BENEJ PEDIATRICS INC. REGISTRATION FORM

Patient Information

Last Name: _____ First Name: _____ MI: _____

Date of Birth: ___/___/___ M: ____ F:____ Marital Status: Single / Married / Separated

Address: _____ City: _____

State: _____ Zip: _____ Social Security Number (If Applicable) : _____ - ____ - _____

Home Phone #: Cell Phone #: Email :

_____ _____ _____

Emergency Contact Name: Relationship to patient: Emergency Contact Phone#:

_____ _____ _____

First, last name and DOB of any siblings that are seen here with us at BENEJ Pediatrics INC:

_____ _____ _____

_____ _____ _____

Preferred Pharmacy: _____ City: _____ Cross Streets: _____

Insurance Information

Primary Insurance Company: _____ Member ID: _____

Responsible Party

Parent / Guardian Information

Last name: _____ First Name: _____ Mi:_____ DOB: ___/___/___

Parent/Guardian Signature: Date:

_____ _____

BENEJ Pediatrics Inc.

Childs Name: _____ Date Of Birth: ____/____/____

Any known drug/ medicine allergies? Yes / No If yes, please list: _____

Mothers Name: _____ Age: _____

Fathers Name: _____ Age: _____

Child's Birth History

Birth Weight: _____lb. _____oz. Length: _____in.

Vaginal or C-Section? _____

Hospital Born at? _____ Other: _____

Was pregnancy full term? _____

Problems with Pregnancy/Labor/Delivery? _____

Did baby receive Hepatitis B? _____ Date? _____

Child's Known Health Issues (Circle all that apply)

YES	NO	Eye/ Vision Problem	YES	NO	Ear/Hearing Problem
YES	NO	Heart Disease/Murmur	YES	NO	Asthma/Breathing Problem
YES	NO	Sickle Cell	YES	NO	Diabetes
YES	NO	Kidney Bladder Problem	YES	NO	Seizures/Epilepsy
YES	NO	Bone/Joint/Muscle Problem	YES	NO	Bleeding Disorder
YES	NO	Tuberculosis Or Positive Tb Test	YES	NO	Anemia, Blood Transfusions
YES	NO	Thyroid Problems	YES	NO	Skin Problems
YES	NO	Allergies	YES	NO	Surgery Or Hospitalization
YES	NO	Problems with Development or School Performance	YES	NO	Serious Illness Or Accident
YES	NO	(Girls) Has She Started Her Period	YES	NO	Measles, Chickenpox, Mumps, Rubella

Family History (Check all that apply)

	Child's Mother	Child's Father	Child's Brother	Child's Sister
Diabetes				
Epilepsy/Convulsions				
Asthma				
Cancer				
Kidney or urinary Disease				
High Blood Pressure				
Allergies				
Eye/Ear Disorder				

Signature: _____ **Date:** __/__/___

Relationship to Child: _____

Reviewer's Signature: _____ **Date:** __/__/___

BENEJ Pediatrics Inc.
11306 Mountain View Avenue Ste E, Loma Linda CA 92354.
Phone: (909)-796-2400 Fax (909)-796-2443

AUTHORIZATION TO TREAT A MINOR & EMERGENCY

I, the parent or legal guardian, acting in behalf of _____
(Minor's Name)
hereby authorize physical examination, diagnostic test(including blood, urine, and skin test's, and non-surgical outpatient medical treatment of the conditions diagnosed for the above minor to be performed by physician supervised assistants and staff of **BENEJ Pediatrics Inc.**

****I also give full authority for my child to be accompanied for medical treatment by the following people: (Please write the names on the bottom of the page)****

_____ _____
Signature of Parent/Guardian Date

**** (If parent not able to come in, legal guardian should bring legal document) ****

AUTORIZACION PARA DAR TRATAMIENTO MEDICO A UN MENOR DE EDAD & EMERGENCIA

(Yo) (Nosotros), padre(s), madre, del suscrito(a) y con la custodia/tutela legal de _____
(Nombre del Menor)
Menor de edad, por medio de esta autorizo(amos) a como agente(s) del suscrito(a) y doy (damos) nuestro consentimiento para que le tomen radiografías, le hagan pruebas de diagnostico (incluyendo análisis de sangre, orina, pruebas en la piel, inmunizaciones) y tratamiento medico externo(no incluyendo cirugia), que se considere prudente y que se efectué bajo la supervisión general o especial de un Doctor en Medicina, con autorización para practicar de acuerdo a lo previsto en el Acta de Practica Medica ya sea que dichos tratamientos o diagnósticos se efectúen en **BENEJ Pediatrics Inc.**

