



**Pediatric Patient Registration**

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last \_\_\_\_\_ Age \_\_\_\_\_  
 Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ SS No. \_\_\_\_\_  
 Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_  
 Fathers Name \_\_\_\_\_ Fathers Social Security # \_\_\_\_\_ Fathers Employer Name/Phone # \_\_\_\_\_  
 Mothers Name \_\_\_\_\_ Mothers Social Security # \_\_\_\_\_ Mothers Employer Name/Phone # \_\_\_\_\_  
 Whom we may contact in case of emergency \_\_\_\_\_ Relationship \_\_\_\_\_  
 Emergency Phone \_\_\_\_\_ Parent's Email Address \_\_\_\_\_  
 Phone # of nearest relative/friend not living with you \_\_\_\_\_  
 Name of nearest relative/friend not living with you \_\_\_\_\_  
 Referring Physician \_\_\_\_\_ Physician Phone \_\_\_\_\_  
 Physician Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
 COS MD Referred By:  Physician  Friend/Relative  Emergency Room  Yellow Pages  Other

**INSURANCE / BILLING INFORMATION**

**Primary**

Insurance Co. \_\_\_\_\_ Policy/ID # \_\_\_\_\_ Group # \_\_\_\_\_  
 Subscriber's Name \_\_\_\_\_ Subscriber's Employer \_\_\_\_\_ Phone # \_\_\_\_\_  
 Subscribers Social Security # \_\_\_\_\_ Subscribers Date of Birth \_\_\_\_\_  
 Patient's Relationship to Subscriber:  Self  Spouse  Child  Other - Explain \_\_\_\_\_  
 Subscribers Address \_\_\_\_\_  
 (If different from Patients)

**Secondary**

Insurance Co. \_\_\_\_\_ Policy/ID # \_\_\_\_\_ Group # \_\_\_\_\_  
 Subscriber's Name \_\_\_\_\_ Subscriber's Employer \_\_\_\_\_ Phone # \_\_\_\_\_  
 Subscribers Social Security # \_\_\_\_\_ Subscribers Date of Birth \_\_\_\_\_  
 Patient's Relationship to Subscriber:  Self  Spouse  Child  Other - Explain \_\_\_\_\_  
 Subscribers Address \_\_\_\_\_  
 (If different from Patients)

Attorney's Name \_\_\_\_\_ Phone # \_\_\_\_\_  
 (Only if applicable) Name and Address \_\_\_\_\_

**INSURANCE AUTHORIZATION AND ASSIGNMENT**

I hereby authorize (a) payment of insurance benefits otherwise due to me to be made directly to Connecticut Orthopaedic Specialists, P.C., and (b) understand that I am financially responsible for payment to Connecticut Orthopaedic Specialists, P.C. for charges related to services provided or incurred by me or my dependents, including items not covered by my insurance. I hereby agree to pay a service charge to COS in the event I provide a check which is not honored by my bank and returned for "insufficient funds".

Signature \_\_\_\_\_ Date \_\_\_\_\_

**ACKNOWLEDGEMENT OF HIPAA / NOTICE OF PATIENT PRIVACY AND HEALTH**

I have received the notice of Use and Disclosure of Protected Information. I understand this notice and have had the opportunity to ask questions regarding any matters of concern. I hereby authorize the release of information to others as needed for COS to receive payment.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Pediatric Patient Registration**

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last \_\_\_\_\_ Age \_\_\_\_\_

Why are you bringing this child to the office? \_\_\_\_\_

If injury, date injury occurred and how? \_\_\_\_\_

Who else has seen your child for this problem? \_\_\_\_\_

Who is your child's primary health care provider? \_\_\_\_\_

Does your child take any medications? . . . . .  Yes  No

If yes, which ones? \_\_\_\_\_

Is your child allergic to anything? . . . . .  Yes  No

If yes, describe medication and reaction \_\_\_\_\_

Has your child had any of the following:

- |                           |  |                                  |  |                        |  |
|---------------------------|--|----------------------------------|--|------------------------|--|
| Blueness(cyanosis)        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Easy Bruising                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Broken bones           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pneumonia                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | High blood pressure              | <input type="checkbox"/> Yes <input type="checkbox"/> No | What kind(s)?and dates | _____  |
| Asthma                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight loss                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____                  | _____  |
| Blood in urine            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Joint pain                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____                  | _____  |
| Urine or Kidney infection | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tiring easily                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Operations             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood transfusion         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Anemia (low blood count)         | <input type="checkbox"/> Yes <input type="checkbox"/> No | What kind(s)?and dates | _____  |
| Head injury               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures (with or without fever) | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____                  | _____  |
| Been unconscious          | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                  |  | _____                  | _____  |

Birth date of child's mother: \_\_\_\_\_  
 Birth date of child's father: \_\_\_\_\_  
 Mother's occupation \_\_\_\_\_ Father's occupation \_\_\_\_\_  
 Has there been any recent travel?  Yes  No If yes, where? \_\_\_\_\_

Have any of the child's parents, grandparents, brothers, or sisters, aunts or uncles, or cousins had any of the following?

