Margiotti & Kroll PEDIATRICS, P.C.

PATIENT REGISTRATION FORMS

In order to serve you, we need the following information. Please print.

Today's Date:	Preferred Office: ☐ Trevose ☐ Newtown ☐ Valley Square ☐ Northeast			
PATIENT INFORMATION				
Patient's Last Name:	First Name:		Middle:	Nickname:
Date of Birth:	Age:	Gender:	Student: ☐ Part Time ☐ Full Time	
Patient's Address:	Apt:	City/Town:	State:	Zip Code:
Primary Phone:	Daytime (Work) Phone:		Mobile (Cell) Phone:	
Patient E-Mail Address: (if applicable)		Emergency Contact:		
Preferred Language:		Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer		
Race: ☐ White ☐ Black or African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Decline to Answer				
Preferred M&K Pediatrics Physician/Clinician:				
Preferred Contact Method: (select one for each **if patient is over 18**)				☐ No Contact (*contact guardian*)
Medical Issues/Problems:		☐ Cell Phone	☐ Home Phone	☐ No Contact (*contact guardian*)
Appointment Reminders:	☐ Text to Cell	☐ E-Mail		☐ No Contact (*contact guardian*)
Due for Visit:	☐ Text to Cell	☐ E-Mail	☐ Cell Phone ☐ Home Phone	☐ No Contact (*contact guardian*)
Hospital:	Obstetrician:		Referred By:	
PHARMACY INFORMATION				
Name of Pharmacy:	Address:		Phone:	
			Fax:	
PARENT/GUARDIAN #1 INFORMATION **(This parent/guardian will be listed as the primary contact for the patient listed above)**				
Parent/Guardian's Last Name:	First Name:		Middle:	Nickname:
SSN:	Date of Birth:	Relation to Patient:	☐ Check here if patient is the genetic child of this parent ☐ Check here if patient lives with this parent/guardian?	
Address: (Leave blank if same as patient)	Apt:	City/Town:	State:	Zip Code:
Primary Phone:	Daytime (Work) Phone:		Mobile (Cell) Phone:	
Preferred Language:		Parent/Guardian Home E-Mail Address:		
Employer:		Occupation:		
Preferred Contact Method: (select one for each)				
Medical Issues/Problems:		☐ Cell Phone	☐ Home Phone	
Appointment Reminders:	☐ Text to Cell	☐ E-Mail		
Due for Visit:	☐ Text to Cell	☐ E-Mail	☐ Cell Phone ☐ Home Phone	

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PATIENT REGISTRATION FORMS

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PARENT/GUARDIAN #2 INFORMATION

(This parent/guardian will be listed as the secondary contact for the patient listed above)

☐ Check here if patient does not have a secondary parent/guardian. (If selected please skip this section)

Parent/Guardian's Last Name:	First Name:	Middle:	Nickname:

SSN:	Date of Birth:	Relation to Patient:	☐ Check here if patient is the genetic child of this parent ☐ Check here if patient lives with this parent/guardian?

Address: (Leave blank if same as patient)	Apt:	City/Town:	State:	Zip Code:

Primary (Home) Phone:	Daytime (Work) Phone:	Mobile (Cell) Phone:

Preferred Language:	Parent/Guardian Home E-Mail Address:

Employer:	Occupation:

Preferred Contact Method: (select one for each) *Only used if primary parent/guardian is unable to be reached unless otherwise specified*

Medical Issues/Problems: ☐ Cell Phone ☐ Home Phone

Appointment Reminders: ☐ Text to Cell ☐ E-Mail

Due for Visit: ☐ Text to Cell ☐ E-Mail ☐ Cell Phone ☐ Home Phone

AUTHORIZED FAMILY MEMBER / CARETAKER INFORMATION

(Persons listed in this section are permitted to accompany and consent to the examination and/or treatment of the patient listed above until expressly revoked by a parent/guardian)

☐ Check here if you do not authorize any additional family members/caretakers to accompany and consent to the examination and/or treatment of this patient in the absence of a parent/guardian. (If selected please skip the next section)

1st Authorized Party Last Name:	First Name:	Relation to Patient:
Phone Number:	This authorization is effective from _____ through_____.	
	This authorization is effective from _____ until revoked by me in writing.	
2nd Authorized Party Last Name:	First Name:	Relation to Patient:
Phone Number:	This authorization is effective from _____ through_____.	
	This authorization is effective from _____ until revoked by me in writing.	
3rd Authorized Party Last Name:	First Name:	Relation to Patient:
Phone Number:	This authorization is effective from _____ through_____.	
	This authorization is effective from _____ until revoked by me in writing.	

