HUDSON HEIGHTS PEDIATRICS
NEWBORN REGISTRATION FORM

PATIENT INFORMATION

*Last Name:________________________ *First Name:________________ *Middle Name:________________ *Birthdate: _________ *Sex: M / F

*Street Address/Apt. #:____

City:____ State:____________________ Zip:____________________

Race ____________________ Ethnicity (please circle) Hispanic / Non-Hispanic / Other Language(s) spoken____________________

With whom does the child live? (please circle) Both Parents / Mother / Father / Shared Custody / Grandparents / Legal Guardian / Other

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If any information is the same as that listed above, you may write 'same' in the sections below.

PARENT 1 INFORMATION – *(PRIMARY CONTACT PERSON)*

***Parent's name** ____ Sex: M / F ***Birthdate** ________________

Parent's address ____

City ____State____________________Zip____________________

***Primary Phone #**________________________________**cell / home / work** ***Consent to text: Y / N**

Secondary Phone # (if applicable)____________________**cell / home / work** ***Email (for patient portal)**________________________

Occupation____ Employer's name ________________________________

Marital status: Single / Married / Divorced / Domestic Partner Spouse's/Partner's name ________________________________

PARENT 2 INFORMATION

***Parent's name** ____ Sex: M / F ***Birthdate**________________

Parent's address ____

City ____ State ____________________ Zip ____________________

***Primary Phone #**________________________________**cell / home / work** ***Consent to text: Y / N**

Secondary Phone # (if applicable)____________________**cell / home / work** ***Email (for patient portal)**________________________

Occupation ____Employer's name ________________________________

Marital status: Single / Married / Divorced / Domestic Partner Spouse's/Partner's name ________________________________

IF PARENTS ARE DIVORCED OR SEPARATED:

Who has custody? ____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? **Y / N**

If yes, please explain below. **We will need a copy of any legal paperwork that supports this restriction.**

____

OTHER PEOPLE IN HOUSEHOLD (including siblings)

Name / Relationship / Sex / Age ____

Name / Relationship / Sex / Age ____

Name / Relationship / Sex / Age ____

EMERGENCY CONTACT INFORMATION (other than parents or guardians)

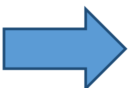
Name ____

Relationship ____ Phone ______________________________

PREFERRED PHARMACY

Name ____ Address ____

Phone ____ Fax ____



PLEASE READ AND SIGN ALL LINES

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any charges not covered by my insurance carrier. I also authorize my medical provider or insurance company to release any information required to process my claims. A copy of this signature is to be used in place of the original.

Patient/Parent/Guardian Signature____ Date_____________

RECEIPT OF HIPAA OF PRIVACY PRACTICES ACKNOWLEDGEMENT

The Notice of Privacy Practices describes how Protected Health Information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

Hudson Heights Pediatrics is required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice which describes the health information privacy practices of our practice, its medical staff and affiliated health care providers that jointly perform payment activities and business operations with our practice. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

I have received the notice of Privacy Practices as is required by State and Federal Regulations

Patient/Parent/Guardian Signature____ Date_______________

PRESCRIPTION HISTORY PROGRAM

I authorize Hudson Heights Pediatrics to obtain my/my child's medication history.

Patient/Parent/Guardian Signature____ Date_______________

PRIMARY INSURANCE INFORMATION

Name of Policy Holder______________________________ Relationship to patient ______________________________

SSN______________________________ Birthdate______________________________ Sex: M / F

Insurance carrier name______________________________ Policy number______________________________

Employer's name______________________________ Group number______________________________

Employer's address____

City______________________________ State______________________________ Zip______________________________

Employer's phone______________________________

SECONDARY INSURANCE (IF ANY)

Name of Policy Holder______________________________ Relationship to patient ______________________________

SSN______________________________ Birthdate______________________________ Sex: M / F

Insurance carrier name______________________________ Policy number______________________________

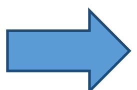
Employer's name______________________________ Group number______________________________

Employer's address____

City______________________________ State______________________________ Zip______________________________

Employer's phone______________________________

Who is responsible for bills? (please circle) Both Parents / Mother / Father / Grandparents / Legal Guardian / Other



Welcome to Hudson Heights Pediatrics! We're glad you are joining the practice. In order to give your child the best possible care, we will need detailed information about your child's and family's medical history.