		Relationship		Relationship
Anesthesia complications	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Clubfoot	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Drug allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Curvature of spine	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Spina bifida	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Urine or kidney trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Congenital heart disease (from birth)	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Childhood cancer or leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Muscle disease	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Hip trouble (childhood) if yes, what kind?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Nerve disease	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Hip trouble (adult) if yes, what kind?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Birth defects	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Hyperactivity	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Hearing loss	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
			Eye disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
			Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No _____

If answered yes to any of the above, please describe in detail:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Pediatric Patient Registration**

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last \_\_\_\_\_ Age \_\_\_\_\_

List all pregnancies of patient's mother in order, giving birth dates of all children including patient. Please include all pregnancies regardless of outcome.

Child's Name	Birth Date	Sex	
		M	F
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

Check if any of the following conditions were present during your pregnancy with this child. Mark in which of the 9 months each occurred

Fever	<input type="checkbox"/>	_____ month	Hospitalizations	<input type="checkbox"/>	_____ month
Rash	<input type="checkbox"/>	_____ month	Reason	_____	_____ month
German Measles	<input type="checkbox"/>	_____ month	Weight gain		
Operations	<input type="checkbox"/>	_____ month	Over 35 pounds	<input type="checkbox"/>	_____ month
Injuries or Accidents	<input type="checkbox"/>	_____ month	Over 15 pounds	<input type="checkbox"/>	_____ month
High Blood Pressure	<input type="checkbox"/>	_____ month	Took non-prescription medicines	<input type="checkbox"/>	_____ month
Bleeding	<input type="checkbox"/>	_____ month	Types: _____		_____ month
X-rays	<input type="checkbox"/>	_____ month	Rh problems	<input type="checkbox"/>	_____ month
What kind? _____		_____ month	Other troubles or conditions	<input type="checkbox"/>	_____ month
Anemia (Low blood count)	<input type="checkbox"/>	_____ month	Explain: _____		_____ month
Diabetes	<input type="checkbox"/>	_____ month	Exposure to toxic products	<input type="checkbox"/>	_____ month
Early labor	<input type="checkbox"/>	_____ month	e.g. pesticides, cigarettes, alcohol, or drugs		_____ month
		_____ month	Prescriptions	<input type="checkbox"/>	_____ month
			Types: _____		_____ month

Was this child born by . . . . .  Cesarean birth  Normal birth

Was this child born breech birth (bottom first) . . . . .  Yes  No

Was this child a twin? . . . . .  Yes  No

    If yes, was other twin identical . . . . .  Yes  No

    If yes, was other twin stillborn . . . . .  Yes  No

Was mother in labor with this child over 24 hours? . . . . .  Yes  No

Was this child born on time? . . . . .  Yes  No

Was he/she born early (premature)? . . . . .  Yes  No

    if yes . . . . . Number of weeks \_\_\_\_\_

Was he/she born late? . . . . .  Yes  No

    if yes . . . . . Number of weeks \_\_\_\_\_

Were there any problems noted at delivery? . . . . .  Yes  No

Did he/she have to go to a special care nursery? . . . . .  Yes  No

Child's birth weight was? . . . . . \_\_\_\_\_ Pounds \_\_\_\_\_ Ounces

Child's birth length was? . . . . . \_\_\_\_\_ Inches

How old was the child when he/she first left the hospital? . . . . . \_\_\_\_\_ Days

**Pediatric Patient Registration**

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last \_\_\_\_\_ Age \_\_\_\_\_

During child's first week of life, did he/she have any of the following?

Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Yellow jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excess vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blueness (cyanosis)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures(convulsions)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No
Need of oxygen	<input type="checkbox"/> Yes <input type="checkbox"/> No	Infection	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breathing trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Poor muscle tone (floppiness)	<input type="checkbox"/> Yes <input type="checkbox"/> No	name them: _____	

During the child's first 12 months was he/she troubles with any of the following?

Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Colic	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ear infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Slow weight gain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleep problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Feeding problems	<input type="checkbox"/> Yes <input type="checkbox"/> No

Give age when child first rolled over . . . . . \_\_\_\_\_ Months

Give age when child first walked without holding on . . . . . \_\_\_\_\_ Months

Give age when child first started speaking single words . . . . . \_\_\_\_\_ Months

Give age when child first used 2 or 3 word sentences . . . . . \_\_\_\_\_ Months

Give age when child first learned to tie his shoes . . . . . \_\_\_\_\_ Months

Give age when child had complete bowel control . . . . . \_\_\_\_\_ Months

Give age when child had complete urine control . . . . . \_\_\_\_\_ Months

Does the child now wet the bed? . . . . .  Yes  No

Does he/she wet pants during the day? . . . . .  Yes  No

School name \_\_\_\_\_ Grade \_\_\_\_\_

Any special classes? . . . . .  Yes  No

Child's school marks are: . . . . .  Below average  Average  Above average

Has child repeated any grades? . . . . .  Yes  No

Does child play well with other children? . . . . .  Yes  No