



Pediatric Patient Registration

Registration form fields: 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, Mothers Name, Whom we may contact in case of emergency, Referring Physician, etc.

INSURANCE / BILLING INFORMATION

Insurance and Billing Information form: Primary and Secondary insurance details, including Insurance Co., Policy/ID #, Group #, Subscriber's Name, etc.

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...

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.

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? _____

If this injury occurred in sports, which sport? _____
 If injury occurred at school, name of school? _____

Was there immediate swelling? Yes No
 If lower extremity, could child walk? Yes No

Who else has seen your child for this problem? _____
 Physician _____
 Emergency Room _____
 Which Hospital _____

Was a fracture set (reduced)? Yes No
 Was a cast applied? Yes No
 Was a splint applied? Yes No

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:

Blood in urine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Broken bones	<input type="checkbox"/> Yes <input type="checkbox"/> No
Head injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	What kind(s)?and dates	_____
Been unconscious	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tiring easily	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Easy Bruising	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia		_____	_____
Anesthesia		(low blood count)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Operations	<input type="checkbox"/> Yes <input type="checkbox"/> No
difficulties	<input type="checkbox"/> Yes <input type="checkbox"/> No			What kind(s)?and dates	_____
				_____	_____
				_____	_____

FAMILY HISTORY

Drug allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Spina bifida or other		_____
Seizures (convulsions)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	spinal disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Congenital heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Birth defects	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	(from birth)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Other heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Mental illness	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Muscle disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Nerve disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Died in childhood	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Hearing loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Urine or kidney trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Eye disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Childhood cancer or		_____	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Hip trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Hyperactivity	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
if yes, what kind?	_____	_____	Other (specify):	_____	_____

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