**** Yo también quiero dar autorización para que mi hijo/hija pueda ser acompañado para tratamiento medico por: (Por favor escriba los nombres en la página abajo) ****

_____ _____
Firma del Padre/Tutor Legal Fecha

****(Si el padre no puede venir, el tutor legal tiene que traer el documento legal)****

_____	_____	_____
(Full Name/ Nombre Completo)	(Relationship/Relacion)	(Phone/Telefono)
_____	_____	_____
(Full Name/ Nombre Completo)	(Relationship/Relacion)	(Phone /Telefono)

PATIENT RECORD OF DISCLOSURE

In general, the HIPAA privacy gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of (PHI) is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY):

☐ Home Telephone_____
- ○ Okay to leave message with detailed information
- ○ Leave message with call back number

☐ Work Telephone_____
- ○ Okay to leave message with detailed information
- ○ Leave message with call back number

Written Communication_____
- Okay to mail to my home address
- Okay to mail to my work/office address
- Okay to fax to this number

Other:_____

Signature_____

Date_____

_____
Print Patient's Name

_____
Date of Birth

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.
*Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

NOTE: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

RECORD OF DISCLOSURE OF PROTECTED HEALTH INFORMATION

DATE	Disclosed to Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose if Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type Key: T= Treatment Records, P= Payment Information, O= Healthcare Operations
(3) Enter how disclosure was made: F= Fax, P=Phone, E= Email, M=Mail, O= Other

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NOTICE OF HEALTH INFORMATION PRACTICES (PRIVACY NOTICE)

This notice describes how medical information about you may be used and how you can get access to this information. Please review it carefully.

How we will use your Health Record Information

- Basis for planning your care and treatment
- Means of communication among other health care professional who contribute to your care
- Legal document describing the care you need
- To ensure accuracy
- To better understand who, what, when, where and why others may access your health information
- Make informed decisions when authorizing disclosure to others

Your Health Information Rights

Although your health/medical record is property of the healthcare provider or facility that complied, you have a right to:

- Obtain a paper copy of the notice of information practices upon request and an accounting of disclosures of your health information
- Inspect and obtain a copy of your health record
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

- Maintain the privacy information
- Notify you if we are unable to agree to requested restriction
- Accommodate reasonable request you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and how to make the new provisions effective for all protected health information we maintain. We will not use or disclose your health information without your authorization, except as described in this notice.

PRIVACY NOTICE ACKNOWLEGEMENT

I understand that as part of my healthcare, this organization originates and maintains health records describing my child's health history, symptoms, examination and test results, diagnoses, treatment, and any plans for the future care or treatment. I understand that this information serves as:

- A basis for planning my healthcare or my child's care and treatment
- Means of communication among other health care professional who contribute to my healthcare or my child's care
- A source of information for applying to my child diagnosis and surgical information to my bill
- A means by which third party payer (insurance) can verify that services bill were actually provided
- A tool for routine healthcare operations such as quality and reviewing the competence of healthcare professionals

I understand that I have the right to review the notice before signing in. I understand that this organization has the right to change their notice and practices. I understand that I have the right to restrict as to how my information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this organization is not required to agree to the restrictions requested.

I acknowledge receipt of this organization privacy practice

PRINT NAME:_____ SIGNATURE:_____

DATE:_____

BENEJ Pediatrics Inc.

Cancelled and Broken Appointment Policy

Patients who fail to keep their scheduled appointments without adequate notice can cause problems for both the office as well as other patients. We are better able to schedule you promptly and in your desired time slot if we know sufficiently in advance that you need to reschedule an appointment.

We make every effort possible to remind all the patients of their schedule appointments. We issue appointment cards at the time the appointment is made, and we call each scheduled patient 2 days prior to their appointment. We may also send email reminder.

