Pediatric Partners
with you, for your child...
for years to come.

Patient Registration

Date: _____

Patient's Full Legal Name:	Date of Birth:	Nickname:
Social Security #:	**Gender:**	
Address:	**City:**	**State:** **Zip:**
Telephone Home #:	**Telephone Work #:**	**Cell #:**

Mother's Information	Father's Information	Guardian's Information
Name:	Name:	Name:
if different than above Address	***if different than above*** Address	***if different than above*** Address
City:	City:	City:
State:_____ZipCode: _____	State:_____ZipCode: _____	State:_____ZipCode: _____
DOB:	DOB:	DOB:
Mother's Telephone Information: Home:_____ Office: _____ Cell: _____	**Father's Telephone Information:** Home:_____ Office: _____ Cell: _____	**Guardian's Telephone Information:** Home:_____ Office:_____ Cell: _____

Preferred Email:_____**Relationship to patient:** *Please Circle:* Mother Father Guardian Other: _____

Primary Language: *Please Circle:* English Spanish Other: _____

Child's Race: *Please Circle All That Apply:*	**Child's Ethnicity:** *Please Circle All That Apply:*
White Black/African American Asian American Indian/Alask a Native Native Hawaiian/Other Pacific Islander *Decline to answer*	Are you Hispanic or Latino? Yes No *Decline to answer*

Guarantor Information

Name:	**Relationship** *Please Circle:* Self Mother Father Guardian
Home address if different than above:	**DOB:** **SS#:**

Insurance Information

Insurance Name:	**Policy Holder's Name:**
Policy Holder's DOB:	**ID#:**
Group #:	**Policy Holder's SS#:** _____
Relationship *Please Circle:* Self Mother Father Guardian	

Thank you for choosing Pediatric Partners

Boca Raton
5458 Town Center Road, Suite 101, Boca Raton, FL 33486
561.393.8555 • Fax 561.393.1904

Palm Beach Gardens
3401 PGA Blvd., Suite 300, Palm Beach Gardens, FL 33410
561.741.0000 • Fax 561.627.0040

Jupiter
1025 Military Trail, Suite 109, Jupiter, FL 33458
561.741.0000 • Fax 561.741.0002

PEDIATRIC PARTNERS

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____or_____am the parents of the following child:_____, and have received a copy of Pediatric Partners' notice of Privacy Practices.

_____
Signature of Patient

_____
Signature of Parent

_____
Date

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561.393.8555 • Fax 561.393.1904

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PEDIATRIC PARTNERS
CONSENT TO TREAT/AUTHORIZATIONS/ATTESTATIONS

_____ 1. I am the parent/guardian of LAURA TEST. I have the legal right to consent to medical and surgical treatment for this patient. I voluntarily authorize and consent to medical care, treatment, and diagnostic tests that the pediatricians and nurse practitioners at Pediatric Partners believe are necessary for this child.

_____ 2. In my absence and in case of emergency, I give my permission to any provider at Pediatric Partners to treat my child.

_____ 3. I hereby assign all medical benefits including Medicaid, Private Insurance and other health plans to Pediatric Partners. I hereby authorize Pediatric Partners to apply for benefits on my behalf for covered services rendered or ordered and release any medical or other information necessary to process claims. I request that payment from my insurance company be made directly to Pediatric Partners.

_____ 4. I authorize Pediatric Partners to use e-prescribing (electronic prescribing) to transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information, and dispensed medication history. I understand that a complete and accurate medication list is essential to effective and safe medical care.

_____ 5. I have received a copy of Pediatric Partners' Financial and Office Policies.

_____ 6. I have received a copy of Pediatric Partners' Notice of Privacy Health Information Policy.

_____ 7. A copy of this authorization may be used in place of the original. The authorizations/attestations and consent to treat will remain \ in effect as long as my child (or myself) remains a patient at this practice or until I withdraw my consent.

_____ 8. I give my pediatricians office consent to review my child's immunization records.

_____ 9. Although I recognize that information left on telephone voicemail/answering machines and sent via electronic mail (e-mail) may not be secure, I give Pediatric Partners permission to relay test results via one or both of these methods as indicated below:

_____Telephone:_____and/or

_____Email: _____

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Guardian Date

_____
Relationship to
Patient

Thank you for choosing Pediatric Partners

Patient Appointment Policies

Pediatric Partners strives to provide the best care possible for the children in our community. At Pediatric Partners, our goal is to provide your family a convenient and efficient health care experience. Our appointments do fill quickly and we want to provide all our patients with the best access to care, so please try your best to honor your child's reserved appointment time.

You may schedule your child's appointment by calling our main telephone number at 561.741.0000 Monday through Friday from 7:30 a.m. to 6:00 p.m. and Saturday mornings from 8:30 a.m. to 12 noon. You can also schedule an appointment 24 hours a day, 7 days a week through our patient portal at www.pediatricpartners.com. Please see our website for more information on our appointment policies and Kids Express (same day) appointments for acute illnesses, injuries and medical emergencies.

We understand that life (and children) can be unpredictable... but please work with us to help minimize missed appointments (no-shows), same day cancellations and late patient arrivals. Thank you for your understanding and support.

