Regal Pediatrics Patient Information

Dr. M. Elghoroury, MD

Child Information

Name____Birthdate________________________Sex_________
Address____City_______________________State_____Zip_______
Who does the child live with? ____
SSN#__________-________-__________
How did you hear about us?____
Preferred Contact # Whose # is this? Home/Work/Cell

Parent or Guardian Information

Guardian's Name____Birthdate_______________
Address (if different than child's)____
City____ State _______________ Zip_________________
SSN#_____-_____-______ Mothers Cell ______-______- __________Email_____________________________________
Relation to child ____
Guardian's Name____Birthdate_______________
Address (if different than child's)____
City____ State _______________ Zip_________________
SSN#_____-_____-______ Fathers Cell _______-______- __________Email_____________________________________
Relation to child ____

Any legal custody issues we should be aware of/ Name changes? ____

Emergency Contact(s)

Name____ Relationship______________________Phone______________
Name____ Relationship______________________Phone______________

Insurance Information

PRIMARY INSURANCE: COMPANY NAME: ____
MEMBER ID #: ____________________________________ GROUP #: _____________________________

SECONDARY INSURANCE: COMPANY NAME:____
MEMBER ID #: ____________________________________ GROUP #: _____________________________

It is our policy that you inform us of all insurance information. If you fail to inform our staff, charges may apply.

I hereby authorize Regal Pediatrics to release any information acquired in the course of my children's examinations or medical treatment to my insurance company. I also understand that I am personally responsible for any and all copays, deductibles, and/or non-covered services incurred by myself and not payable by insurance.

SIGNATURE: ____ **DATE**: _________________________

Regal Pediatrics Patient History Information

Name ______________________ Nickname ______________________ D.O.B ______________

Birth History

1. Birth weight ________________ Birth length ____________
2. Mother's age at baby's birth: __________
3. Type of delivery: ☐ Vaginal ☐ C-section If so, reason ______________
4. Gestational age: ☐ Full-term ☐ Preterm if so, # of weeks ____ ☐ Post-term
5. Initial feeding: ☐ Breast ☐ Formula / Current feeding ☐ Breast ☐ Formula
6. Supplements taken: ____________________
7. Did mother use cigarettes, alcohol, recreational drugs or medications? ☐ Yes ☐No
   If yes, explain ____
8. Were there any problems during pregnancy? (i.e. diabetes, infections, high blood pressure, breech presentation) ☐ Yes ☐ No
   If yes, explain ____
9. Were there any problems during labor or nursery stay? (i.e. jaundice, feeding difficulties, breathing problems, birth defects) ☐Yes ☐No
   If yes, explain ____

Medical History

10. List allergies, including allergic reactions to drugs______________________________
11. List any hospitalizations, surgeries and/or serious illnesses and the corresponding dates.
12. List any medical troubles?(i.e. speech, hearing, skin, ADHD, seizures) ☐ Yes ☐No
    If yes, explain ____
13. Do you immunize your child? ☐Yes ☐No
14. Are their immunizations up to date? ☐Yes ☐No
15. Is your child exposed to smoke? ☐Yes ☐No
17. Do they go to school regularly? ☐Yes ☐No

18. **Any other medical/social/behavioral issues not listed above?**______________________

Family History

Patients name:_____________________ DOB:___________________

Has anyone in your family (parents, grandparents, sisters/brothers, aunts/uncles) had any of the following?

High/ Low blood pressure	Yes ☐ No ☐	If yes, who?____________
Diabetes	Yes ☐ No ☐	If yes, who?____________
Hearing loss	Yes ☐ No ☐	If yes, who?____________
Kidney problems	Yes ☐ No ☐	If yes, who?____________
Alcohol/Drug abuse	Yes ☐ No ☐	If yes, who?____________
Seizures	Yes ☐ No ☐	If yes, who?____________
Psychological Problems	Yes ☐ No ☐	If yes, who?____________
Exposure to TB, STI or HIV	Yes ☐ No ☐	If yes, who?____________
Heart disease	Yes ☐ No ☐	If yes, who?____________
Mental illness	Yes ☐ No ☐	If yes, who?____________
Cystic fibrosis	Yes ☐ No ☐	If yes, who?____________
Cerebral palsy	Yes ☐ No ☐	If yes, who?____________
Speech problems	Yes ☐ No ☐	If yes, who?____________
Birth defects	Yes ☐ No ☐	If yes, who?____________
Asthma	Yes ☐ No ☐	If yes, who?____________
Learning problems/ attention deficit disorder	Yes ☐ No ☐	If yes, who?____________
Family violence	Yes ☐ No ☐	If yes, who?____________

Is there any other family history not listed above that you would like Dr. Elghoroury to be aware of?

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HIPAA Authorization & Consent Form

Regal Pediatrics has taken measures to protect all of our patient's medical information. We will not release any information to anyone unless you have provided the requested information below. These would include people other than what is allowed through HIPAA. The Health Insurance Privacy & Accountability Act does allow us to release information to outside entities on your behalf. These would include, your insurance company, your pharmacy, and another medical office when making appointments or hospitals.

Please see medical staff at the front desk with any questions prior to signing this authorization form.

I, ______________________________, authorize the person(s) listed below to obtain medical information about my child. I understand that Regal Pediatrics is not responsible for the information provided as long as it was given to the authorized person(s) listed below.

I fully understand the HIPAA policy and its contents.

1. Name: ______________________D.O.B:____________ Relationship:
2. Name: ______________________D.O.B:____________ Relationship:
3. Name: ______________________D.O.B:____________ Relationship:
4. Name: ______________________D.O.B:____________ Relationship:

Parent's signature: ______________________________Date:

I, ______________________________, **do not** authorize Regal Pediatrics to release any of my child's protected medical information to anyone other than the entities protected by **HIPAA.**

I fully understand the HIPAA policy and its contents.

Parent's signature: ______________________________Date:

You have the right to obtain copies of your medical information for an applied fee based on the circumstances (accept in the case of an emergency) please allow our office staff to retrieve all information within 5-7 business days.