In an effort to establish daily schedules that are efficient as well as considerate of your time and ours; we have adopted the following policy regarding broken and late cancelled appointments:

1. A late cancellation is defined as any scheduled appointment that a patient cancels without giving at least 24 hours advance notice.
2. A broken appointment is any appointment which a patient fails to keep and provides no advance notice.
3. Two late cancellations may result in a charge of $25 to the patient.
4. One broken appointment will not incur a charge, but the second and every broken appointment thereafter will incur the $25 charge.
5. Insurance is not responsible for broken appointment charges.

We realize that circumstances sometimes arise on short notice which may result in the necessity to cancel an appointment on short notice. When such circumstances occur, we will exercise discretion on the decision to charge a fee. It is our sincere desire to be considerate of your time, and as we make every effort to do so, we hope that our patients will also be considerate of our desire to predictably serve our patients with the time available to us.

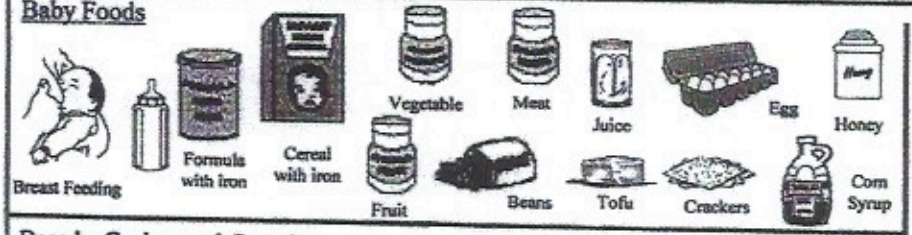
Thank you for your consideration and cooperation.

Signature of patient or guardian:_____ Date:_____

What Does Your Child Eat?

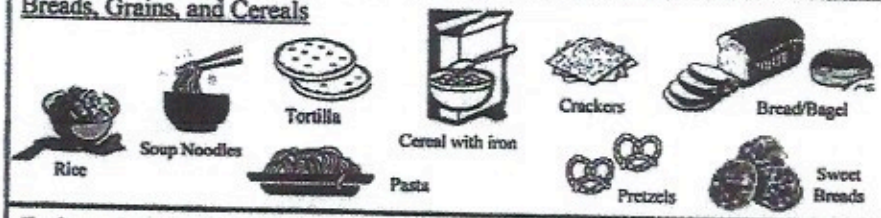
Circle the foods your child ***eats*** every day or at least 3 times per week:

Baby Foods

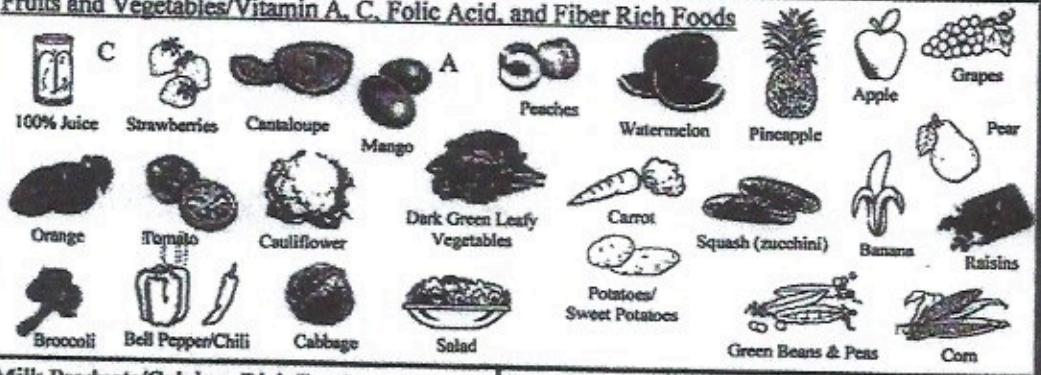


How does your child feel about mealtimes?

