LittleStar PEDIATRICS

10575 W. Indian School Rd. Suite E-103
Avondale, Arizona 85392
Phone: (480) 747-0045
Fax: (480) 454-4115

REGISTRATION FORM

Today's date:			Referred By:		
PATIENT INFORMATION					
Patient's last name: First: Middle:					
Is this patient's legal name? ❑ Yes ❑ No	If not, what is the legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:		Primary phone no: ( )		Other phone no.: ( )	
P.O. box:	City:		State:	ZIP Code:	
Parent/Guardian email address:					
INSURANCE INFORMATION					
(Please give your insurance card(s) and ID to the receptionist.)					
Person responsible for bill:	Birth date: / /	Address (if different):		Primary phone no.: ( )	
Occupation:	Employer:	Employer address:		Employer phone no.: ( )	
Is this patient covered by insurance? ❑ Yes ❑ No					
Please indicate primary insurance					
Subscriber's name:	Subscriber's id. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Parent	❑ Legal Guardian	❑ Other	
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:	❑ Self	❑ Parent	❑ Legal Guardian	❑ Other	

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AUTHORIZED INDIVIDUALS TO WHOM MEDICAL INFORMATION MAY BE RELEASED

Name:	Relationship to patient:	Birth date:	Primary phone no.: ( )
Name:	Relationship to patient:	Birth date:	Primary phone no.: ( )

PHARMACY INFORMATION

Pharmacy: Address:

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Primary phone no.: ( )	Other phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to JB Healthcare LLC d/b/a Little Star Pediatrics. I understand that I am financially responsible for any balance. I also authorize JB Healthcare LLC d/b/a Little Star Pediatrics or my insurance company to release any information required to process my claims.

Parent/Guardian signature *Date*

AUTHORIZATION TO VIEW AND OBTAIN EXTERNAL PRISCRIPTION HISTORY

I authorize the medical providers of JB Healthcare LLC d/b/a Little Star Pediatrics to view and obtain my child's external prescription history via electronic prescription services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff through these services, and may include prescriptions back in time for several years.

Parent/Guardian signature *Date*

NOTICE OF PRIVACY PRACTICES

I certify that I have received a copy of Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my child's protected health information that might occur in my treatment, payment of my bills or in the performance of JB Healthcare LLC d/b/a Little Star Pediatrics . The Notice of Privacy Practices also describes my child's rights and JB Healthcare LLC d/b/a Little Star Pediatrics' duties with respect to my child's protected health information. The Notice of Privacy Practices can also be found on the JB Healthcare LLC d/b/a Little Star Pediatrics website at littlestarpeds.com.

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JB Healthcare LLC d/b/a Little Star Pediatrics reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, asking for one at the time of my next appointment, or accessing the practice website.

Parent/Guardian signature *Date*

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PRENATAL/BIRTH/DEVELOPMENTAL/MEDICAL HISTORY

CHILD'S CURRENT PROBLEM: Purpose of this visit: _____Wellness Check-up _____Injury or Accident _____Other Please explain:

_____

If your child is experiencing Pain/Discomfort please identify where and for how long

_____

_____

1. When did the Problem first begin? Date ___/___/___ __Unknown __Gradual __Sudden
2. Ever had this problem before? ___ No ___Yes If yes, when? _____
3. Any bowel or bladder problems since this problem began?: If yes, describe:

_____
_
4. Have you seen any other doctors for this problem? ___No ___Yes If yes, who?

_____
_
5. How long ago? _____Days _____Weeks _____Months _____Years
6. What were the results of past treatment? _____
7. How is this problem NOW?: o Rapidly Improving o Improving Slowly o About the Same o Gradually Worsening o On & Off
8. Please list any medication taken for this problem: _____
9. Has your child ever sustained an injury playing organized sports? ___ No ___ Yes If yes; please explain:

_____
_
_____
_
_____
_
10. Has your child ever sustained an injury in an auto accident? ___ No ___ Yes If yes; please explain:

_____
_
_____
_
_____
_

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HAS YOUR CHILD EVER SUFFERED FROM: Check all that apply:

○ Headaches	○ Fainting	○ Heart Trouble
○ Orthopedic Problems	○ Arm Problems	○ Joint Problems
○ Digestive Disorders	○ Stomach Aches	○ Constipation
○ Behavioral Problems	○ Ruptures/Hernia	○ Growing Pains
○ Dizziness	○ Seizures/Convulsions	○ Chronic Earaches
○ Neck Problems	○ Leg Problems	○ Backaches
○ Poor Aphghgpetite	○ Reflux	○ Diarrhea
○ ADD/ADHD	○ Muscle Pain	○ Asthma
○ Colds/Flu	○ Fall in baby walker	○ Fall off slide
○ Sleeping Problems	○ Fall from bed or couch	○ Fall from changing table
○ Bed Wetting	○ Fall from crib	○ Fall off monkey bars
○ Colic	○ Fall down stairs	○ Fall off skateboard/skates
○ Broken Bones	○ Fall off bicycle	○ Fall off slide
○ Fall off swing	○ Fall from high chair	○ Other:
○ Other:	○ Other:	

Allergies to_____

Other: _____

Please list any and all prescription medications that your child is presently using and has used on more than one occasion. # of Doses of antibiotics your child has taken:

_____
_____
_____
_____

Over the counter drugs (Tylenol, cough syrup, laxatives, etc.)

_____
_____
_____
_____

FEEDING HISTORY

Breast Fed: Y/N How long? _____ Formula Fed: Y/N How long? _____ Type:_____
Introduced to: Solid Foods @_____months Cow's milk @_____months Rice Cereal Y/N @ _____ months
Allergies or intolerances: Y/N List: _____

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PRENATAL HISTORY

Name of Obstetrician/ Midwife: _____

Weeks Pregnant at time of Delivery _____

Complications during pregnancy/ delivery? Y/N

Explain:_____

_____

Induced into Labor ? Y/N

Epidural? Y/N

Ultrasounds during pregnancy? Y/N How many?_____

Medications taken during pregnancy/ delivery? Y/N

List:_____

Cigarette/ Alcohol use during pregnancy? Y/N

Birth Intervention (circle one): Forceps Vacuum Extraction Caesarian Section. If Caesarian Section, was it: _____Emergency or _____ Planned (check one)

Genetic disorders/ disabilities? Y/N List:

_____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____

Fully Vaccinated: Y/ N

Any Reactions to Vaccines? Y/N

Explain_____

DEVELOPMENTAL HISTORY

At what age was your child able to:

_____ Respond to stimuli

_____ Cross Crawl

_____ Stand alone

_____ Sit up

_____ Respond to visual stimuli

_____ Hold head up

_____ Walk alone