Prototype Health, Inc.
Pediatric Registration Form
Confidential Information

Date of Birth_____ ▫ **Male** ▫ **Female**

Last Name _____**First Name**_____ **MI** _____

Mother's Name:_____**Father's Name**:_____

Address_____ **Apt #** _____

City_____ **State** _____**Zip Code**_____

Phone:Home(____)_____Work(____)_____Cell(____)_____

Email: _____

Is it ok to call: ▫ Yes ▫No Is it ok to send a letter: ▫ Yes ▫No Is it ok to email: ▫ Yes ▫No

Ethnicity: ▫ Hispanic ▫ Non-Hispanic ▫ Unknown **Preferred Language**:_____

Race: ▫ African or African American ▫ Caucasian or European American ▫ Native Hawaiian or other Pacific Islander ▫ Asian or Asian American ▫ Native American or Native Alaskan ▫ Other/Unknown

Marital Status of Parents: ▫Single ▫Married ▫Widowed ▫Divorced ▫Domestic Partner

Financial: This clinic offers a sliding scale based on income. To apply for the sliding scale, please provide the following information:

Family Size: # adults in household:_____# children_____Total Family Income per year:$_____

How did you hear about this clinic?_____

If we did not have this service, where would you go?_____

Insurance: ▫ Yes ▫ No AHCCCS: ▫ Yes ▫ No

In case of emergency, contact:

Name_____Phone(____)_____Relationship_____

STAFF USE ONLY
Payment Source: □ Self Pay □ AHCCCS □ Private Insurance
Sliding Scale: ▫ 0% ▫ 30% ▫ 50% ▫ 75% ▫ 100%

Prototype Health, Inc.

GENERAL CONSENT FOR CARE AND TREATMENT

I, _____(circle one: Patient/Authorized representative), hereby authorize the Prototype Health, Inc. staff and its representatives to render routine health care to myself or to my child _____(write "N/A" or "not applicable" if there is no child).

I authorize the following individuals to obtain medical care for my child in my absence: (write "N/A" or "not applicable" if there is no child).

1. _____ 2. _____ 3. _____

I understand that routine health care is confidential and voluntary and may involve provider office visits that include history taking, examination of all parts of the body, administration of medications, laboratory and diagnostic tests, and/or minor procedures. I further understand that referrals will be made for further diagnosis or treatment if needed and that I am responsible for obtaining such follow-up. I understand that I may discontinue services at any time. I understand that if tests are taken for communicable disease and certain positive results obtained, reporting to the public health department is required by law.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of my examination or treatment at Prototype Health, Inc. I understand that there is a chance for error with laboratory or diagnostic tests performed.

I hereby give my permission to the agency named above to use information contained in my medical record for statistical purposes with the understanding that confidentially will be maintained.

I have been informed of my right and responsibilities regarding eligibility for services.

_____ _____

Signature of Patient/Authorized Representative Date

_____ _____

Witness Date

Prototype Health, Inc.

FINANCIAL POLICY ACKNOWLEDGEMENT

Payment is Due at Time of Service

Forms of payment accepted are:

- Cash
- Debit cards
- Visa
- Mastercard
- Discover
- American Express

Fees May Be Applied for the Following:

- Office Visit
- In-Office Procedures
- In-Office Diagnostic Testing
- Lab Analysis Ordered
- Medicines

In order to evaluate your condition, it may be necessary to conduct tests in the office or administer certain treatments. Please ask to see our fee schedule for more information. You can ask for this at the Reception Desk at any time.

Fees for No-Shows and Missed Appointments

There will be a **$5** fee for all missed appointments. This will be due at the time of the next appointment.

Acknowledgement

I have read and understand the above financial policy and agree to the conditions listed.

_____ _____

Signature of Patient or Authorized Representative Date

Prototype Health Inc.
Pediatric Medical History

Patient Name_____DOB_____Gender_____Grade in School_____

HEALTH CONCERNS

Reason for today's visit (in order of concern)	How long has child had this condition?
_____	_____
_____	_____
_____	_____
_____	_____

▢ Yes ▢ No Has child been seen by any other physicians/practitioners for these concerns?

