

Mercer Island Pediatrics, Inc. P.S.  
REGISTRATION FORM

ID#

Today's Date

Physician

PATIENT INFORMATION

Patient's last name:		First:	MI	Birth Date:	Sex:	Patient's cell:
Street Address:			SSN:	Home phone:		
City:				State:	ZIP	
Sibling names/DOB:						

PARENT INFORMATION

MOTHER/GUARDIAN			FATHER/GUARDIAN		
Last name:	First:	MI:	Last name:	First:	MI:
Address (if different from patient)			Address (if different from patient)		
Home phone:	Work :	Cell :	Home phone:	Work :	Cell :
Employer:		Occupation:	Employer:		Occupation:
Emp. Address:			Emp. Address:		
Relation to Pt:		DOB:	Relation to Pt:		DOB:
Send bills to this address Yes <input type="checkbox"/> No <input type="checkbox"/>			Send bills to this address Yes <input type="checkbox"/> No <input type="checkbox"/>		

INSURANCE INFORMATION

Is this patient covered by insurance? Yes  No  Please give your insurance card to the receptionist.

Primary insurance	Group no.:	Policy no.:	Co-payment:
Subscriber's name:	Subscriber's SSN		DOB
Pt's relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Other			
Secondary insurance:	Group no.:	Policy no.:	Co-payment:
Subscriber's name:	Subscriber's SSN		DOB
Pt's relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Other			

EMERGENCY CONTACTS

Name of local friend or relative (not living at same address): \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_

Phones: [H] \_\_\_\_\_ [W] \_\_\_\_\_ [C] \_\_\_\_\_

The above information is true to the best of my knowledge.

Name	Signature	Relationship to Patient	Date
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Mercer Island Pediatrics, Inc. P.S.  
**PEDIATRIC PATIENT QUESTIONNAIRE**

Today's Date \_\_\_\_\_

Updates \_\_\_\_\_

Patient's Name \_\_\_\_\_ DOB \_\_\_\_\_

Siblings	DOB	Health
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Past Medical History**

Allergies to medications, food or insects \_\_\_\_\_

Medications taken regularly \_\_\_\_\_

Problems during mom's pregnancy, the birth or newborn period \_\_\_\_\_

Hospitalizations \_\_\_\_\_

Surgeries \_\_\_\_\_

Serious illness or medical problems \_\_\_\_\_

Please check any of the following your child has had:

- |  |  |  |
|--|--|--|
| <input type="radio"/> Vision problems    | <input type="radio"/> Motor delays                   | <input type="radio"/> Urine infections |
| <input type="radio"/> Hearing problems   | <input type="radio"/> Learning problems              | <input type="radio"/> Constipation     |
| <input type="radio"/> Speech problems    | <input type="radio"/> Mental health concerns         | <input type="radio"/> Soiling          |
| <input type="radio"/> Poisoning/overdose | <input type="radio"/> Concussion/serious head injury | <input type="radio"/> Anemia           |
| <input type="radio"/> Serious accident   | <input type="radio"/> Hay fever or asthma            | <input type="radio"/> Heart murmur     |

Briefly explain the above concerns: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Family History**

Please check any of the following conditions that any close blood relative of your child has had:

- |  |   |   |
|--|---|---|
| <input type="radio"/> Child is adopted.                |   |   |
| <input type="radio"/> Birth defects/malformations      | <input type="radio"/> Death before 1 year of age    | <input type="radio"/> Alcoholism/substance abuse                  |
| <input type="radio"/> Mental retardation               | <input type="radio"/> Diabetes                      | <input type="radio"/> Cancer                                      |
| <input type="radio"/> High cholesterol                 | <input type="radio"/> Vision or hearing loss        | <input type="radio"/> Migraine headaches                          |
| <input type="radio"/> Heart attack or stroke by age 50 | <input type="radio"/> Hip problems at birth         | <input type="radio"/> Learning problems/school problems           |
| <input type="radio"/> Anemia or blood disorder         | <input type="radio"/> Eating disorder               | <input type="radio"/> Hyperactivity or attention deficit disorder |
| <input type="radio"/> Asthma or wheezing               | <input type="radio"/> Kidney problems               |   |
| <input type="radio"/> Tuberculosis                     | <input type="radio"/> Mental illness/suicide        |   |
| <input type="radio"/> Seizures                         | <input type="radio"/> Emotional problems/depression |   |

Comments (more room on back) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# Mercer Island Pediatrics, Inc. P.S.

