

**GLENS FALLS PEDIATRIC CONSULTANTS  
PATIENT REGISTRATION**

Date \_\_\_\_\_

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

Primary Doctor: \_\_\_\_\_ Primary Language: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnic Origin: \_\_\_\_\_

Pharmacy of Choice: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_  
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: \_\_\_\_\_

Phone #: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_  
Street City State Zip

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Mother's Maiden Name: \_\_\_\_\_

**Father's Name:** \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_  
Street City State Zip

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: \_\_\_\_\_

**IN CASE OF EMERGENCY, PLEASE PROVIDE A CONTACT OTHER THAN THE PARENTS**

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

\*\*\*\*\*

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

Medical Information

On home phone     # \_\_\_\_\_  
 On cell phone     # \_\_\_\_\_  
 On office phone    # \_\_\_\_\_

On home phone     # \_\_\_\_\_  
 On cell phone     # \_\_\_\_\_  
 On office phone    # \_\_\_\_\_

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 TO BE USED FOR VACCINES**):

\_\_\_\_\_ Relationship to patient \_\_\_\_\_,  
 \_\_\_\_\_ Relationship to patient \_\_\_\_\_,  
 \_\_\_\_\_ Relationship to patient \_\_\_\_\_,  
 \_\_\_\_\_ Relationship to patient \_\_\_\_\_,

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# \_\_\_\_\_,

Specific HIPAA 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



**Pediatric & Adolescent Medicine**

154 Warren Street, Glens Falls, NY 12801  
Telephone (518) 798-9985

4 Carpenter Ln, Saratoga Springs NY 12866  
Telephone (518) 587-3823

Guy D. Lehine, MD, FAAP  
Richard M. Anderson, MD FAAP  
Susan E. Moore, MF FAAP  
Lisa A. Adeson, MD FAAP  
Stuart B. Wright, MD FAAP  
Martin J. Breen, MD FAAP  
Syed A. Kamal, MD FAAP

Amy E. McGarry, MD FAAP  
Phillip C. James, MD FAAP  
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

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### FOR OFFICE USE ONLY

- [ ] Receipt received by \_\_\_\_\_ on \_\_\_\_\_  
[ ] Patient refused to sign receipt. \_\_\_\_\_ (Signature of Practice Representative)