SIBLINGS

Last Name:	First Name:	Date of Birth:	Gender:
Last Name:	First Name:	Date of Birth:	Gender:
Last Name:	First Name:	Date of Birth:	Gender:
Last Name:	First Name:	Date of Birth:	Gender:

Margiotti & Kroll PEDIATRICS, P.C.

PATIENT REGISTRATION FORMS

In order to serve you, we need the following information. Please print.

PRIMARY INSURANCE INFORMATON			
Insurance Company Name:	ID Number:		Group Number:
Guarantor's Name:	Gender:	Date of Birth:	Patient Relation to Guarantor:
Employer:		Employer Address:	

SECONDARY INSURANCE INFORMATON			
Insurance Company Name:	ID Number:		Group Number:
Guarantor's Name:	Gender:	Date of Birth:	Patient Relation to Guarantor:
Employer:		Employer Address:	

IMPORTANT NOTICE REGARDING FINANCIAL RESPONSIBILTY FOR SERVICES RENDERED

Out staff is anxious to assist you in obtaining reimbursement from your insurance carrier to the best of our ability. At every visit, you will be required to present the patient's current insurance card and update any guarantor/subscriber information. Each medical insurance plan has its own rules and regulations. We strongly encourage you to become familiar with your insurance plan. This includes, but is not limited to: knowledge of capitation requirements, referrals, co-payments, deductibles, covered and non-covered services, and other administrative requirements issued by your carrier. We will submit claims for reimbursement for the majority of our services to all insurance carriers with which we participate. It is your financial responsibility to pay any remaining balance resulting from co-insurances, deductibles, non-covered services, etc. Our office adheres to the recommendations set forth by the American Academy of Pediatrics (AAP) for routine well child care including the schedule of well visits, immunizations, and preventative screenings. Please be aware that your insurance carrier may assign you a charge for these services. We are dedicated to providing our services at times convenient to our patients. Please be aware that your insurance carrier may apply a higher co-pay or patient responsibility for a visit during our evening or weekend office hours. Margiotti & Kroll Pediatrics, P.C. reserves the right to apply a billing fee for all co- payments that are not collected at the time of service. Please be sure to remit payment promptly upon receiving any bill. Please contact our billing department with questions at 215-364-5801, option 2.

AUTHORIZATION FOR TREATMENT AND ACKNOLEDGEMENT OF FINANCIAL RESPONSIBILTY

- I hereby authorize all parents, guardians, family members, and caretakers listed above to accompany the above named patient to office visits at Margiotti & Kroll Pediatrics, P.C., and consent to the examination and/or treatment of the above named patient during the office visits. Parents and/or guardians must be listed above in order to obtain access to this patient's records via the Online Patient Portal.
- I hereby authorize Margiotti & Kroll Pediatrics, P.C. personnel to communicate via mail, phone call, answering machine message, text message, and/or e-mail according to the information I have provided above.
- I hereby authorize Margiotti & Kroll Pediatrics, P.C. and associated parties to release medical and/or other information acquired in the course of my examination and/or treatment (with the exception of mental health records) to necessary insurance companies, third party payors, and/or other physicians or healthcare entities required to participate in my care.
- I certify that myself/my dependent(s) have health insurance coverage as indicated above. I hereby authorize Margiotti & Kroll Pediatrics, P.C. and/or its subsidiaries to submit for reimbursement on my/our behalf for all services rendered and assign directly to Margiotti & Kroll Pediatrics, P.C. all insurance benefits otherwise payable to me. I understand that all co-pays, co-insurances, and deductibles are due at the time of service and that a billing fee will be added to any co-pays not paid at the time of service. I further understand that if Margiotti & Kroll Pediatrics, P.C. is unable to verify active insurance coverage for this patient and/or the claim for reimbursement is not paid by my insurance that the patient (or patient's guardian, if a minor) is ultimately responsible for payment for services rendered. I agree that any balance due for services rendered will be paid immediately upon receipt of a bill. In the event that I do not pay my bill, I understand that I will be held responsible for all reasonable collection and legal fees.

Patient/Parent/Guardian Name:	Relationship to Patient:
Patient/Parent/Guardian Signature:	Date:

Margiotti & Kroll PEDIATRICS, P.C.

PATIENT REGISTRATION FORMS

In order to serve you, we need the following information. Please print.

