Victor Wilson, M. D.
PEDIATRIC PATIENT REGISTRATION

PATIENT REGISTRATION

Patient Name _____ Social Security No. _____
LAST FIRST MI
Mailing Address _____ City _____ State _____ Zip _____

Date of Birth _____ Sex: M F Home Phone # _____ Cell # _____

E-mail address _____

Who referred you to our office? _____ Previous Physician _____

Race_____ Ethnicity_____ Language Preference _____

FATHER'S INFORMATION

Name _____ Date of Birth _____ Social Security # _____
LAST FIRST MI
Address _____ City _____ State _____ Zip _____

Home Phone # _____ Cell # _____ Work # _____

MOTHER'S INFORMATION

Name _____ Date of Birth _____ Social Security # _____
LAST FIRST MI
Address _____ City _____ State _____ Zip _____

Home Phone # _____ Cell # _____ Work # _____

PRIMARY INSURANCE SUBSCRIBER'S INFORMATION

Primary Insurance _____ ID# _____ Group # _____

Subscriber's Name _____ Subscriber's Date of Birth _____

Subscriber's Social Security # _____ Relationship to patient _____

SECONDARY INSURANCE SUBSCRIBER'S INFORMATION

Secondary Insurance _____ ID# _____ Group # _____

Subscriber's Name _____ Subscriber's Date of Birth _____

Subscriber's Social Security # _____ Relationship to patient _____

PERSON TO CONTACT IN EVENT OF EMERGENCY (OTHER THAN PARENTS)

Name _____ Relationship to patient _____

Best Phone Number to Contact _____

NO CALL/NO SHOW POLICY

Missed appointments prevent us from providing care to our patients in a timely manner and increase our costs. **If your family misses 3 appointments** during a calendar year without canceling at least 3 hours in advance, **we will no longer be able** to provide medical care for your children.

Parent's Signature _____

Initial History Questionnaire

Child's Name _____

Birth Date _____ Gender F M

Form completed by:_____ **Date form completed** _____/_____/_____

Family History: Please list all those living in the child's home

Name	Relationship to child	Name	Relationship to child

If mother and father are not living together or if child is not living with parents, what is the child's custody status?_____

Birth History: Please circle and explain the answer

Birth weight _____ Birth length _____ Birth Place_____

Was baby full term …..... No Yes Explain _____

Did mother have any illness with pregnancy? ….....No Yes Explain_____

Did the baby go home with mother from hospital? ….....No Yes Explain_____

Did baby have any problems right after birth? ….....No Yes Explain_____

During pregnancy, did mother ….....Smoke _____ Drink alcohol _____ Use drugs or medications_____

Was the delivery Vaginal _____ Cesarean _____ If cesarean, why?_____

Was the initial feeding Breast _____ Bottle _____

General

Do you consider your child to be in good health?	Yes	No	Explain_____
Does your child take any medications?	Yes	No	Explain_____
Is your child allergic to any medicines or drugs?	Yes	No	Explain_____
Does your child have any serious illness or medical conditions?	Yes	No	Explain_____
Has your child had any serious injuries or accidents?	Yes	No	Explain_____
Has your child had any surgeries or been hospitalized?	Yes	No	Explain_____

Development

Are you concerned about your child's ____Physical development? _____Mental or emotional development? _____Attention span?

Explain_____

How is his/her behavior in school? _____ Failed or repeat any grade in school?_____

How is he/she doing in academic subjects? _____ Attends special school or classes?_____

Past History

Does your child have, or has he/she ever had:

Chickenpox ….....	Yes	No	When _____
Frequent ear infections, problems with ears or hearing.....	Yes	No	Explain_____
Problems with eyes or vision ….....	Yes	No	Explain_____
Nasal allergies ….....	Yes	No	Explain_____
Asthma, bronchitis, bronchiolitis, or pneumonia ….....	Yes	No	Explain_____
Any heart problem or heart murmur ….....	Yes	No	Explain_____
Anemia, bleeding problem, or blood transfusion ….....	Yes	No	Explain_____
Frequent abdominal pain ….....	Yes	No	Explain_____
Constipation requiring doctor visits ….....	Yes	No	Explain_____
Bladder or kidney infection ….....	Yes	No	Explain_____
Bed wetting (after 5 years old) ….....	Yes	No	Explain_____
Any chronic or recurrent skin problem (acne, eczema, etc) ….....	Yes	No	Explain_____
Frequent headaches ….....	Yes	No	Explain_____
Convulsions or other neurological problem ….....	Yes	No	Explain_____
Diabetes ….....	Yes	No	Explain_____
Thyroid or other endocrine problem ….....	Yes	No	Explain_____
Any other significant problem ….....	Yes	No	Explain_____
(For girls) Has she started her menstrual periods?.....	Yes	No	Explain_____
(For girls) Are there any problems with her periods ….....	Yes	No	Explain_____

Family History Please circle if more than one answer (example: Allergies or Asthma)

Has any family member had the following?

