KIDS CARE PEDIATRICS, INC.

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LATROBE OFFICE
108 Horner Lane
Latrobe, PA 15650
p: 724-537-2131
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NEW ALEXANDRIA OFFICE
Keystone Plaza
8279 State Route 22, Suite 2
New Alexandria, PA 15670
p: 724-668-5023
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NEW PATIENT REGISTRATION FORM

Name: Last_____First _____ Middle_____
Gender: ___ Male ___ Female **Date of Birth**:_____
Address:_____
City: _____ _____ **State:**_____ **Zip:**_____
Primary phone#: _____**Email:**_____
Race/Ethnicity (please check all that apply):
□ White □ Black/African American □ American Indian/Alaskan Native
□ Asian / Pacific Islander □ Other_____
Primary language:_____

PARENT/LEGAL GUARDIAN INFORMATION:

Name (Father/Legal Guardian): First_____ **Last**_____
Address (if different than above):_____
City: _____ **State:** _____ **Zip:**_____
Home Phone: _____ **Cell:** _____**Work:**_____
Date of Birth:_____

Name (Mother/Legal Guardian): First_____ **Last**_____
Address (if different than above):_____
City: _____**State:**_____ **Zip:**_____
Home Phone:_____ **Cell:** _____**Work:**_____
Date of Birth:_____

Financially Responsible Party (who we send bills to if insurance does not pay): _____

_____

EMERGENCY CONTACT (not listed above):
Name of Contact:_____
Phone:_____ **Relationship to Patient:**_____
Authorized to make medical decisions? □Yes □ No
Authorized to bring patient to visit if parent/guardian cannot? □Yes □ No

PRIMARY PHARMACY:_____**LOCATION:**_____

How did you hear about Kids Care Pediatrics? □ Family □ Friend □ Internet
□ Newspaper or Magazine ad □ Sign □ Other_____

Patient Name: _____

Consent to Obtain Medication History

Our medical practice has adopted an electronic medical record system in order to improve the quality of our services. This system also allows us to collect and review your "medication history." A medication history is a list of prescription medicines that we or other doctors have recently prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurer. An accurate medication history is very important to helping us treat you properly and in avoiding potentially dangerous drug interactions.

By signing this consent form you give us permission to collect, and give your pharmacy and your health plan permission to disclose, information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health conditions, such as depression. This information will become part of your medical record.

This medication history is a useful guide, but it may not be completely accurate. Some pharmacies do not make drug history available to us, and the drug history from your health plan might not include drugs that you purchased without using your health insurance. Your medication history might not include over the counter medicines, supplements or herbal remedies. It is still very important for us to take the time discuss everything you are taking, and for you to point out to us any errors in your medication history.

I give permission for *KIDS CARE PEDIATIRCS, INC*. to obtain my child's medication history from the pharmacy, health plans and other healthcare providers.

_____

PARENT/GUARDIAN SIGNATURE DATE

PRIVACY NOTICE

In accordance with the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996, patients of this practice are entitled to the greatest degree of privacy possible. This office will strive to ensure that patient information is used only for authorized purposes as agreed to by the patient or parent/guardian.
Parents/guardians are advised that they have a right to review their child's medical records upon reasonable notice to the practice and during normal business hours, and to make comments to the same.
The complete Notice of Privacy Practices is posted in our office waiting room and on our website.

Please list the names of those whom you authorize to view or receive medical information regarding the patient:

_____

Name Relationship to patient

_____

Name Relationship to patient

_____

Name Relationship to patient

_____

Parent/Guardian signature Date