INITIAL HEALTH HISTORY QUESTIONNAIRE

Patient's Last Name:	First Name:	Age:	Date of Birth:	Gender:
Form Completed By:		Date Completed:		

HOUSEHOLD

Please list all those living in the child's home:

Name	Relationship to Child	Date of Birth	Health Problems

Are there siblings not listed? If so, please list their names, ages, and where they live:

What is the child's living situation if not with both biological parents?
☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody ☐ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

BIRTH HISTORY [☐ Don't know birth history]

Birth weight:	Was the baby born at term? ☐ Yes or ☐ No _____ weeks	Vaginal ☐ Cesarean ☐ If Cesarean, why?

Were there any prenatal or neonatal complications? ☐ No ☐ Yes If Yes, explain:

Was a NICU stay required? ☐ No ☐ Yes If Yes, explain:

During pregnancy, did mother: Use tobacco? ☐ No ☐ Yes Drink alcohol? ☐ No ☐ Yes Use drugs? ☐ No ☐ Yes If Yes, explain:

Was initial feeding: ☐ Formula ☐ Breast milk How long breastfed?

Did your baby go home with mother from the hospital? ☐ Yes ☐ No If No, explain:

GENERAL HISTORY [DK= don't know]

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ DK explain:

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ DK explain:

Has your child had any surgery? ☐ Yes ☐ No ☐ DK explain:

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ DK explain:

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ DK explain:

Do you feel your family has enough to eat? ☐ Yes ☐ No ☐ DK explain:

PATIENT REGISTRATION FORMS

In order to serve you, we need the following information. Please print.

PAST HISTORY [DK= don't know]

Does your child have, or has your child ever had?

Chickenpox	☐ Yes ☐ No ☐ DK	When:
Frequent ear infections	☐ Yes ☐ No ☐ DK	Explain:
Problems with ears or hearing	☐ Yes ☐ No ☐ DK	Explain:
Nasal allergies	☐ Yes ☐ No ☐ DK	Explain:
Problems with eyes or vision	☐ Yes ☐ No ☐ DK	Explain:
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes ☐ No ☐ DK	Explain:
Any heart problem or heart murmur	☐ Yes ☐ No ☐ DK	Explain:
Anemia or bleeding problem	☐ Yes ☐ No ☐ DK	Explain:
Blood transfusion	☐ Yes ☐ No ☐ DK	Explain:
HIV	☐ Yes ☐ No ☐ DK	Explain:
Organ transplant	☐ Yes ☐ No ☐ DK	Explain:
Malignancy/bone marrow transplant	☐ Yes ☐ No ☐ DK	Explain:
Chemotherapy	☐ Yes ☐ No ☐ DK	Explain:
Frequent abdominal pain	☐ Yes ☐ No ☐ DK	Explain:
Constipation requiring doctor visits	☐ Yes ☐ No ☐ DK	Explain:
Recurrent urinary tract infections and problems	☐ Yes ☐ No ☐ DK	Explain:
Congenital cataracts/retinoblastoma	☐ Yes ☐ No ☐ DK	Explain:
Metabolic/Genetic disorders	☐ Yes ☐ No ☐ DK	Explain:
Cancer	☐ Yes ☐ No ☐ DK	Explain:
Kidney disease or urologic malformations	☐ Yes ☐ No ☐ DK	Explain:
Bed-wetting (after 5 years old)	☐ Yes ☐ No ☐ DK	Explain:
Sleep problems; snoring	☐ Yes ☐ No ☐ DK	Explain:
Chronic or recurrent skin problems (eg, acne, eczema)	☐ Yes ☐ No ☐ DK	Explain:
Frequent headaches	☐ Yes ☐ No ☐ DK	Explain:
Convulsions or other neurologic problems	☐ Yes ☐ No ☐ DK	Explain:
Obesity	☐ Yes ☐ No ☐ DK	Explain:
Diabetes	☐ Yes ☐ No ☐ DK	Explain:
Thyroid or other endocrine problems	☐ Yes ☐ No ☐ DK	Explain:
High blood pressure	☐ Yes ☐ No ☐ DK	Explain:
History of serious injuries/fractures/concussions	☐ Yes ☐ No ☐ DK	Explain:
Use of alcohol or drugs	☐ Yes ☐ No ☐ DK	Explain:
Tobacco use	☐ Yes ☐ No ☐ DK	Explain:
ADHD/anxiety/mood problems/depression	☐ Yes ☐ No ☐ DK	Explain:
Developmental delay	☐ Yes ☐ No ☐ DK	Explain:
Dental decay	☐ Yes ☐ No ☐ DK	Explain:
History of family violence	☐ Yes ☐ No ☐ DK	Explain:
Sexually transmitted infections	☐ Yes ☐ No ☐ DK	Explain:
Pregnancy	☐ Yes ☐ No ☐ DK	Explain:
(For girls) Problems with her periods	☐ Yes ☐ No ☐ DK	Explain:
Has had first period	☐ Yes ☐ No	Age of first period:

Any other significant problem(s): _____

_____

In order to serve you, we need the following information. Please print.