Deafness ….....	Yes	No	Who _____	Comments_____
Nasal allergies or asthma ….....	Yes	No	Who _____	Comments_____
Tuberculosis ….....	Yes	No	Who _____	Comments_____
Heart disease ….....	Yes	No	Who _____	Comments_____
High blood pressure or high cholesterol ….....	Yes	No	Who _____	Comments_____
Anemia or bleeding disorder ….....	Yes	No	Who _____	Comments_____
Liver or kidney disease ….....	Yes	No	Who _____	Comments_____
Diabetes ….....	Yes	No	Who _____	Comments_____
Bed wetting (after 10 years old) ….....	Yes	No	Who _____	Comments_____
Epilepsy or convulsions ….....	Yes	No	Who _____	Comments_____
Alcohol or drug abuse ….....	Yes	No	Who _____	Comments_____
Mental illness or development problems ….....	Yes	No	Who _____	Comments_____
Immune problems, HIV, or AIDS ….....	Yes	No	Who _____	Comments_____

Authorization for Medical Treatment
I, the undersigned, authorize Victor T. Wilson, M.D., P.C. (hereinafter "The Clinic") and its Medical Staff to administer to the patient any medical, diagnostic or therapeutic treatment as is necessary. I acknowledge that no guarantees have been made as the result of the treatment or examination. I further understand that the physician or provider may order an HIV Antibody (AIDS) test as part of diagnosis and treatment. I also understand that I have the right to consent or refuse consent to any proposed procedure or therapeutic course absent emergency or extraordinary circumstances.

Disclosure of Information
I understand that my medical records and billing information are made and retained by The Clinic, and are accessible to its personnel and medical staff. Employed personnel and physicians in attendance may use and disclose medical information for treatment, payment, and health care operations to any other physician or health care personnel involved in my course of care. Safeguards are in place to discourage improper access. The Clinic and its medical staff are authorized to disclose all or part of the patient's medical record to any insurance carrier, workers compensation carrier, or self-insurance employer group liable for any part of The Clinic's charges and to any health care provider who is or may become involved with patient's care. I further consent to release of information as necessary for payment and health care operations. Oklahoma law requires that The Clinic advise you that information authorized for disclosure may include information which may be considered a communicable or venereal disease, including, but not limited to: Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome (AIDS). By signing this agreement you are consenting to such disclosure.

Release of Responsibility
The Clinic is hereby released from any responsibility for any items or personal property brought onto The Clinic premises.

Financial Agreement and Assignment of Benefits
For services rendered to the patient, I assign and authorize payment to The Clinic of any health care insurance benefits including Major Medical Benefits. Physician or provider benefits otherwise payable to the insured are to be made payable to the physician responsible for my care. I understand that I am responsible for and guarantee payment of any health insurance deductibles and any remaining reasonable charges after Title XVIII payment. I fully understand that this bill is subject to any charges and/or credits not available at the time care is rendered, as well as changes in the estimate insurance benefits, fees, and court costs related to collection of this account. I also understand by signing, that the Financial Agreement and Assignment of Benefits will NOT expire even if patient is no longer being seen by The Clinic.

I hereby certify that I have read each of the above statements, and have had them explained to me to my satisfaction, and accept the terms herein. I further certify that I am the parent or guardian of the patient and am duly authorized to accept these terms in his or her behalf. A photocopy or digital image of this shall be considered the same as the original.

Patient Name: _____ **Date of Birth** _____

_____	_____	_____	_____
Parent or Guardian Signature	Date	Relationship	Witness

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

A complete description of how the patient's medical information will be used and disclosed by The Clinic is in the Notice of Privacy Practices, which is available upon request.

_____	_____	_____	_____
Parent or Guardian Signature	Date	Relationship	Witness