HEALTH HISTORY

Known Allergies to food, medications, environment, animals

Allergen	Type of Reaction
_____	_____
_____	_____
_____	_____
_____	_____

Major Hospitalizations, Surgeries, and Injuries: please indicate dates and complications (if any)

Year	Illness, Surgery, Injury, Major Medical Diagnosis
_____	_____
_____	_____
_____	_____
_____	_____

Please list all current prescription medications, over-the-counter medicines, vitamins, supplements

Name of Medicine/Supplement	Strength (mg)	How many	How often	Last Dose
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Family medical History (Mother, Father, Sister, Brother, Aunt, Uncle)

▢ Yes ▢No Heart attack before age 55
▢ Yes ▢No Stroke before age 55
▢ Yes ▢No Blood clot in legs/lungs
▢ Yes ▢No High Blood Pressure
▢ Yes ▢No High cholesterol/lipids
▢ Yes ▢No Diabetes
▢ Yes ▢No Cancer: type_____
▢ Yes ▢No Alcoholism
▢ Yes ▢No Asthma/COPD
▢ Yes ▢No Depression/Suicide
▢ Yes ▢No Genetic Disorder
▢ Yes ▢No Thyroid disease
▢ Yes ▢No Other_____
▢ I do not know child's family history

Prototype Health Inc.
Pediatric Medical History

Mother's Pregnancy History

Age at conception:_____ ▢ Yes ▢ No Had other children already
▢ Yes ▢ No Smoking ▢ Yes ▢ No Recreational drugs
▢ Yes ▢ No Diabetes ▢ Yes ▢ No Preeclampsia
▢ Yes ▢ No Emotional stress ▢ Yes ▢ No Excessive nausea/vomiting
▢ Yes ▢ No Vaginal birth ▢ Yes ▢ No Traumatic birth:_____

Early Childhood History

Health of baby at birth:_____

▢ Yes ▢ No Breastfed For how long:_____ Age solid food introduced:_____

Type of formula used (or indicate n/a):_____

Age at child's first tooth:_____Age First Talked:_____Age First Walked:_____

▢ Yes ▢ No Jaundice ▢ Yes ▢ No Bad foot odor ▢ Yes ▢ No Nightmares
▢ Yes ▢ No Cradle cap ▢ Yes ▢ No Excessive sweating ▢ Yes ▢ No Bed-wetting
▢ Yes ▢ No Eczema/Psoriasis ▢ Yes ▢ No Hyperactivity ▢ Yes ▢ No Tantrums
▢ Yes ▢ No Diarrhea ▢ Yes ▢ No Growing pains ▢ Yes ▢ No Disobedient
▢ Yes ▢ No Constipation ▢ Yes ▢ No Colic ▢ Yes ▢ No Fears/phobias
▢ Yes ▢ No Finicky eating ▢ Yes ▢ No Anemia ▢ Yes ▢ No Diaper Rash
▢ Yes ▢ No Poor teeth ▢ Yes ▢ No Asthma ▢ Yes ▢ No Early Puberty
▢ Yes ▢ No Chronic sniffles ▢ Yes ▢ No Warts ▢ Yes ▢ No Stomach aches
▢ Yes ▢ No Frequent Ear Infections If yes, how many total:_____Last Occurance:_____
▢ Yes ▢ No Frequent Colds If yes, how many total:_____Last Occurance:_____
▢ Yes ▢ No Frequent Strep throat If yes, how many total:_____Last Occurance:_____

▢ Yes ▢ No ▢ I don't know Hearing tests normal
▢ Yes ▢ No ▢ I don't know Vision tests normal
▢ Yes ▢ No ▢ I don't know Speech Impediments
▢ Yes ▢ No ▢ I don't know Learning impediments

Vaccination History

▢ Yes ▢ No ▢ Partial Hep B ▢ Yes ▢ No ▢ Partial Influenza/Flu
▢ Yes ▢ No ▢ Partial RV/Rotavirus ▢ Yes ▢ No ▢ Partial MMR
▢ Yes ▢ No ▢ Partial DPT/TDaP ▢ Yes ▢ No ▢ Partial Varicella/Chicken Pox
▢ Yes ▢ No ▢ Partial Hib ▢ Yes ▢ No ▢ Partial Hep A
▢ Yes ▢ No ▢ Partial PCV/pneumococcal ▢ Yes ▢ No ▢ Partial MCV4/meningococcal
▢ Yes ▢ No ▢ Partial IPV/Polio ▢ Yes ▢ No ▢ Partial HPV
▢ Yes ▢ No Reactions to vaccinations:_____

Environmental Exposure

Please list any particular household stressors the child has witnessed or gone through:

1. _____ 3. _____
2. _____ 4. _____

▢ Yes ▢ No Lived near a refinery, polluted area, home with leaded paint_____
▢ Yes ▢ No Lived in a house with new carpet, paint, cabinets, or other refurbishing_____
▢ Yes ▢ No Is particularly sensitive to perfumes, gasoline or other vapors_____
▢ Yes ▢ No Exposed to sprayed pesticides, herbicides or other chemicals around the home_____

Is there anything else you would like to share?_____

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