Pediatric Wellness of Northern New York
19474 Howell Drive, Watertown NY, 13601
Tel: (315) 782-7330 · Fax: (315) 782-5773

PATIENT REGISTRATION FORM

Patient Name:_____ DOB: _____

Patient Adress: _____

☐ MALE ☐ FEMALE Patient SS# _____-_____-_____

Gender Identity Optional): _____
Race (optional): American Indian/Alaskan Native, Asian, Black/African American, Hawaiian/Pacific Islander, White, Other Decline/Refuse to Answer/Unknown
Ethnicity: Hispanic Non-Hispanic **Primary Language**: _____

Parent/Guardian Demographics

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

Address: _____ Address: _____

_____ _____

DOB: _____ SSN# _____ DOB: _____ SSN# _____

Phone number: _____ Phone Number:_____

Cell Phone:_____ Cell Phone: _____

Legal Guardian Name: _____ DOB: _____ SSN# _____
(IF OTHER THEN BIOLOGICAL PARENTS)
Phone number: _____ Cell Phone: _____

Responsible Party Name: _____ Phone: _____

Emergency Contact: _____ Phone: _____

E-Mail for portal use: _____

Insurance Information

Primary Insurance: _____ ID# _____ Effective Date:_____

Policy Holder: _____ DOB: _____ Employer: _____

Secondary Insurance: _____ ID# _____ Effective Date: _____

Acknowledgement of Receipt of Privacy Practices

I, _____ have read **PEDIATRIC WELLNESS OF NORTHERN NEW YORK PC** Notice of privacy practices effective April 14, 2003.

Signature: _____ Date: _____

Advanced Beneficiary Notice (ABN)

Your health insurance may only pay for certain items(s), or services (s) offered through our practice. The plan you have chosen as your health insurance does not necessarily cover all your health care cost. Insurance only pays for covered items and services. Covered and non-covered items and services can be found in your health insurance contract or by contacting your health insurance plan. We do not know your health insurance plan and it is your responsibility to know whether certain items or services are or are not covered. The fact that your health insurance plan may not pay for a particular service does not mean that you should not receive them, especially if your physician recommends that you should receive the items or services.

Signature: _____ Date: _____

Pediatric Wellness of Northern New York Office Policies

- I authorize the release of any medical or necessary information to the insurance company to process any insurance claims.
- I authorize payment of medical benefits to **PEDIATRIC WELLNESS OF NORTHERN NEW YORK, PC.**
- I authorize **PEDIATRIC WELLNESS OF NORTHERN NEW YORK, PC** to provide medical treatment to my child.
- I authorize the release of my child's immunization records and physical to his/his school per my request.
- I understand three (3) or more missed appointments may lead to dismissal.
- I understand that a parent or guardian must always be present at the time of appointment for ages under 18years.
- I give Pediatric Wellness of Northern New York permission to send out my child's cultures or nasal swabs to Samaritan Medical Center at 830 Washington St, Watertown NY 13601 for testing.

Signature: _____ Date: _____

OFFICE USE VERIFIED/ENTERED BY: _____

Front and Back

Pediatric Health History Form -- Initial Visit

Child's Name_____ Date of Birth / / / Age _____ ☐ Male ☐ Female

Child's Perferred Name _____ Gender Identity: ☐ Male ☐ Female ☐ Nonbinary ☐ X

Parent's Name _____ Parent's Name _____

Form filled out by _____ Date_____

Child's Past Medical History

Pregnancy/Neonatal Period

Where was your child Born?_____

Is the child yours by ☐birth ☐adoption ☐stepchild ☐other _____

Delivery by ☐Vaginal ☐C-Section

Reason for c-section_____

Complications _____

Was your child premature ☐No ☐Yes

If yes how many weeks?_____

Any Complications _____

Was your child in the NICU? ☐ Yes ☐ No

If yes how long? _____

Infancy/Childhood/Adolescence

Has your child ever been treated for or diagnosed with any of the following:

- ☐ Asthma or reactive airway disease
- ☐ Wheezing or bronchiolitis
- ☐ Seasonal allergies or eczema
- ☐ Food allergy
- ☐ Recurrent ear infections
- ☐ Pneumonia
- ☐ Urinary tract infections
- ☐ Genetic Syndrome
- ☐ Seizures
- ☐ Anemia
- ☐ Broken Bone
- ☐ Learning Disability
- ☐ Depression/anxiety

Other chronic medical conditions _____

_____

Has your child ever been hospitalized ☐Yes ☐No explain:_____

_____

Previous surgeries and dates_____

_____

Is your child allergic to medicine or drugs :

☐Yes ☐No Explain:_____

_____

Social History

Who lives in the childs household?

☐Mom ☐Dad ☐Step ☐Grandparent

☐Other_____ ☐ Siblings (#_____)

Family History

Do any family members have any of the following conditions:

	Mother	Father	Sibling	Grandparent	
Asthma	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐
Blood disorder	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Throid disease	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐
Migraines	☐	☐	☐	☐	☐
Depression/anxiety	☐	☐	☐	☐	☐
Alcholism	☐	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐	☐
Hearing loss	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐
Liver disease	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐
Developmental Disability	☐	☐	☐	☐	☐
Immune problems	☐	☐	☐	☐	☐

Reviewed by _____

Date: _____

PLEASE ALSO COMPLETE REVERSE SIDE

NYS Health Related Social Needs Screening Questionnaire

Housing/ Utilities	
1. What is your living situation today?	I have a steady place to live I have a place to live today, but I am worried about losing it in the future I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
2. Think about the place you live. Do you have problems with any of the following? CHOOSE ALL THAT APPLY	Pests such as bugs, ants, or mice Mold Lead paint or pipes Lack of heat Oven or stove not working Smoke detectors missing or not working Water leaks None of the above
3. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?	Yes No Already shut off
Food Security	
4. Within the past 12 months, you worried that your food would run out before you got money to buy more.	Often true Sometimes true Never true
5. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.	Often true Sometimes true Never true
Transportation	
6. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?	Yes No
Employment	
7. Do you want help finding or keeping work or a job?	Yes, help finding work Yes, help keeping work I do not need or want help
Education	
8. Do you want help with school or training? For example, starting or completing job training or getting a high school diploma, GED or equivalent.	Yes No
Interpersonal Safety **Because violence and abuse happens to a lot of people and affects their health we are asking the following questions.**	**A score of 11 or more when the numerical values for answers to [the four questions] are added shows that the person might not be safe**
9. How often does anyone, including family and friends, physically hurt you?	Never (1) Rarely (2) Sometimes (3) Fairly often (4) Frequently (5)
10. How often does anyone, including family and friends, insult or talk down to you?	Never (1) Rarely (2) Sometimes (3) Fairly often (4) Frequently (5)
11. How often does anyone, including family and friends, threaten you with harm?	Never (1) Rarely (2) Sometimes (3) Fairly often (4) Frequently (5)
12. How often does anyone, including family and friends, scream or curse at you?	Never (1) Rarely (2) Sometimes (3) Fairly often (4) Frequently (5)

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Tel: (315) 782-7330 · Fax: (315) 782-5773

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Honeylee D. Augustin, M.D.
Jennifer Hess, PA-C
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PERMISSION FOR TREATMENT OF MINOR

(PLEASE FILL OUT COMPLETELY)

Parent's Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone Number: _____ Cell Phone Number: _____

Name of Child: _____ Date of Birth: _____

I, _____ authorize the below mentioned person(s), to act on my behalf in my absence for the patient listed above.

Name: _____ Relationship: _____ # _____

Name: _____ Relationship: _____ # _____

Name: _____ Relationship: _____ # _____

Name: _____ Relationship: _____ # _____

DATES OF AUTHORIZATION

☐ Indefinitely OR Beginning _____ - _____ - _____ Ending _____-_____-_____

CHECK ALL THAT APPLY

☐ TREATMENT ☐ PRESCRIPTIONS ☐ APPOINTMENT SCHEDULING

☐ VACCINE ☐ VACCIINE ☐ RECORDS ☐ PAYMENTS

☐ OTHER _____

SIGNATURE: _____ DATE: _____

WITNESS: _____ (Must be witnessed by office staff.)

*Please remember to have above mentioned person bring photo I.D. and the patients' Insurance Card.