

HRN \_\_\_\_\_

Rec'd by \_\_\_\_\_

Date Entered: \_\_\_\_\_

**PEDIATRIC REGISTRATION FORM****PLEASE PRINT CLEARLY****Patient's Legal Name:** \_\_\_\_\_ **AKA (Also Known As):** \_\_\_\_\_**SSN:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_ **Primary Care Provider:** \_\_\_\_\_**Gender:** ☐ Male ☐ Female**Ethnicity** (select one): ☐ Hispanic or Latin Origin ☐ NOT Hispanic or Latin Origin**Race** (Select one):☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White**If American Indian/Alaskan Native:**

Tribe: \_\_\_\_\_ Enrollment #: \_\_\_\_\_ Indian Blood Quantum: \_\_\_\_\_

If you are not American Indian/Alaskan Native, are you a member of an Indian household? ☐ Yes ☐ No**Primary Language:** \_\_\_\_\_ **Preferred Language:** \_\_\_\_\_ **Interpreter Required:** ☐ Yes ☐ No**English Proficiency:** ☐ Not at all ☐ Not Well ☐ Well ☐ Very Well**Home Address:** \_\_\_\_\_ **Apt #** \_\_\_\_\_**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_**Home Phone#:** \_\_\_\_\_ **Cell Phone #:** \_\_\_\_\_Can we leave a message on the above phone numbers? ☐ Yes ☐ No **Preferred Method of Contact:** ☐ Phone ☐ Email ☐ Mail**Internet Access:** ☐ Yes ☐ No**Email Address:** \_\_\_\_\_

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**Emergency Contact Information****Primary Contact Name** (Parent/Guardian): \_\_\_\_\_ **Relationship:** \_\_\_\_\_**Home Phone#:** \_\_\_\_\_ **Work Phone** \_\_\_\_\_ **Ext:** \_\_\_\_\_**Home Address:** \_\_\_\_\_ **City/State/Zip Code:** \_\_\_\_\_**Secondary Contact Name/Next of Kin:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_**Home Phone#:** \_\_\_\_\_ **Work Phone** \_\_\_\_\_ **Ext:** \_\_\_\_\_**Home Address:** \_\_\_\_\_ **City/State/Zip Code:** \_\_\_\_\_

**PEDIATRIC REGISTRATION FORM****Parent's Information**

Father's Name: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Address (if different from patient) : \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone#: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Employer Phone #: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Address (if different from patient) : \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone#: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Employer Phone #: \_\_\_\_\_

**Custodial Information**Custodial Parent is: ☐ Mother ☐ Father ☐ Both ☐ Other \_\_\_\_\_**In addition to myself, I authorize the following individuals to consent for Medical/Dental care for my child:**

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

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**As a Federally Qualified Health Center, SDAHIC is required to report the following information for the population we serve:**Number of People in Household (Immediate family *only*) \_\_\_\_\_ Household Income (Monthly) \_\_\_\_\_Migrant Worker (or dependent of): Yes ☐ No ☐ Homeless: Yes ☐ No ☐

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**I hereby authorize Medical /Dental Treatment for the above patient**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name (Parent or Guardian): \_\_\_\_\_

Relationship: \_\_\_\_\_



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## Insurance Information

**PLEASE PRINT CLEARLY**

Patient's Legal Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

### Primary Insurance

Insurance Co: \_\_\_\_\_

Insurance Phone#: \_\_\_\_\_

Subscriber: \_\_\_\_\_

Subscriber's Date of Birth: \_\_\_\_\_

Subscriber's SSN: \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_

Policy #: \_\_\_\_\_

Group #: \_\_\_\_\_

Effective/Issue Date: \_\_\_\_\_

### Secondary Insurance

Insurance Co: \_\_\_\_\_

Insurance Phone#: \_\_\_\_\_

Subscriber: \_\_\_\_\_

Subscriber's Date of Birth: \_\_\_\_\_

Subscriber's SSN: \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_

Policy #: \_\_\_\_\_

Group #: \_\_\_\_\_

Effective/Issue Date: \_\_\_\_\_

### Dental Insurance

Insurance Co: \_\_\_\_\_

Insurance Phone#: \_\_\_\_\_

Subscriber: \_\_\_\_\_

Subscriber's Date of Birth: \_\_\_\_\_

Subscriber's SSN: \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_

Policy #: \_\_\_\_\_

Group #: \_\_\_\_\_

Effective Date: \_\_\_\_\_

**PLEASE COMPLETE REVERSE SIDE**



HRN \_\_\_\_\_

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## Assignment of Benefits

By signing below:

- I, the undersigned, hereby authorize assignments of and direct billing to Medi-Cal, Medicare and/or any other insurance benefits to San Diego American Indian Health Center for services provided to the patient.
- I further agree and acknowledge that my signature on this document authorizes San Diego American Indian Health Center to obtain and release any medical/dental/behavioral and billing information to Medi-Cal, Medicare and/or any other insurance necessary to process my claim(s), including determining eligibility and seeking reimbursement for services provided.
- If my insurance company reimburses me directly instead of San Diego American Indian Health Center, I will submit payment in the same amount to San Diego American Indian Health Center within thirty (30) days on my receipt of the payment.
- I am responsible for notifying San Diego American Indian Health Center within thirty (30) days of my receipt of the payment.
- I am responsible for notifying San Diego American Indian Health Center if there is any change in my insurance, including the addition and/or loss of any insurance coverage. If I fail to notify the clinic of any such changes in insurance, I may be responsible for any charges as a result.
- Lab Work – I have the option of billing my services or paying for the cost of the labs at the time of the visit.
- I understand that I am responsible for the deductible non covered services and any balance due after insurance.
- I understand and waive my right to confidentiality if a collection service or court action becomes necessary to collect my delinquent account.

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Name of Responsible Party (Please Print)

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Signature of Responsible Party

Date



HRN \_\_\_\_\_

Received By: \_\_\_\_\_

Date Entered: \_\_\_\_\_

## ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have received from the San Diego American Indian Health Center a Clinic Services Information brochure. This brochure contains general clinic services information which includes the following:

- Eligibility For Services
- Payment Policy
- Billing Inquiries
- Appointments Policy
- Appointment Cancellation Policy
- Late Arrival Policy
- Missed Dental Appointment Policy
- Medical/Dental/Behavioral Health Services Information
- Patient Rights and Responsibilities
- Other Services
- Notice of Privacy Practices
- Additional Uses of Information
- Dental Material Fact Sheet

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Patient Name (Please Print)

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Signature

Date

Please complete reverse side



*Promoting Excellence in Health Care with Respect for Custom and Tradition*

## GENERAL CONSENT FOR TREATMENT & ASSIGNMENT OF BENEFITS

**Patient's Name:** \_\_\_\_\_ **Chart Number:** \_\_\_\_\_

1. Consent to Medical, Dental, Psychological, Nursing and Surgical Procedures:

The undersigned consents to the patient entering the Center identified above and receiving medical, dental, psychological, general duty nursing or surgical procedures, which may include examination, radiological services, emergency services, laboratory procedures, anesthesia and other procedures under the general and specific instructions of the patient's healthcare provider(s). The undersigned acknowledges that the patient or the legal representative of the patient will be required to sign additional consent forms for complex treatments and procedures which require the patient's provider to obtain informed consent from the patient or the patient's legal representative for such treatment or procedures.

2. Release of Patient Information:

The Center will not release patient identifiable information to any third party without the patient's written consent, except as permitted or required by law: The undersigned agrees that the Center may release information without a patient consent, to the extent necessary, (1) to insure continued treatment by healthcare providers and (2) to determine who is responsible for payment and to obtain payment or reimbursement for services provided to the patient. Third parties who may receive such information under this paragraph include insurance companies, utilization reviewers, case managers, federal and state agencies, consulting and treating providers, patient's employer and managed care plans who are responsible for payment of covered services. (Psychological/HIV/AIDS information will require a special consent prior to release).