FAMILY HEALTH HISTORY

- Asthma Who? ____________________
- Bleeding Disorders / Hemophilia Who? ____________________
- Cancer Who? ____________________
- Chemical Dependency Who? ____________________
- Developmental Disability / Genetic Disorder Who? ____________________
- Diabetes Who? ____________________
- Hip Problems in Person < 50 yrs Who? ____________________
- Hearing Loss Who? ____________________
- Heart Disease Who? ____________________
- High Blood Pressure Who? ____________________
- High Cholesterol Requiring Medication Who? ____________________
- Kidney Disease Who? ____________________
- Mental Illness Who? ____________________
- Migraine Who? ____________________
- Seizures / Epilepsy Who? ____________________
- Sudden Death in Person < 55 yrs Who? ____________________
- Tuberculosis Who? ____________________
- Other ____________________

BIRTH HISTORY

Which pregnancy is this child? ____________________

Is your child adopted? Y / N *If so, please describe the following to the best of your knowledge.*

Did the mother have any health problems during the pregnancy? Y / N

If yes, please describe____________________

Hospital / city of birth____________________

Any previous miscarriage? Y / N

If yes, reason?____________________

Born by vaginal delivery or c/section?____________________If c/section, reason____________________

How many weeks gestation at birth?____________________

Birth weight____________________APGAR score (if known)____________________

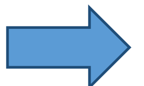
Did the child leave the hospital with the mother? Y / N Length of hospital stay____________________

If no, reason____________________

Please list problems, if any, after birth (jaundice, feeding problems, infections, etc)____________________

Thank you, and we are excited to get to know you and your children.

Joseph Richter, MD
Jessica Wang, MD
Cathy-Marie Hamlet, MD



Office Policies

Cancellation/Missed Appointment Policy:

If you are unable to make your appointment it must be canceled 24 hours in advance. If you must cancel your appointment less than 24 hours before its scheduled time or fail to show up for your appointment there will be a $20 cancellation fee. **You are responsible for payment of the fee.**

Late Policy:

Hudson Heights Pediatrics strongly enforces our 20 minute rule. **If you arrive 20 minutes or more late for your Well Child or Follow-Up Appointment you will be re-scheduled.** The reason for this rule is to attempt to keep as close to schedule as possible. If you are late for an appointment, your time runs into the next scheduled appointment and so on. Other patients who have arrived on time will be forced to wait. Please be courteous to those who are scheduled after your visit.

We know that your time is valuable, but emergencies do occur. We ask for your understanding while waiting in the office. All visits are given the necessary time.

Forms Policy:

Our office receives a great deal of forms, all of which must be reviewed and signed by a doctor. Please get all school, daycare, and camp forms to our office as early as possible! **Our doctors can only complete a form if your child has been seen for a *wellness visit* in the past 12 months**. Forms will be completed within seven days to ten days after we receive them in the office.

There is a $5 fee for forms. The only exception to the $5 fee are WIC forms, which will be completed either during your appointment or within 24-hours of your request.

Otherwise, if you need your form expedited, we can have it ready for you in 24 hours for a $20 fee. *If you send us a form, please contact us to ensure that we have received it.

Vaccine Policy:

In the interest of the safety of our patient base, we require all families to adhere to the minimum guidelines issued by the New York City Department of Health and Mental Hygiene regarding School Admission Immunization Requirements. We believe it is important for children and adults to get vaccinated to help protect communities by slowing or stopping disease outbreaks. While all patients must receive full vaccinations, any concerns can be discussed with a doctor. Our suggested vaccine schedule is available on our website. **If you are unable to commit to completing vaccines within one year of when they are required, we cannot continue to care for your children in this practice.**

Code of Conduct:

We strive to make Hudson Heights Pediatrics a welcoming environment for all of our patients and caregivers. Upon arriving in our office, please check in with reception. If the area is busy, please be as understanding as possible. The waiting area is equipped with books and toys to entertain the children while they are waiting to be seen. While you are waiting, we ask that you please:

1. Be respectful in your interactions with the staff and other caregivers
2. If you need to make a call, please speak in hushed tones so as not to disturb others
3. Supervise your children while they are playing
4. Bring any interpersonal issues to the attention of the staff that are sitting at reception so that we can address your needs

Please note, we do not tolerate sustained raised voices, verbal threats, and physical acts of aggression, and will be forced to notify our security. While the receptionists will try their very best to answer all of your queries, if you are unsatisfied with your service in the office we have a practice manager who you can ask to speak to at any time.

Please sign to acknowledge that you have read and consent to these policies

Patient/Parent/Guardian Signature____ Date_____________