GLENS FALLS PEDIATRIC CONSULTANTS
PATIENT REGISTRATION

Date: _____

PATIENT NAME_____ **DOB:** _____
First Middle Initial Last

GENDER AT BIRTH Male Female **IDENTIFIES GENDER AS** Male Female Non-binary

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

Pharmacy of Choice:_____
Name Street City State Zip

Patient's Address**:**_____
Street City State Zip

Email Address:_____

Mother's Name: _____ DOB: _____
or Legal Guardian: _____ Relationship to Patient: _____

Address:_____
Street City State Zip
Phone # (Home): _____ (Work): _____ (Cell): _____

Occupation: _____ Employer: _____
Maiden Name: _____

Father's Name: _____ DOB: _____
or Legal Guardian: _____ Relationship to Patient: _____

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:_____ ID number _____

<u>Responsible Party</u> (Person to Receive Billing Statements): _____

****

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 payer. In the event that my insurance carrier does not pay, I agree to be financially responsible for any debts incurred.

Signature:_____**Date:**_____

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 □ #_____
Texting on cell □ #_____
On office phone □ #_____

Medical Information

On home phone □ #_____
On cell phone □ #_____
Texting on cell □ #_____
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 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 _____,

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 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

1 Lawrence Street, Glens Falls, NY 12801
Telephone (518) 798-9985

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

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			

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)

Glens Falls Pediatric Consultants, P.C.
&
Pediatric Associates of Saratoga

Patient Portal Account Activation

Creating a patient portal account is making a commitment to reducing our environmental impact and improving the way we serve you.

This portal will share important documents, including visit summaries, vaccines and physical forms. You may use the portal as direct communication with the patient's PCP, request patient appointments, and for prescription refills. The portal allows you to view and pay your bills, the opportunities are endless!

***We do not recommend that the patient portal be used for urgent messages. ***

Access to our patient portal is located on our website - www.gfpeds.com. Click on the icon that says Patient Portal Login. If you have an account activated but forget the username or password, just click on the appropriate box and you will be able to reset it.

If you have never been on the patient portal you will need an activation code – request the link by email to glensfallspeds@gfpeds.com and a member of our reception team will send a link to the email. You may complete this form and leave it with anyone of our team members, and we will send a code to the email provided!

Thank you for helping us take this step toward a greener future!

Patients Name: _____Patient DOB: _____

Patient Authorized Representative for Portal (only for patients under the age of 18 years):

Parent Name: _____Parent DOB: _____

Email Address: _____

Please provide the guarantor, or the contact information for financial responsibilities on this account. The messages will be sent via email or text messages

Name: _____

Email Address: _____

Cell phone number: _____