3. Payment for services:

I, the undersigned, certify that the information given to the Center in applying for payment by third parties is correct. I hereby authorize payment of benefits on my behalf for services furnished to me, and authorize the Center to release minimum necessary patient health information pertaining to the visit to the Health Care Financing Administration or to the California Department of Health Services or other agents which is necessary to determine benefits or payment for services under these programs.

**Patient's Name:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

Patient/Legal Representative

San Diego American Indian Health Center

**Pediatric History Form**

**CHILD'S NAME:** \_\_\_\_\_ **GENDER: M/F** **DOB:** \_\_\_\_\_

**CHIEF COMPLAINT:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**DRUG ALLERGY**(Name of Medicine and reaction): \_\_\_\_\_

**CURRENT MEDICATIONS**(Include over the counter medicines):

NAME	DOSAGE

**BIRTH HISTORY**

Birth Weight \_\_\_\_\_ lbs \_\_\_\_\_ ozs. Birth date: \_\_\_\_\_ Due Date: \_\_\_\_\_ Place \_\_\_\_\_

**FAMILY MEDICAL HISTORY** Has either parent or any relative in either family had: (if yes, write relationship, age at time of disease, and if alive at present)

**YES NO**


Tuberculosis: \_\_\_\_\_

Diabetes: \_\_\_\_\_

Heart Disease: \_\_\_\_\_

Alcoholism/Drug Abuse: \_\_\_\_\_

Other Diseases: \_\_\_\_\_

Anyone in the family smoke inside the home?

Is child exposed to second hand smoke?

**YES NO**


Cancer: \_\_\_\_\_

Mental illness: \_\_\_\_\_

Asthma: \_\_\_\_\_

**PLEASE COMPLETE BACK OF FORM**



**PAST HISTORY** Less than 7 yrs old only

**GENERAL DEVELOPMENT**

Sat at \_\_\_\_\_ mos.

Walked at \_\_\_\_\_ mos.

First words at \_\_\_\_\_ mos.

Toilet trained \_\_\_\_\_ mos.

**FEEDING HISTORY** less than 1 Year Only, Please Circle

Breast fed? YES NO How Long? \_\_\_\_\_

Formula fed? YES NO How Long? \_\_\_\_\_

Age formula started: \_\_\_\_\_

Solid Food Started: \_\_\_\_\_

Food

Allergies: \_\_\_\_\_

Has the child had any problems in school? YES NO Explain: \_\_\_\_\_

Is there any violent behavior in the family? YES NO Explain: \_\_\_\_\_

**CHILDHOOD DISEASES**

Has your child had any serious medical illness or hospitalizations? **YES NO**

Has your child had any operations? **YES NO**

Has your child had any injuries? **YES NO**

**If yes, What type? When? Where?** \_\_\_\_\_

Has your child needed any medications? **If yes, Which ones and at what age?**

\_\_\_\_\_  
\_\_\_\_\_

Has your child had any delay in reaching developmental milestones? **YES NO**

**If yes, Please explain:**

\_\_\_\_\_

**IMMUNIZATION HISTORY**

IMMUNIZATIONS UP TO DATE? **YES NO** **IF NOT, LIST IMMUNIZATIONS NEEDED:** \_\_\_\_\_

\_\_\_\_\_

**COMPLETED BY:** \_\_\_\_\_ **RELATIONSHIP TO PATIENT:** \_\_\_\_\_

**REVIEWED BY:** \_\_\_\_\_ **DATE:** \_\_\_\_\_



HRN #: \_\_\_\_\_  
DATE: \_\_\_\_\_  
NAME: \_\_\_\_\_

**SECTION 1: PHQ-2 BEHAVIORAL HEALTH SCREEN**

**Over the past 2 weeks, how often have you been bothered by any of the following problems?**

**1. Little interest or pleasure in doing things:**

- a. Not at all
- b. Several days
- c. More than half the days
- d. Nearly every day

**2. Feeling down, depressed or hopeless:**

- a. Not at all
- b. Several days
- c. More than half the day
- d. Nearly every day