Missed Appointments (No-Shows) and Same Day Cancellations

Unpredictable incidents and emergencies can dictate a missed appointment (no-show) or same day cancellation. If you have one of these rare incidents, we will be glad to work with you to reschedule the appointment without a service charge. Otherwise patients who miss (no-show) their appointment or cancel on the same day of their scheduled appointment will be charged a service fee based on the following schedule:

- Courteous fee waiver for first occurrence.
- $25 fee for second occurrence within a 12-month period.
- $50 fee for third or more occurrences within a 12-month period.

If you consistently miss your scheduled appointments (four or more times), this may result in dismissal from our practice. Our goal is to provide your child with timely access to healthcare; please let us know how we can help you in ensuring a successful experience (e.g., transportation, insurance, communication assistance).

PATIENT LATE ARRIVAL POLICY

In order to provide service to all families that have scheduled appointment times, families who arrive 20 minutes late or more for their scheduled physicals, consults and med check appointments may be asked to reschedule their appointment for a different time and day. However, we will still see your child on the same day, if she or he is acutely ill or injured, although you may have to wait until we're able to accommodate your visit between other schedule patients.

Our office sends out appointment reminders 48 hours prior to your scheduled appointment. Please advise us of your preference in communication delivery:

_____Text Message Mobile phone number:_____
_____Telephone Call Preferred phone number:_____
_____E-mail Notification E-mail address:_____

Parent/Patient Signature:_____ Date: _____

Family History

Today's Date:_____

Family Social History

Fill in and Check appropriate boxes:	Occupation	Employer	Daycare	Year in School	GED	HS Diploma	Trade/Vocational	Associate Degree	Bachelor's Degree	Post Graduate
Patient			Yes No							
Mother			Yes No							
Father:			Yes No							
Guardian			Yes No							

Home and Family Environment

Parental Marital Status: *Circle:* Married Divorced Separated Single Widowed Other: _____

Household Members. *Circle all that apply:* Mother Father Stepmother Stepfather Grandparent Guardian Siblings Other: _____

Sibling(s) Name	DOB (MM/YY)	Gender	Sibling(s) Name	DOB (MM/YY)	Gender
1.		Male Female	4.		Male Female
2.		Male Female	5.		Male Female
3.		Male Female	6.		Male Female

Are there pets in the home?	Yes	No	Does your pool have a fence?	Yes	No N/A
Is a seatbelt/carseat used consistently?	Yes	No	Is there smoking in the home?	Yes	No
Is sunscreen used consistently?	Yes	No	Are there guns in the home? Yes No Are they in a locked area/safe? Yes No		

Family Medical History

Check the appropriate boxes:	Alive	Deceased	ADHD	Anemia	Asthma	Bleeding/Clotting issues	Blood Pressure	Cancer	Deafness	Diabetes	GI Problems	Headaches	Heart Disease	High Cholesterol	Immune/Infectious Disease	Kidney Problems	Mental Health	Seizures	Thyroid Disease	Other Medical History
Mother	A	D																		
Father	A	D																		
Sister(s)	A	D																		
Brother(s)	A	D																		
Maternal Grandmother	A	D																		
Maternal Grandfather	A	D																		
Paternal Grandmother	A	D																		
Paternal Grandfather	A	D																		
Maternal Aunt	A	D																		
Maternal Uncle	A	D																		
Paternal Aunt	A	D																		
Paternal Uncle	A	D																		
Cousin(s)	A	D																		

Thank you for choosing Pediatric Partners

Patient Full Legal Name:_____ **DOB:** _____

Patient Medical History

Today's Date: _____

Current Status			
Are your child's vaccines upto date? Yes No			
Does your child have any significant allergies to:	Medication Yes No	Food Yes No	Environmental Yes No
List allergies	Reaction	List allergies	Reaction
1)		3)	
2)		4)	
Does your child have any significant/major current health problems? Yes No **Please List Below:**			
1)		3)	
2)		4)	
3)		6)	
Do you have any concerns about your child's:	Development? Yes No	Behavior? Yes No	Social Skills? Yes No Schooling? Yes No
Birth History			
Premature: Yes No Weeks?_____	Birth Weight____Lbs.____Ounces	Discharge Weight:____Lbs..____Ounces	
Problems during Pregnancy or Delivery?	Yes No List:	Infant Feeding:	Breast Bottle Both
Any use of alcohol, tobacco, drugs or medications during pregnancy	Yes No List:	Newborn hearing screening passed?	Yes No
Was the baby in the NICU?	Yes No List:	Metabolic screening (heel stick) Done	Yes No

Patient's Medical History

Check appropriate boxes	***Yes***	***No***		***Yes***	***No***		***Yes***	***No***
ADHD			Cancer			Hearing Problems		
Allergies			Chickenpox Year: ____			Heart Disease/Murmur		
Anemia			Congenital Anomalies			Mental Health Issues		
Asthma (recurring wheezing)			Constipation			Mononucleosis		
Autism			Developmental Delay			Pneumonia		
Bed Wetting			Diabetes			Seizure		
Bladder/Kidney Disease (UTI's)			Eye Problems			Skin Issues (eczema, acne)		
Blood Disease			Failure to Thrive			Sleep Issue		
Blood Pressure, High			G.I. Problems			Thyroid Disease		
Blood Transfusions			GERD (reflux)			Other Medical History		
Broken Bones			Headaches/Migraines					

Patient's Hospitalization & Surgical History			
Has your child ever been hospitalized (overnight?) Yes No		Has your child ever had surgery? Yes No	
Reason	Date	Reason	Date
1)		3)	
2)		4)	

Thank you for choosing Pediatric Partners