Austin Association of Otolaryngologists

Pediatric Registration

Patient Information

Last name	First	Middle	Age & Date of birth
Address		City, State & Zip	Phone number Home: Cell:
Birth Hospital, Birth weight & problems at Birth		Past Illnesses	Referred by
History of Family Illnesses		Allergies	Pharmacy
List Medications taken		List brothers, sisters & date of birth	
Is there a Custodial Order of medical treatment for this child? ____Yes____No If yes, we will need a copy of the order for our records.			
Parent's email:			

Responsible Party (Please give your insurance card to the receptionist)

Father's name:	Date of Birth	Phone number
Place of employment	Occupation	Work number
Mother's name:	Date of Birth	Phone number
Place of employment	Occupation	Work number
Insurance Company	ID number	Group number
Insurance Address		Phone number
Policy Holder name	Date of birth	Employer

In case of Emergency

Name of relative	Relationship to patient	Phone number

Authorization: I authorize Assignment of Insurance Benefits to Melba F. Lewis, MD. I understand I am responsible for payment of services provided but not covered by insurance. I authorize release of Medical Records and other information to requesting insurance companies. I acknowledge responsibility for payment of lab services provided by outside lab services. I acknowledge responsibility for referral procedures and payments to specialist and other healthcare professionals.

_____ _____

Parent/Guardian Signature Date

Pediatric Medical History

Date	Child's name	Nickname	DOB	Sex
Mother's full name		Father's full name		
Pediatrician		Pharmacy (Address & Phone)		

Current and Past History

Is your child currently on any medications? ____Yes____No
List medications: _____

Does your child have any serious or chronic illnesses? ____Yes____No
List illnesses: _____

Has your child had serious injuries or accidents? ____Yes____No
List event and dates: _____

Has your child had any surgeries? ____Yes____No
List surgery and dates: _____

Has your child ever been hospitalized? ____Yes____No
Dates of hospitalization: _____

Is your child allergic to any medications? ____Yes____No
List: _____

Current Illnesses and Conditions

Asthma, recurrent cough, bronchitis, or pneumonia	____Yes____No
Nasal allergies or eczema	____Yes____No
Frequent ear infections or sore throat	____Yes____No
Problems with ears or hearing	____Yes____No
Problems with eyes, vision or teeth	____Yes____No
Frequent headaches or neurological problems	____Yes____No
Frequent abdominal pain	____Yes____No
Constipation	____Yes____No
Bladder/kidney problems or bedwetting	____Yes____No
Heart problems/murmur	____Yes____No
Anemia or bleeding problems	____Yes____No
Thyroid or other gland problems	____Yes____No
Diabetes	____Yes____No
ADD/ADHD	____Yes____No
Mental Health issues	____Yes____No
Use of drugs or alcohol	____Yes____No

Family Medical History

Alcohol/substance abuse	____Yes____No
Allergies	____Yes____No
Asthma	____Yes____No
Birth defects	____Yes____No
Blood disorders	____Yes____No
Bone disorders	____Yes____No
Cancer	____Yes____No
Diabetes	____Yes____No
Endocrine disease	____Yes____No
Ear/Nose/Throat disorders	____Yes____No
Eye disorders	____Yes____No
Gastrointestinal disorders	____Yes____No
Heart disease	____Yes____No
High blood pressure	____Yes____No
High Cholesterol	____Yes____No
Immune disorders	____Yes____No
Joint problems	____Yes____No
Kidney disease	____Yes____No
Liver disease	____Yes____No
Lung disease	____Yes____No
Migraine headaches	____Yes____No
Metabolic disorders	____Yes____No
Obesity	____Yes____No
Seizure disorders	____Yes____No
Skin disorders	____Yes____No
Stroke history	____Yes____No
Thyroid disorders	____Yes____No
Mental health	____Yes____No
Other	____Yes____No

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Pediatric HIPAA Acknowledgement Consent Form

I understand that under Health Insurance Portability and Accountability Act (HIPAA) of 1996, I have certain rights to privacy regarding my child's protected health information. I understand that this information can will be used to:

- Conduct, plan and direct my treatment and follow-up care among the doctor and other designated healthcare professionals.
- Conduct normal healthcare operations such as assessments/evaluations and certifications.
- Assignment of payments from your insurance company.

I have been informed of the HIPAA Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information available in print. I have reviewed the HIPAA Notice of Privacy Practices and acknowledge the review. I understand that this office has the right to change the HIPAA Notice of Privacy Practices as warranted and directed by local/state/federal entities.

I understand that I may request in writing that this practice restrict how my private information is used or disclosed for treatment and payment. I understand the practice is not required to agree to any requested restrictions.

Is there a Custodial Order of medical treatment for this child? ____Yes____No

Will you allow our staff to leave lab results on your voice mail? _____Yes _____NO

I consent to allow the following caretakers to bring my child for treatment:

Name	Relationship	Phone number

I understand I may revoke this consent in writing at any time.

_____ _____

Patient Name Date of Birth

_____ _____

Parent or legal guardian signature Date

Rev 8/16/19