GLENS FALLS PEDIATRIC CONSULTANTS
PATIENT REGISTRATION

Date _____

Patient's Name: _____ Sex: ***M/F*** (Circle) DOB _____
First Middle Initial Last

Primary Doctor: _____ Primary Language: _____ Race: _____ Ethnic Origin: _____

Pharmacy of Choice: _____
Name Street City State Zip

Patient's Address: _____
Street City State Zip

Email Address: _____
(Please provide if willing to be contacted by email)

Mother's Name: _____ DOB _____ SS# _____

Address: _____
Street City State Zip

Phone #: (Home) _____ (Work) _____ (Cell) _____

Occupation: _____ Employer: _____

Mother's Maiden Name: _____

Father's Name: _____ DOB _____ SS# _____

Address: _____
Street City State Zip

Phone #: (Home) _____ (Work) _____ (Cell) _____

Occupation: _____ Employer: _____

Name of Primary Insurance: _____

Subscriber's Name: _____ Subscriber's DOB _____ Subscriber's SS# _____

Address _____

Name of Secondary Insurance: _____

Subscriber's Name _____ Subscriber's DOB _____ Subscriber's SS# _____

Address _____

RESPONSIBLE PARTY (Person to Receive Billing Statements):

Name: _____

****

I authorize Glens Falls Pediatric Consultants to use or disclose my personal health information (PHI) to treat my condition, Obtain payment for that treatment, and run the business operation. I also give my permission to disclose my personal Health information (PHI) for payment activities and certain business operations of another healthcare provider or payor.
*****In the event that my insurance carrier does not pay, I agree to be financially responsible for any debts incurred.*****

Signature: _____ Date _____
Parent or Legal Guardian

Glens Falls Pediatric Associates
Pediatric Associates of Saratoga
HIPAA Privacy Information
Authorization for Treatment of a Minor when a Parent is Not Present

Patient Name _____ DOB: _____

Parent/Guardian _____ Relationship_____

How may we communicate information to you (PLEASE CHECK ALL THAT APPLY).

Appointment Information

On home phone □ #_____
On cell phone □ #_____
On office phone □ #_____
Message with family member at home phone □

Medical Information

On home phone □ #_____
On cell phone □ #_____
On office phone □ #_____
Message with family member at home phone □

As a parent of the above named minor, I give permission for staff at Glens Falls Pediatrics Consultants/Pediatric Associates of Saratoga to discuss my child's medical care/treatment with any of the following:

_____ Relationship to patient _____ PH# _____,

_____ Relationship to patient _____ PH# _____,

_____ Relationship to patient _____ PH# _____,

I/We the undersigned parents(s)/legal guardian(s), authorize the following to bring the above listed patient to Glens Falls Pediatrics for healthcare in my absence.

****Not authorization to consent for vaccines at visit -- form available online at www.gfpeds.com.****

_____ Relationship to patient _____,
_____ Relationship to patient _____,
_____ Relationship to patient _____,
_____ Relationship to patient _____,

Specific HIPPA Instructions:

This consent shall remain in effect until revoked, in writing, by parents(s) or legal guardian(s), or until the child may legally consent for him or herself.

_____ _____
Signature of parent/legal guardian Date

_____ _____
Signature of witness Date

Glens Falls Pediatric Consultants, P.C.

Pediatric & Adolescent Medicine

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Kathryn D. Parker, MD FAAP
Mindy Mifsud, PA-C
Julie W. Pirozzolo, PCP-C
Stephanie A. Messercola, PA-C
Ashley C.Gilman, PA-C

NEW PATIENT INFORMATION FORM
FOR PATIENT'S FOUR WEEKS AND OLDER

Date: _____

Patient Name _____ DOB: _____ Age: _____ Sex ___F ___M

SOCIAL HISTORY

Who does the child live with / Primary care giver to child? _____ Relationship? _____

Highest grade level completed by parents? Mother _____ Father _____

Are parents/guardians employed? _____

Will the child be attending daycare? ____YES ____ NO Will be cared for in the home? ____YES ____ NO

Are there pets in the child's home? ____YES ____ NO If yes, what type of pets? _____

PATIENT'S PAST MEDICAL HISTORY

Child's general health: _____ Concerns: _____ Allergies _____

Child's Current Medications: _____

Does your child have any Development Delays? ____YES ____ NO Behavioral Concerns? ____YES ____ NO

If yes, please explain: _____

Are you aware of any Physical and/or Sexual abuse ____YES ____ NO

If yes, please explain: _____

Childhood Diseases: _____

Hospitalizations: Where? _____ When? _____ For What? _____

Where? _____ When? _____ For What? _____

Specialists: Who? _____ For What? _____

Who? _____ For What? _____

FAMILY HISTORY – As the parent of the newborn child, are any of the following significant health issues?

Conditions	Mother	Father		Mother	Father		Mother	Father		Mother	Father
Allergies			Blindness			Developmental Disabilities			Kidney Disease		
Asthma			Cancer			Deafness			Lung (C/F)		
Birth Defects			Cardiac Issues			Diabetes (Juv)			Seizures		

HEALTH CONDITION OR RELEVANT HEALTH CONCERNS

RELATIONSHIP TO PATIENT	NAME	AGE	HEALTH CONDITION OR RELEVANT HEALTH CONCERNS
Mother			
Father			
Sibling			
Sibling			
Sibling			
Sibling			
Sibling			
Pat Grandfather			
Pat Grandmother			
Mat Grandfather			
Mat Grandmother			

PATIENT TREATMENT WAIVER
WHEN PCP CANNOT BE VERIFIED

I, _____, am requesting treatment for_____,

from Dr._____, without the necessary verification that one of the physicians from Glens Falls Pediatric Consultants, PC, is indeed my child's Primary Care Physician.

Therefore, I am agreeing that I shall be responsible for payment in full for any charges related to all dates of service until the necessary verification has been made.

Furthermore, my insurance company shall not be responsible for any charges connected with unauthorized visits.

Signature:_____

Date:_____

Witness:_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I, _____, understand that as part of my health care, Glens Falls Pediatric Consultants, PC originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, as well as plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means to facilitate communication among the many healthcare professionals who contribute to my care;
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided; and
- A tool for healthcare operations of Glens Falls Pediatric Consultants, PC such as assessing quality of care and reviewing the competence of healthcare professionals

I understand that as part of Glens Falls Pediatric Consultants, PC treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity for the purposes stated above.

I understand and have been provided with a ***Notice of Privacy Practices*** that provides a more complete description of how Glens Falls Pediatric Consultants, PC may use and disclosure my protected healthcare information. I further understand that Glens Falls Pediatric Consultants, PC reserves the right to change its ***Notice of Privacy Practices.*** Should Glens Falls Pediatric Consultants, PC change its ***Notice of Privacy Practices***, an amended copy will be posted in a prominent location in the practice site, or, upon my request, an amended copy will be sent to the address I have provided.

I agree that Glens Falls Pediatric Consultants, PC may do the following unless I specifically give direction prohibiting such activity:

- ☐ Send visit reminders and test results to the address I have provided.
- ☐ Send routine correspondence, such as billing statements, to the address I have provided.
- ☐ Leave messages on an answering machine or voice mail associated with the telephone numbers I have provided to either confirm appointments or to request that I call the Practice on medical or billing matters.

_____

Patient's Signature or Signature of Personal Representative

_____

Date

FOR OFFICE USE ONLY

[ ] Receipt received by _____ on _____.

[ ] Patient refused to sign receipt. _____ (Signature of Practice Representative)