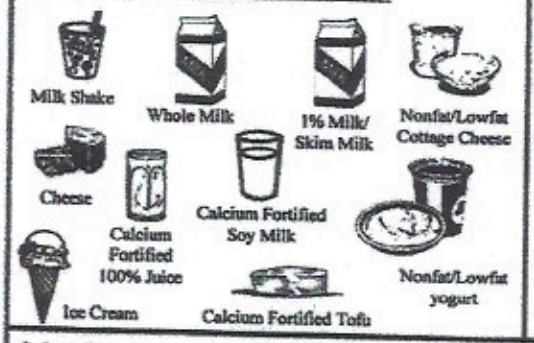
Breads, Grains, and Cereals



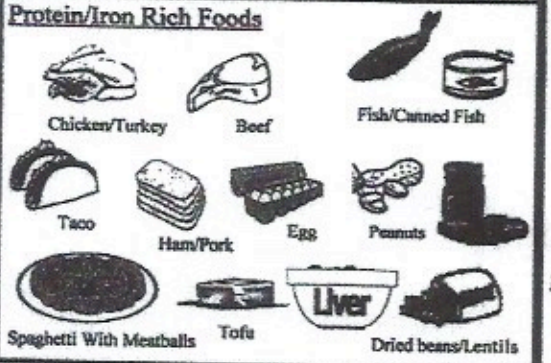
Fruits and Vegetables/Vitamin A, C, Folic Acid, and Fiber Rich Foods



Milk Products/Calcium Rich Foods

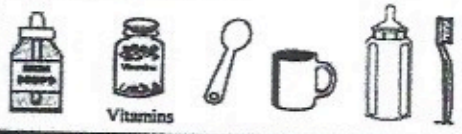


Protein/Iron Rich Foods



Other Foods

Circle if baby/child uses:



Circle if your baby or child receives food from:

Food Stamps **School Lunch** **Head Start** **WIC**

Circle activities your baby or child does every day.

Drinks water?

Child's name: _____ **Record #:** _____

Age: _____ **yrs.** _____ **mos.** **Wt:** _____ **lbs.** **Ht:** _____ **in.** **Date:** ___/___/___

Adapted from the Orange and San Bernardino Counties CHDP Programs.
DHCS 4035 A (09/07)

Office Use Only
Feeding milestones to check/visit

Baby: Birth to 24 months

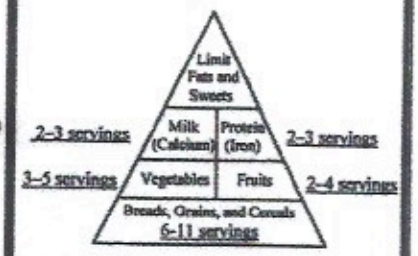
Yes / No

- ☐ ☐ Breast-fed 8–12 times/24 hours during early weeks of lactation OR every 3–4 hours/day for older infants?
- ☐ ☐ Formula-fed w/iron no less than 20 ounces/day? Correct dilution?
- ☐ ☐ No honey/Karo Syrup until 1 year?
- ☐ ☐ 4–6 months: Start on baby cereal with iron?
- ☐ ☐ 5–7 months: Start on pureed vegetables and fruits?
- ☐ ☐ 6–7 months: Drink from a cup?
- ☐ ☐ 6–8 months: Start on pureed or ground meat, i.e., poultry, beef, pork, fish, egg yolk, beans, tofu?
- ☐ ☐ 7–9 months: Eats finger foods and mashed/chopped foods, NO grapes, nuts, popcorn, hotdogs, hard candy?
- ☐ ☐ 1 year: Drinks regular milk no less than 16 ounces/day?
- ☐ ☐ 9–12 months: Feeds self, joins family meal and snack times?
- ☐ ☐ 12–24 months: Eats variety of foods: small portions, i.e., 1–2 Tbsp., ½ c juice, ½ slice of bread.

Child: 2 to 8 years

Yes / No

- ☐ ☐ Eats recommended variety and amounts of foods daily for age from the food guide pyramid?



Mealtime/Others:

Yes / No

- ☐ ☐ Set meal and snack times?
- ☐ ☐ Brush teeth by himself at 5 years?
- ☐ ☐ Good food supply?
- ☐ ☐ Takes vitamins, iron, or fluoride?
- ☐ ☐ Growing normally according to his/her growth patterns?
- ☐ ☐ Does child play with or eat dirt, plaster, clay, and paint chips?
- ☐ ☐ Any food intolerances or allergies? _____
- ☐ ☐ Referral for identified nutrition problem? Where? _____

Activity:

- ☐ ☐ Actively plays everyday, i.e., running, biking, sports, 1 hour/day?
- ☐ ☐ TV viewing: 2 hours or less/day?