**SECTION 2: ALCOHOL SCREENING (AUDIT –C)**

**1. How often do you drink alcohol?**

- a. Never
- b. Monthly or less
- c. 2 – 4 times a month
- d. 2 – 3 times a week
- e. 4 or more times a week

**2. How many standard drinks containing alcohol do you have on a typical day?**

- a. 1 or 2
- b. 3 or 4
- c. 5 or 6
- d. 7 to 9
- e. 10 or more

**3. How often do you have six or more drinks on one occasion?**

- a. Never
- b. Less than monthly
- c. Monthly
- d. Weekly
- e. Daily or almost daily

**PLEASE COMPLETE BACK SIDE**



**SECTION 3: TOBACCO USE SCREENING** (please check the following)

**Do you currently smoke or chew/dip tobacco?**

\_\_\_ YES, I USE TOBACCO    \_\_\_ SMOKE?    \_\_\_ CHEW/DIP?    \_\_\_ BOTH?

\_\_\_ OR YES, I USE TOBACCO FOR CEREMONIAL OR RELIGIOUS PURPOSES:

Method used? \_\_\_\_\_ (for example: pipe)

**If YES:** How many packs per day? \_\_\_\_\_ **OR** How much? \_\_\_\_\_ **AND How often?**

\_\_\_\_\_

Would you consider quitting? \_\_\_ YES    \_\_\_ NO

How can we help you quit? \_\_\_\_\_

\_\_\_ NO, I HAVE **NEVER** SMOKED OR CHEWED TOBACCO.

\_\_\_ NO, I DO NOT CURRENTLY USE TOBACCO (I have smoked or chewed tobacco in the past).

The last time I smoked was:    \_\_\_ within 0-6 months    \_\_\_ over 6 months ago

The last time I chewed/dipped was:    \_\_\_ within 0-6 months    \_\_\_ over 6 months ago

**SECTION 4: DOMESTIC VIOLENCE SCREENING** (please circle yes or no)

Do you ever feel afraid or threatened by your partner?    YES    NO

Within the last year have you been hit, slapped, kicked, or physically hurt by someone?    YES  
NO

**SECTION 5: DENTAL SCREENING**

When was your last dental visit? \_\_\_\_\_ Where?

\_\_\_\_\_

☐ Patient refusal

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

## TB EXPOSURE RISK ASSESSMENT

Patient's Name \_\_\_\_\_ HRN \_\_\_\_\_

Have you (Has the child) or anyone you see regularly been diagnosed or suspected of being sick with active TB disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you (Does the child) or have you had symptoms of TB, such as cough, chest congestion, fever, night sweats, and/or weight loss?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you (Does the child) have family members or frequent visitors who were born in high TB prevalent countries (most countries from Asia, Africa, Latin America, or parts of Eastern Europe)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Were you (Was the child) born in, or travel to high TB prevalent countries (most countries from Asia, Africa, Latin America, parts of Eastern Europe)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you (Does the child) live in out-of-home placements (such as board & care or residential facilities)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you (Does the child) have HIV infection, or another immunosuppressive condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you (Does the child) live with someone who is HIV seropositive?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you (Does the child) live, or frequently visit, with persons who have been incarcerated in the last 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you (Does the child) live among or frequently been around individuals who are homeless, migrant workers, users of street drugs, or residents in nursing homes?	<input type="checkbox"/> Yes <input type="checkbox"/> No

### CLINIC USE ONLY:

Administer a Mantoux TB skin test to adults or children who have any of the above risk factors (indicated by a Yes response) UNLESS:

1. The patient has a previously documented (including date performed, method of testing and millimeter reading) positive Mantoux TB skin test.
2. The patient has had a TB skin test within the last 12 months and has not had recent exposure to an individual with active TB.

*Note: In accordance with AAP and CDC guidelines, only trained licensed personnel may read/interpret the skin test.*

Healthcare worker initials: \_\_\_\_\_ Date: \_\_\_\_\_