9675 SE 36th St., Ste. 100  
Mercer Island, WA 98040

www.mipediatics.com

Tel: 206-275-2122  
Fax: 206-275-0860

## PATIENT AGREEMENT

Patient \_\_\_\_\_ Medical Record Number \_\_\_\_\_

### Assignment of Insurance Benefits:

I hereby authorize Mercer Island Pediatrics to request and directly collect, on my behalf, all public and private insurance coverage benefits due for products and services provided by Mercer Island Pediatrics. If insurance benefits are paid directly to me, I will endorse these checks for such payments to Mercer Island Pediatrics.

### Medical Consent:

I consent to all routine, usual, and customary patient tests, procedures, and exams performed or prescribed by the physicians of Mercer Island Pediatrics.

### Release of Medical Information:

I authorize Mercer Island Pediatrics to release any health care information necessary to facilitate the processing of claims, and audit of payments relative to the services provided to me or my child by Mercer Island Pediatrics.

A special Consent for Release of Confidential Information must be signed for those patients receiving services related to HIV/AIDS. Mercer Island Pediatrics will keep a record of the health care services provided to me or my child. I may see that record and copy it. Mercer Island Pediatrics will not disclose my record to others unless I direct Mercer Island Pediatrics to do so, or unless the law authorizes them to do so. The receptionist can answer your medical record questions.

**THE PATIENT/GUARANTOR AGREES THAT HE/SHE IS HEREBY FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED FOR SERVICES PROVIDED INCLUDING THOSE THAT MAY NOT BE COVERED BY YOUR INSURANCE. THESE MAY INCLUDE FEES FOR MEDICAL SUPPLIES, AFTER-HOURS AND EMERGENCY OFFICE VISITS, HOME VISITS AND AFTER-HOURS PHONE CALL CHARGES.**

\_\_\_\_\_  
Signature of Patient/Guarantor

\_\_\_\_\_  
Date

NOTE: A duplicate copy of this Patient Agreement shall be considered the same as the Original.

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## NOTICE OF PRIVACY PRACTICES —ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see, and copy, that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Mercer Island Pediatrics Privacy Officer.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

**By my signature below I acknowledge receipt of the Notice of Privacy Practices.**

\_\_\_\_\_  
Printed name of patient

\_\_\_\_\_  
Patient or legally authorized individual signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship  
(parent, legal guardian, personal representative)

(Notation, if any, by staff)

This form will be retained in your medical record.

# Authorization for Mercer Island Pediatric Associates to Use or Disclose My Health Care Information

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Release from: \_\_\_\_\_

Previous Physician/OrganizaTion \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

## I. My Authorization

**You may use or disclose the following health care information (check all that apply):**

- All health care information in my medical record
- Health care information in my medical record relating to the following treatment or condition: \_\_\_\_\_
- Health care information in my medical record for the date(s): \_\_\_\_\_
- Other (e.g., X rays, bills), specify date(s): \_\_\_\_\_

**You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):**

- HIV (AIDS virus)
- Sexually transmitted diseases
- Psychiatric disorders/mental health
- Drug and/or alcohol use

**You may disclose this health care information to:**

Name (or title) and organization: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Reason(s) for this authorization (check all that apply):**

- at my request
- other (specify) \_\_\_\_\_
- This authorization ends:** *(This document does not permit disclosure of health information created more than 90 days after the date it is signed.)*
- in 90 days from the date signed
- when the following event occurs: \_\_\_\_\_  
(no longer than 90 days from date signed)
- check only if [practice/ facility] requests the authorization for marketing purposes
- check only if [practice/facility] will be paid or get something of value for providing health information for marketing purposes

## II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Mercer Island Pediatric Associates based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from the Mercer Island Pediatric Associates. Or
- Write a letter to the Mercer Island Pediatric Associates.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

\_\_\_\_\_  
Patient or legally authorized individual signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Printed name if signed on behalf of the patient

\_\_\_\_\_  
Relationship

(parent, legal guardian, personal representative)