Mesquite Pediatrics Family Registration

Patient Last Name	First Name	MI	Date of Birth	Sex	PCP	A=Abdy
						C=Couchman
						G=Gioannetti
						Y=Yell

Address _____ City, State, Zip _____

How did you hear about Mesquite Pediatrics? _____

Parent/Guardian 1 Information

Name_____ DOB_____

Address _____ City, State, Zip _____

Home Phone _____ Cell _____

Employer _____ SS#_____

Relationship to patient _____ Email_____

Parent/Guardian 2 Information

Name_____ DOB_____

Address _____ City, State, Zip _____

Home Phone _____ Cell _____

Employer _____ SS#_____

Relationship to patient _____ Email_____

Emergency Contact _____ Phone# _____

Insurance

Primary Insurance Company_____

Policy Holder Name_____ Date of Birth _____

Relationship to patient_____

Policy Number_____ Group Number _____

Address to mail claims_____

I certify that the information provided pertaining to my health insurance coverage is true and correct. I authorize that payment for services rendered should be made payable to Mesquite Pediatrics and authorize release of medical information necessary to process this (these) claim(s). I have read all the terms and conditions contained in this agreement and agree to be bound by these terms and conditions.

Signature_____Date_____

List all children for whom this contact form applies:

Name	Date of birth

Mesquite Pediatrics Contact Preferences

Who is the primary contact?

Name _____ Relationship _____

Other Authorized Persons

I, _____, hereby give permission to the individuals listed below to bring my child to Mesquite Pediatrics and to make any and all medical decisions at the time of the visit. This permission will remain in effect until such time that I specifically revoke it.

People, **other than parents,** who may bring the child:

Name	Relationship to patient	Phone Number

Responsible Party Signature	Print Name	Date

For children age 16 and older: I give permission for them to present to Mesquite Pediatrics for care without the presence of an adult guardian. This permission will remain in effect until such time that I specifically revoke it.

Responsible Party Signature	Print Name	Date	Child's phone number

Mesquite PEDIATRICS

Family History Questionnaire (list all children with the same family history)

Patient Name	Date of Birth	Patient Name	Date of Birth

With which adult(s) do the children reside? _____ Today's Date: _____

Is there a smoker in the household? Yes No

Is there a gun in the household? Yes No If "Yes", is it securely locked? Yes No

Indicate any medical problems that a close biological relative has (include the children's parents, siblings, grandparents, aunts and uncles) by listing which relative has the condition (i.e. "maternal grandmother" or "father's sister") and listing other details if applicable

Condition	**Details**	**Which relative(s)?**
Anemia		
Bleeding disorder (specify what)		
High Blood Pressure		
High Cholesterol		
Obesity/Overweight		
Heart Disease (specify what)		
Heart Attack before age 50		
Asthma		
Allergies/allergic rhinitis		
Eczema		
Diabetes (specify type 1 or 2)		
Thyroid disease (specify)		
Cancer (specify)		
Stomach or GI disorder (specify)		
Migraines		
ADD/ADHD		
Developmental/Learning Problem		
Mental Health Problem (specify)		
Any other significant conditions		

Family Vaccine Policy Agreement

We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives. We firmly believe in the safety of our vaccines. We firmly believe that all children and young adults should receive all recommended vaccines according to the schedule published by the Centers for Disease Control and the American Academy of Pediatrics (AAP).

All patients in the practice are required to receive a minimum of DTaP, Hib, polio, hepatitis B, pneumococcal and rotavirus vaccines by three months of age. By 9 months of age patients must have all immunizations recommended by the AAP in the first six months of life. By 18 months of age patients must have all immunizations recommended by the AAP in the first 15 months of life. Additional requirements include 2 Hepatitis A vaccines by age 2, all AAP recommended kindergarten booster vaccines by age 5, the meningococcal and Tdap vaccines by age 12, and the second meningococcal vaccine by age 17.

If you refuse to vaccinate your child despite all our efforts, we will ask you to find another health care provider who shares your views. We do not keep a list of such providers nor would we recommend any such physician. Please recognize that by not vaccinating, you are putting your child at unnecessary risk for life-threatening illness, disability, and even death.

Finally, if you agree to vaccinate your child, we draw up or open a vaccine, and then you change your mind and decide not to vaccinate, you agree to pay us for the vaccine unless there is another patient for whom we are able to use it.

Please sign below to indicate that you are aware of and plan to abide by this policy. List all children in the family.

Patient Name	Date of Birth	Patient Name	Date of Birth
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

_____ _____

Parent/Guardian Signature Date