BIOLOGICAL FAMILY HISTORY [DK= don't know]

Have any family members had the following?

Childhood hearing loss	☐ Yes ☐ No ☐ DK	Who:	Comments:
Nasal allergies	☐ Yes ☐ No ☐ DK	Who:	Comments:
Asthma	☐ Yes ☐ No ☐ DK	Who:	Comments:
Tuberculosis	☐ Yes ☐ No ☐ DK	Who:	Comments:
Heart disease (before 55 years old)	☐ Yes ☐ No ☐ DK	Who:	Comments:
High cholesterol/takes cholesterol medication	☐ Yes ☐ No ☐ DK	Who:	Comments:
Anemia	☐ Yes ☐ No ☐ DK	Who:	Comments:
Bleeding disorder	☐ Yes ☐ No ☐ DK	Who:	Comments:
Dental decay	☐ Yes ☐ No ☐ DK	Who:	Comments:
Cancer (before 55 years old)	☐ Yes ☐ No ☐ DK	Who:	Comments:
Liver disease	☐ Yes ☐ No ☐ DK	Who:	Comments:
Kidney disease	☐ Yes ☐ No ☐ DK	Who:	Comments:
Diabetes (before 55 years old)	☐ Yes ☐ No ☐ DK	Who:	Comments:
Bed-wetting (after 10 years old)	☐ Yes ☐ No ☐ DK	Who:	Comments:
Obesity	☐ Yes ☐ No ☐ DK	Who:	Comments:
Epilepsy or convulsions	☐ Yes ☐ No ☐ DK	Who:	Comments:
Alcohol abuse	☐ Yes ☐ No ☐ DK	Who:	Comments:
Drug abuse	☐ Yes ☐ No ☐ DK	Who:	Comments:
Mental illness/depression	☐ Yes ☐ No ☐ DK	Who:	Comments:
Developmental disability	☐ Yes ☐ No ☐ DK	Who:	Comments:
Immune problems, HIV, or AIDS	☐ Yes ☐ No ☐ DK	Who:	Comments:
Tobacco use	☐ Yes ☐ No ☐ DK	Who:	Comments:

Additional family history _____

_____

In order to serve you, we need the following information. Please print.

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT	
I certify that I have been offered and/or have received a copy of Margiotti & Kroll Pediatrics, P.C.'s Notice of Privacy Practices.	
Patient/Parent/Guardian Name:	Relationship to Patient:
Patient/Parent/Guardian Signature:	Date:

Please list below the names and dates of birth of all of your children / dependents who are patients of Margiotti & Kroll Pediatrics, P.C. with whom you wish to include in this authorization:

Name	Date of Birth

In order to serve you, we need the following information. Please print.

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

(Complete to permit the disclosure of information to Outside Entity OR Parent/Guardians if Patient is over 18 years of age)

Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164

1. AUTHORIZATION:

By signing this authorization, I authorize Margiotti & Kroll Pediatrics, P.C. to use and/or disclose certain protected health information (PHI) about me to:

Name of Person/Entity **Receiving** Information:	Relationship to Patient: (if applicable)

2. EFFECTIVE PERIOD :

This authorization for release of information covers the period of healthcare from:

A:	☐	Start Date:	End Date:

****OR****

B:	☐	All past, present, and future periods.

3. EXTENT OF AUTHORIZATION :

A:	☐	I authorize the release of my complete health record (including but not limited to records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

****OR****

B:	☐	I authorize the release of my complete health record with the exception of the following information:
		☐ Mental health records; ☐ Communicable diseases (including HIV and AIDS); ☐ Alcohol/drug abuse treatment; ☐ Other (Please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct;
5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires;
6. I understand I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage at the insurer has a legal right to contest a claim;
7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization;
8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Patient/Guardian/Personal Representative/ Signature:	Date:
Printed Name of Patient/Guardian/Personal Representative:	Relationship to Patient: