



Patient Registration

Tell us about the patient

Last Name: _____ First Name: _____ MI: _____

Nickname: _____ Age: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Gender: Male Female

Tell us about the family

Parent/Guardian Last Name: _____ First Name: _____ MI: _____

Address (if different from patient): _____

City: _____ State: _____ Zip: _____

Phone (Home): _____ (Cell): _____ (Work): _____

Occupation: _____ Employer: _____

Parent/Guardian Last Name: _____ First Name: _____ MI: _____

Address (if different from patient): _____

City: _____ State: _____ Zip: _____

Phone (Home): _____ (Cell): _____ (Work): _____

Occupation: _____ Employer: _____

Siblings:
Name _____ Date of Birth: _____

Name _____ Date of Birth: _____

Name _____ Date of Birth: _____

Name _____ Date of Birth: _____

Name _____ Date of Birth: _____

Name _____ Date of Birth: _____

Who should we call in case of emergency?

Last Name: _____ First Name: _____ MI: _____

Phone (Home): _____ (Cell): _____ (Work): _____

Relationship to Patient: _____

Will insurance be used for today's visit?

- No. The visit will be paid for today.
- Yes. Please provide the receptionist with your insurance card. If you are covered by multiple insurance companies, indicate which is primary, secondary, etc.

Acorn Pediatrics accepts most major insurance plans. Check with the receptionist for more information.

Privacy Policy (Please mark all that apply)

- I acknowledge that I have received the Acorn Pediatrics Notice of Privacy Policy.
- I authorize Acorn Pediatrics to contact me regarding my child's appointment, health information, lab results, billing problems or any other situation relating to my child's healthcare.
- I authorize Acorn Pediatrics to leave a detailed message regarding my child's healthcare. Mark all that apply:
 - Voicemail
 - With the following individual(s): _____ Phone: _____

Authorization to Treat in Absence of Parent or Guardian (optional)

- I authorize my child to be brought to Acorn Pediatrics by _____. I consent for my child to be treated, and I agree to be responsible for the cost of such care.

Agreement to Pay

I authorize the release of my child's medical records to my health plan, insurance company, or Medicaid, as applicable, for payment. **I request that my health plan, insurance company, or Medicaid, as applicable, make payment for services I receive at Acorn Pediatrics directly to Acorn Pediatrics, LLC.** I understand that I am responsible for payment for any services that are not covered by any health plan, insurance company, or Medicaid, including co-payments and deductibles. I understand **co-payments are due prior to my child being seen.** I understand that if my child does not have health insurance, or if I do not mark this circle, I will be responsible for payment which is due at the end of each visit. For any balance that remains unpaid 60 days after the date of service, I agree to pay 1.5% monthly interest charges (18% APR). Should any balance be referred to a collection agency, I agree to pay an additional fee.

By signing below, I am confirming that I understand and consent to the assignment of benefits, payment responsibility, treatment(s), and disclosures above.

Patient Name: _____ Date: _____

Signature: _____

Relationship to patient: Parent Guardian Other: _____

Thank you for choosing our practice for the care of your child. How did you hear about us? Please check one:

- Acorn website
- Referred by another health care provider, if so which provider _____
- Word of mouth
- Referred by friend/family, if so please list name _____
- Montana Parent magazine
- Outside Bozeman magazine
- Other Internet/online site, if so please list _____
- Other _____



Patient Medical History

Patient Name: _____ Date of Birth: _____

Birth History

Birth weight: _____

Where was your child born? _____

Was your child born prematurely (before 37 weeks gestation)? Yes No

If yes, how many weeks gestation when born? _____

Did your child develop jaundice? Yes No

If yes, was treatment with lights required? Yes No

Did your child pass the infant hearing test (older children will not have had this test)? Yes No

Was blood collected for the Newborn Screening Test? Yes No

Describe any other problems during the newborn period: _____

Medications

Please list any prescription or over-the-counter / herbal medications taken by your child.

Preferred Pharmacy Please list the pharmacy at which you prefer to fill your Medication prescriptions

Allergies

Mark all that apply to this patient:

- | | |
|--|----------------------------------|
| <input type="radio"/> NONE | <input type="radio"/> Peanuts |
| <input type="radio"/> Penicillin (including Amoxicillin and Augmentin) | <input type="radio"/> Other nuts |
| <input type="radio"/> Cephalosporin (including Keflex/Omnicef//Rocephin) | <input type="radio"/> Shellfish |
| <input type="radio"/> Latex | <input type="radio"/> Eggs |
| <input type="radio"/> Bee Stings | <input type="radio"/> Dairy |
| <input type="radio"/> Pollen | <input type="radio"/> Wheat |
| <input type="radio"/> Dust / dust mites | <input type="radio"/> Cats |
| <input type="radio"/> Mold | <input type="radio"/> Dogs |

Other allergies? Please list: _____

Past Medical Problems

Mark all that apply to this patient:

- NONE
- Autism
- Developmental Delay or Intellectual Disability
- Ear Infections
- Speech or Language Delay
- Constipation
- Headaches
- Depression
- Urinary Tract Infection

- Asthma
- ADD/ADHD
- Gastroesophageal Reflux Disease (GERD)
- Pneumonia
- Seizure With fever only? Yes No
- Chronic Abdominal Pain
- Anxiety
- Sleep Problems
- Other? _____

Past Surgery

Mark all that apply to this patient:

- NONE
- Tonsillectomy
- Ear tubes
- Hernia Repair
- Appendectomy

- Circumcision
- Adenoidectomy
- Tear Duct Repair
- Hypospadias Repair
- Other? _____

Family History

Mark all that apply to the **family members of this patient**:

Problem	Mother	Father	Brother	Sister	Grandmother	Grandfather
Asthma						
Allergies						
Specify:						
Eczema						
Autism						
ADD/ADHD						
Developmental Delay						
Intellectual Disability						
Celiac Disease						
Inflammatory Bowel Disease						
Heart Defect						
Specify:						
Heart Disease						
Diabetes						
High Blood Pressure						
Kidney Disease						
Thyroid Disease						
Anxiety						
Depression						
Alcoholism						
Seizures						
Migraine						
Cancer						
Specify:						
Stroke						

Other? _____

Social History

- Smoke Exposure at home? Yes No
- Violence Exposure at home? Yes No
- School Concerns? Yes No
- Travel Outside the U.S.? Yes No
- Guns at home? Yes No If yes, stored locked? Yes No
- Pets at home? Yes No