosed to our business associates to enable them to perform the job we ask them to do. These business associates must properly safeguard your child's health information.

For Public Health and Safety: Health information may be used and disclosed as appropriate to a health oversight agency or individual charged with controlling disease, injury, or disability or preventing a risk to public health and safety. This may include the U.S. Food and Drug Administration or the Arizona Health Department.

Law Enforcement and Litigation: Health information may be used and disclosed for law enforcement purposes or litigation as required by law, in response to a valid subpoena or other court order.

Registration and Waiting Areas: Health information may be used and disclosed on registration / sign-in forms and when your child is called out in the waiting room.

Your Authorization: We will not use or disclose your child's health information, without your permission / authorization, except as described in this Notice or as required by law. You may give us written authorization to use or disclose health care information to anyone for any purpose that meets the requirements of the law. You may revoke such authorization in writing at any time.

Questions and Complaints: If you want more information about our privacy practices or have a question or concern, please contact us. If you believe your child's privacy rights have been violated or you disagree with a decision made about access to your records, please contact the person designated below. You may also submit a written complaint to the U.S. Department of Health and Human Services. We can provide you with the address to file your complaint. Your child's care will not be adversely affected for filing a complaint.

Contact: Jayne A. Sanson-Jaraczewski, MD, PC

Telephone: 928-649-1559

Fax: 928-649-1427

Address: 203 S. Candy Lane, Suite 6B, Cottonwood, AZ 86326

Changes in Notice: We reserve the right to change this Notice and privacy practices and to make new changes effective for all of your child's health information we currently have and any we receive in the future. We will post any significant changes in the waiting room.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have read and agree to this Notice of Privacy Practices.

Date: _____

Patient Name (s): _____

Parent or Guardian Signature: _____

Printed Name: _____

SANSON PEDIATRICS
Jayne Sanson-Jaraczewski, MD, PC
203 S. Candy Lane, Ste. 6B, Cottonwood, AZ 86326 (928) 649-1559

PARENTS PLEASE READ AND SIGN

ADMINISTRATIVE POLICIES AND PROCEDURES "NO-SHOW POLICY"

The purpose of this policy is to improve scheduling opportunities and encourage parents to call and cancel or reschedule their child's appointments in a reasonable amount of time, which will allow for better use of patient, staff and physician time.

It is the policy of our office to confirm scheduled appointments prior to the date of the visit. We will call 1 – 2 days before your child's appointment in an attempt to confirm. In the event we are unable to reach you directly, we will leave a message if given this option. If you are unable to keep your appointment, we would appreciate at least a 24 hour advance notice. If our office is closed, please leave us a message on our voice mail. We understand that unplanned things can happen. However, it is as simple as a phone call. Ultimately, the responsibility is yours.

All insured and non-insured patients will be charged a \$20.00 "No-Show" fee beginning with the second missed appointment. This fee will not be charged to your insurance, it is due and payable by you. No future appointments will be scheduled until these fees have been paid. A dismissal from the practice may result after three No-Shows.

1st No-Show – The parent will receive a phone call informing them they missed their child's appointment and that another missed appointment, without notifying the office, will result in a \$20.00 fee.

2nd No-Show – The parent will receive a letter informing them that they have now missed two of their child's appointments without notifying the office and they will be charged a \$20.00 fee.

3rd No-Show – The parent will receive a letter informing them that they will again be charged a \$20.00 fee, their child's account has been flagged for habitual no-shows and that another no-show will result in another \$20.00 fee and dismissal from the practice.

Double Appointment No-Show – Parents who have 2 or more children's appointments scheduled at the same time will be restricted from scheduling double appointments in the future. Each child's account will be flagged for restriction and a no-show.

Patient Name

Signature of Parent or Legal Guardian

Date



Screening Form to Determine History of Chickenpox
(Varicella) Disease

ADHS Var 6/05

Student Name: _____ Date of Birth: _____
School Name: _____ Grade: _____
Parent/Guardian Name (please print):

Address:

Telephone Number (where you can be reached during the day):

If your child saw a doctor for a rash that the doctor said was chickenpox, please fill out this box.
Doctor's Name: _____
Approximate Date of the Doctor Visit: Month: _____ Year: _____
Parent/Guardian Signature: _____ Date: _____

If you filled out this box then your child will not need to get the chickenpox vaccine for school admission.
Present
this to the school nurse as proof of chickenpox disease.

If you think your child had chickenpox even though he or she was not taken to the doctor, please fill out this box.
Approximate Date of Illness: Month: _____ Year: _____
Did your child have a rash on his/her body for 3 or more days? Yes No Don't Know
Did the rash have blisters? Yes No Don't Know
Did the blisters itch? Yes No Don't Know
Did the blisters turn into scabs? Yes No Don't Know
Parent/Guardian Signature: _____ Date: _____

If you answered "Yes" all the questions in this box then your child will not need the chickenpox vaccine for admission to school. Present this to the school nurse as proof that your child already had chickenpox.

If you answered "No" or "Don't Know" to any of the questions in this box, then your child will need the chickenpox vaccine for school admission.

RELEASE OF MEDICAL INFORMATION AUTHORIZATION FORM

DATE: _____

PATIENT NAME: _____ DATE OF BIRTH _____
FIRST M.I. LAST

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

CONTACT PHONE #: _____ E-MAIL: _____

I AM REQUESTING AND AUTHORIZING A RELEASE OF MY/MY CHILD'S MEDICAL RECORDS. PLEASE COPY AND SEND:
(CHECK APPROPRIATE BOX)

ENTIRE MEDICAL RECORD

OR

ALL FILES DURING THE FOLLOWING DATES: _____

OR

SPECIFIC RECORDS (SUCH AS LABS, X-RAY, EKG, ETC)

(PLEASE INCLUDE APPROX. DATES FOR THE TESTS/FILES YOU'RE LOOKING FOR)

MAIL RECORDS FROM:

OR

JAYNE A. SANSON-JARACZEWSKI, MD
203 SOUTH CANDY LANE, SUITE 6B
COTTONWOOD, AZ 86326
928-649-1559
928-649-1427 FAX

MAIL RECORDS TO:

JAYNE A. SANSON-JARACZEWSKI, MD
203 SOUTH CANDY LANE, SUITE 6B
COTTONWOOD, AZ 86326
928-649-1559

OR

OTHER ADDRESS:

SIGNATURE (REQUIRED): _____ DATE: _____

NAME (PRINTED): _____ RELATIONSHIP TO PATIENT
 PARENT
 LEGAL GUARDIAN
 OTHER

PLEASE CHECK APPROPRIATE BOX FOR MEDICAL RECORDS

ACKNOWLEDGE RECEIPT OF MEDICAL RECORDS FROM THE OFFICE OF SANSON PEDIATRICS PC

CHOOSE NOT TO RECEIVE COPIES OF MEDICAL RECORDS. PLEASE

SHRED. DATE: _____

