GOLD COAST PEDIATRICS
18 Railroad Ave Glen Head, NY 11545
TEL: 516-247-6005 FAX: 516-214-9686
Goldcoastpediatrics18@gmail.com

MINOR/CHILD REGISTRATION FORM

PATIENT INFORMATION

Legal Name of Minor

First: Middle: Last: Today's Date: / /

Birth date: / / Age: Sex: ❑ Male ❑ Female

Home address:

Billing address: City: State: ZIP Code:

Person financially responsible for child: Phone: Email:

Which parent does child reside with? ❑ Both parents or ❑ One parent (please specify which parent) _____

Whom may we thank for referring you?

In the event of an emergency, whom should we contact (other than parents)?
Name: Relationship: Phone:

Name: Relationship: Phone:

PARENT AND INSURANCE INFORMATION

Parent/Guardian's Name:	Parent/Guardian's Name:
Address (if different):	Address (if different):
City: State: ZIP Code:	City: State: ZIP Code:
Primary ph: Cell ph:	Primary ph: Cell ph:
Birth date: / / Sex: ❑ Male ❑ Female	Birth date: / / Sex: ❑ Male ❑ Female
Soc. Sec. #	Soc. Sec. #
Employer: Work ph:	Employer: Work ph:
Insurance Carrier:	Insurance Carrier:
Policy #: Group #:	Policy #: Group #:
Are you the primary policy holder? ❑ Yes ❑ No	Are you the primary policy holder? ❑ Yes ❑ No
Is this your child's primary insurance plan? ❑ Yes ❑ No	Is this your child's primary insurance plan? ❑ Yes ❑ No

Which parent should be the primary contact? _____

PLEASE PRESENT INSURANCE CARD WITH THIS FORM

FAMILY HISTORY

Has any member of the family or close relative had any of the following?

Yes	No		Yes	No		Yes	No	
❑	❑	Arthritis	❑	❑	Diabetes	❑	❑	Mental Disorders
❑	❑	Asthma or Hay Fever	❑	❑	Heart Disease	❑	❑	Migraine
❑	❑	Cancer	❑	❑	Hemophilia – Bleeding Disorder	❑	❑	Tuberculosis
❑	❑	Chemical Dependency	❑	❑	High Blood Pressure	❑	❑	Sudden Death
❑	❑	Convulsion or Epilepsy	❑	❑	Kidney Disease	❑	❑	Other_____

BIRTH HISTORY

Hospital:		Obstetrician/Midwife:	
Type of delivery:		Complications:	
Birth Weight:	Birth Length:	Discharge Weight:	Discharge Date:

Did baby have any complications at or immediately following birth?

Was Newborn Screening test done at hospital? Newborn Screening number:

HEALTH HISTORY

Minor/Child's Physician:		City/State:	Phone:
Date of last physical exam?		Results/Concerns?	
Is Minor/Child under care of a physician now? Yes❑ No❑		Food or medication allergies? Yes❑ No❑ If yes, please list allergies below:	

Has Minor/Child ever been hospitalized? Yes❑ No❑
If yes, please list below:

Date	Hospital	Reason

Taking any medications? Yes❑ No❑ If yes, please list all medications below:

_____

_____

_____

Has Minor/Child been immunized? Yes❑ No❑ If yes, please submit immunization record at initial visit.

Has Minor/Child had any history of or difficulty with any of the following:

Yes	No		Yes	No		Yes	No		Yes	No	
❑	❑	ADHD	❑	❑	Chicken Pox	❑	❑	Heart Problems	❑	❑	Rheumatic Fever
❑	❑	Anemia	❑	❑	Constipation, Diarrhea	❑	❑	Hepatitis	❑	❑	Sinus Problems
❑	❑	Asthma	❑	❑	Convulsions	❑	❑	Kidney Disease	❑	❑	Speech Problems/Developmental concerns
❑	❑	Bed Wetting	❑	❑	Diabetes	❑	❑	Lead Poisoning	❑	❑	Thyroid Disease
❑	❑	Birth Defects	❑	❑	Drug/Alcohol Abuse	❑	❑	Liver Disease	❑	❑	Tuberculosis
❑	❑	Bladder Problems	❑	❑	Ear Infections	❑	❑	Measles	❑	❑	Urinary Diseases
❑	❑	Bleeding, excessive	❑	❑	Epilepsy	❑	❑	Mononucleosis	❑	❑	Vision Problems
❑	❑	Cancer	❑	❑	Fainting	❑	❑	Mumps	❑	❑	Social Concerns
❑	❑	Cerebral Palsy	❑	❑	Hearing Problems	❑	❑	Pneumonia	❑	❑	Other

HIPAA NOTICE OF PRIVACY STATEMENT AND OFFICE/BILLING POLICIES AND PROCEDURES

I have received a copy of the Gold Coast Pediatrics Notice of Privacy Practices and a copy of the Office/Financial responsibilities. Please initial here X_____

I have the following request(s) for confidential communication:

_____

_____

RELEASE AND ASSIGNMENT

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my minor/child's medical status.
I certify that my minor/child is covered by insurance with _____and assign directly to Gold Coast Pediatrics all
Name of Insurance Company(ies)
insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____
Signature of Parent/Guardian Date