TODAY'S DATE

FIRST CHOICE Kidcare
Where your kid's health is #1.

PATIENT REGISTRATION FORM - PEDIATRICS

Social Security No.:	First Name:	Middle:	Last:

Sex:
☐ Male
☐ Female

Gender Identity:
☐ Male ☐ Female ☐ Other ☐ Decline to Answer
☐ Transgender Male (Female-to-Male)
☐ Transgender Female (Male-to-Female)
☐ Genderqueer (Neither exclusively Male nor Female)

Sexual Orientation:
☐ Straight ☐ Gay ☐ Lesbian
☐ Bisexual ☐ Other ☐ Unknown
☐ Decline to Answer

Birth Date:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

Race: ☐ Asian ☐ Black/African American ☐ White ☐ American Ind./Alaska Nat. ☐ Native Hawaiian ☐ Pacific Islander ☐ Haitian Black ☐ Haitian White ☐ More Than One Race

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic

Preferred Language:

Employed: ☐ Yes ☐ No

Employer:

Street Address:	Home Phone:
City: State: ZIP Code:	Cell Phone:

Email:	Work Phone:	Preferred Method of Contact:

Referral Source: ☐ Referring Provider ☐ Ins. Company ☐ Flyer/Mailing ☐ Walk-In ☐ Hospital ☐ School ☐ Yellow Pages ☐ Newspaper ☐ Health Fair ☐ Family/Friend ☐ Other/Unknown ☐ Outreach Event

INSURANCE INFORMATION
(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Ins. Carrier:	Pt's Relationship to Subscriber:	Group No.:	Policy No.:

EMERGENCY CONTACT INFORMATION

☐ Parent ☐ Spouse ☐ Child ☐ Other Sex: ☐ M ☐ F

First Name:	Middle:	Last:

Preferred Language:	Home Phone:	Cell Phone:	Work Phone:

PARENT / GUARDIAN INFORMATION

☐ Parent ☐ Spouse ☐ Child ☐ Other Sex: ☐ M ☐ F

First Name:	Middle:	Last:

Social Security No.:	Birth Date:	Preferred Language:	Home Phone:	Cell Phone:	Work Phone:

PREFERRED PHARMACY

Pharmacy Name:	Phone:	Fax:

Street Address or Cross Street:	City:	State:	Zip Code:

TODAY'S DATE

GENERAL CONSENT FOR TREATMENT AND BILLING	
1.	I, the undersigned, give permission for myself or minor child, as indicated above, to undergo all necessary tests, examinations, treatments, or other procedures required by the medical or dental staff for Family Health Centers of Southwest Florida, Inc. (FHCSWF) to diagnose and/or treat illness(es).
2.	I realize that the practice of medicine, surgery, and dentistry is not an exact science, and I acknowledge that no guarantees have been made to me as a result of treatments or examinations by FHCSWF.
3.	I consent to the release of my medical and dental information by FHCSWF and/or authorized institutions or agencies accepting the patient for medical, dental, or institutional care. I consent to the release of medical and dental information to patient's insurer. I give permission to release data (medical, dental, and personal) to such government agencies as is required of FHCSWF.
4.	I hereby authorize payment to FHCSWF of benefits due to me in my pending claim and/or MAJOR MEDICAL BENEFITS otherwise payable to me, but not to exceed the health center and/or physician's or dentist's regular charges for this period of treatment.
5.	Family Health Centers is affiliated with various educational facilities. I understand I will be notified by these personnel that they are a student and have the right to refuse to have them involved in my care. I also understand that if they are involved in my care, an employed healthcare professional of Family Health Centers is overseeing all services and care provided.

FHCSWF PATIENT BILL OF RIGHTS AND RESPONSIBILITIES	
1.	I acknowledge that a copy of the FHCSWF Patient Bill of Rights and Responsibilities, a mutual agreement between me and FHCSWF, has been made available to me. A printed copy is available upon request.

HIPAA – NOTICE OF FHCSWF PRIVACY PRACTICE

1. I acknowledge that a copy of the Statement of Patient Privacy Practices, which explains the commitment of FHCSWF to protecting my personal health information in compliance with the law, has been made available to me. A printed copy is available upon request. I do hereby authorize the unrestricted release of my personal health information to the following individuals:

NAME:	RELATIONSHIP (e.g. – Mother, Sister, Spouse, etc.)
1.	
2.	
3.	

