

BEVERLY HILLS PEDIATRICS

PATIENT REGISTRATION FORM Thank you for completing in full

DATE: _____

PERSONAL DATA:

CHILD'S NAME: _____ DOB: _____ SEX: _____
(Last) (First) (Middle)

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ HOME PHONE: _____

PARENT #1 NAME: _____ Date of Birth: _____ SS# _____

Occupation: _____ Work Phone: _____ Cell Phone: _____

PARENT #2 NAME: _____ Date of Birth: _____ SS# _____

Occupation: _____ Work Phone: _____ Cell Phone: _____

Child's parents are: Married: _____ Divorced: _____ Never married: _____ Separated: _____ Widow(er): _____ Other _____

SIBLINGS:

Name	Date of Birth	Name	Date of Birth
_____	_____	_____	_____
_____	_____	_____	_____

If child is from a previous relationship:

OTHER PARENT(S) NAME: _____ Date of Birth: _____

Occupation: _____ Work Phone: _____

Custody relationship: _____

EMERGENCY CONTACT _____ PHONE _____

INSURANCE INFORMATION:

Name of Insurance Company: _____

Address of Insurance Company: _____

Who is the Policy Holder? _____ DOB: _____

ID #: _____ Group #: _____

PLEASE BE SURE TO HAVE OUR FRONT OFFICE COPY YOUR CURRENT INSURANCE I.D. CARD. IT IS YOUR RESPONSIBILITY TO NOTIFY US OF ANY CHANGES. THANK YOU

MEDICAL HISTORY

NAME: _____

DATE OF BIRTH: _____

PLACE OF BIRTH: _____

BIRTH WEIGHT: _____ BIRTH LENGTH: _____

PROBLEMS: (E.G. JAUNDICE, PREMATURITY)

FAMILY HISTORY:

DIABETES YES _____ NO _____ COMMENTS _____

SEIZURES YES _____ NO _____ COMMENTS _____

ALLERGIES YES _____ NO _____ COMMENTS _____

HEART DISEASE YES _____ NO _____ COMMENTS _____

HIGH BLOOD PRESSURE YES _____ NO _____ COMMENTS _____

ELEVATED CHOLESTEROL YES _____ NO _____ COMMENTS _____

CANCER YES _____ NO _____ COMMENTS _____

DEVELOPMENTAL HISTORY (if applicable) At what ages did the following occur?

Sat up without help _____ Fed Self _____ Crawled _____ Bladder Control _____

Walked _____ Bowel Control _____ Spoke 1st words _____ Dressed Self _____

Used simple sentences _____ Was child breast or bottle fed? _____ Any problems? _____

HEALTH AND MEDICAL HISTORY (if applicable)

Childhood Illnesses (Fill in circle if yes-note frequency & age)

Multiple Ear Infections _____ Tubes in Ears _____

Asthma _____ Allergies (to what?) _____

Seizures (when was last one?) _____

Please list & describe any other important injuries, illnesses, major operations or developmental problems & when they occurred: _____

Please list medications child is currently taking and what they are being taken for:

Name of Medication For What

Has vision been examined? _____ Results: _____ Does child wear glasses? _____ At what age were they prescribed? _____

Has hearing been tested? _____ Results: _____ Does child wear hearing aid? _____ At what age was it prescribed? _____

I hereby authorize examination and whatever services deemed necessary by Beverly Hills Pediatrics, Scott Cohen, MD, and Bess Raker, M.D.

I have read and understand the office policies. I hereby authorize all insurance benefits to be paid directly to Beverly Hills Pediatrics for services rendered. I understand that I am financially responsible for charges as designated by my insurance company (e.g. deductibles, coinsurances and co-pays). I am also responsible for charges not covered by insurance, including but not limited to, school or camp forms, emergency medications administered in the office, telephone management, and finance fees incurred on unpaid balances. I authorize Beverly Hills Pediatrics, Scott Cohen, MD, and Bess Raker, M.D. to release information to my insurance company when requested. I have also received a copy of my privacy notice that describes how medical information about my child may be used and disclosed and how I can access this information.

Name of Guarantor/Parent

Name of Child

Signature

Name of Child

Date

Name of Child

Name of Child

Name of Child

Name of Child