ADVANCE DIRECTIVES – RIGHT TO DECIDE – END OF LIFE DECISIONS

You cannot remove all uncertainty about your future healthcare needs but, by having Advanced Directive, you can have the peace of mind that comes from making your wishes known in advance.

1. Do you have a Living Will?
   - ☐ I have a Living Will – Please make a copy and FHCSWF will place in your Medical Record.
   - ☐ I do NOT have a Living Will.
2. Do you have a Health Care Surrogate?
   - ☐ I have a designated Health Care Surrogate who is_____and can be reached at_____.
   - ☐ I do NOT have a designated Health Care Surrogate.
3. Do you have a Durable Power of Attorney?
   - ☐ I have an appointed Durable Power of Attorney who is_____and authorized to make Health Care decisions for me.
   - ☐ I have NOT appointed a Durable Power of Attorney for my Health Care decisions.

Signature of Patient/Responsible Party/Guarantor:_____ Date:_____

TODAY'S DATE _____

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PATIENT HISTORY FORM

Why have you come to see the doctor? _____

How long have you had this problem? _____

Are you taking any medications? Yes _____ No _____ If YES please list below

_____

_____

_____

Have you ever been in the hospital? Yes _____ No _____ If YES please list below

WHERE	WHEN	WHY	DOCTOR

Have you ever had any operations? Yes _____ No _____ If YES please list below

OPERATION	WHEN	WHERE	DOCTOR

Do you have any allergies to any medications, drugs, foods or other things? Yes _____ No _____
If yes, please list below what you are allergic to and type of reaction:

_____

_____

_____

SOCIAL HISTORY

	YES	NO	If YES, how much in one day
Do you drink alcohol?			
Do you smoke tobacco?			
Do you drink coffee?			
Do you drink tea?			
Do you use drugs?			

WEIGHT GAIN/LOSS

	YES	NO	If yes, how much
Have you gained weight recently?			
Have you lost weight recently?			

FAMILY HISTORY

Have any members of your family had any of the following diseases?

	YES		NO		If YES, who	
Cancer						
Tuberculosis						
Diabetes						
High Blood Pressures						
Heart Attack						
Stroke						
Epilepsy (Seizures)						

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PATIENT HISTORY FORM

Have you had any of the following diseases?

	YES	NO
Asthma		
Bronchitis		
Cancer		
Chickenpox		
Diabetes		
Epilepsy (Seizures)		
Eye Infections		
German Measles		
Hepatitis		
Hernia		
Hives or Rashes		
Influenza (Flu)		
Liver Disease		
Malaria		
Measles		
Mononucleosis		
Mumps		
Pneumonia		
Rheumatic Fever		
Scarlet Fever		
Tonsillitis		
Tuberculosis		
Venereal Disease		
	YES	**NO**
FOR WOMEN ONLY		
Date of First Period		
Periods Regular?		
Length of periods (# days)		
Pain During periods?		
Headaches?		
Age at time of Menopause		
Vaccines/Immunizations for	**YES**	**NO**
Influenza – Flu		
Pneumovax – Pneumonia		
Measles		
Polio		
Diphtheria		
Pertussis – Whooping Cough		
Rubella		
Tetanus		
Date of Last Tetanus		

Do you have any of the following problems?

	YES	NO
Frequent Colds		
Pain in Chest		
Vomiting		
Headaches		
Nausea		
Tonsillitis		
Swollen Neck Glands		
Double Vision		
Loss of Voice		
Cough		
Difficulty Swallowing		
Earaches		
Shortness of Breath		
Toothaches		
Sinus Pain		
Swelling in the Feet		
Hoarseness		
Loss of Hearing		
Nose Bleeds		
Pain in the Eyes		
Sore Tongue		
Bleeding Gums		
Sore Throat		
Vomiting Blood		
Constipation		
Diarrhea		
Indigestion		
Blood in Stools		
Difficult Urination		
Blood in Urine		
Burning during Urination		
Pain on Urination		
Empty Bladder Often		
Dribbling		
Nervous Spells		
Dizziness		
Muscle Spasm		
Muscle Pain		
Joint Pain		
Loss of Feeling		
Paralysis		
Mental Illness		
Depression		
Anxiety		
Confusion		

Other medical information: