PEACOCK PEDIATRICS
PEDIATRIC PATIENT REGISTRATION FORM

All areas in the form are required to be completed and shot records must be received before scheduling occurs.
Please email all completed forms for St. Joseph to: info@peacockpediatrics.com
Please email all completed forms for Platte City to: plattecity@peacockpediatrics.com

Today's Date:_____

Do you vaccinate for all state required vaccines? Y / N (If NO, you will need to seek another physician office)

Transferring from: Office/Dr. _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

Requestor Name: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Relationship to patient: _____
Email: _____ Would you like Patient Portal access? Y / N

(Circle) Requested Provider: **St. Joseph:** DR. CEBULKO DR. WILLIAMS DANA KAPP SARAH SASS
Platte City: DR. FORD GENESE MARSHALL

1. PATIENTS NAME: Last_____ First_____ Middle_____
Date of Birth:_____ (Circle) Gender: M / F School_____
MEDICAL HISTORY/DIAGNOSIS: #1_____ #2_____ #3_____
CURRENT MEDICATIONS: #1_____ #2_____ #3_____
ANY CONCERNS? _____
INSURANCE: Primary_____ Member/Subscriber #_____
Secondary_____ Member/Subscriber #_____
RACE_____ ETHNICITY_____ LANGUAGE_____

2. PATIENTS NAME: Last_____ First_____ Middle_____
Date of Birth:_____ (Circle) Gender: M / F School_____
MEDICAL HISTORY/DIAGNOSIS: #1_____ #2_____ #3_____
CURRENT MEDICATIONS: #1_____ #2_____ #3_____
ANY CONCERNS? _____
INSURANCE: Primary_____ Member/Subscriber #_____
Secondary_____ Member/Subscriber #_____
RACE_____ ETHNICITY_____ LANGUAGE_____

Secondary Contact Name: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Relationship to patient: _____ Live with patient? Y / N

Peacock Staff Use Only_____
ACCEPTED: Y/N Dr. C_____ Dr.W_____ Dr.F_____ DK_____ SS_____ GM_____

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE AND SIGN

I. I, _____, hereby voluntarily authorize the disclosure of information from my health record. *(Name of Patient)*

II. **The information is to be disclosed by:**	**And is to be provided to:**
NAME OF FACILITY:	NAME OF PERSON/ORGANIZATION/FACILITY:
ADDRESS:	ADDRESS:
CITY/STATE:	CITY/STATE:
PHONE:	PHONE: FAX:

III. The purpose or need for this disclosure is:

☐Further Medical Care ☐Attorney ☐School ☐Research ☐Other (Specify): _____

☐Personal Use ☐Insurance ☐Disability ☐Health Information Exchange:_____

IV. The information to be disclosed from my health record: *(check appropriate box(es))*

- ☐ Immunization Record
- ☐ Growth Charts
- ☐ Last Well Child Check or Preventative Visit (Wellness)
- ☐ Office visits or referrals related to Chronic Conditions
- ☐ Office visits or referrals related to Behavior Health/ADHD Managements
- ☐ Diagnostic Labs or Imaging
- ☐ Referrals to specialists
- ☐ Entire Record

☐ Only the period of events from _____ to _____ ☐ Other (specify): _____

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment

☐ Sexually Transmitted Diseases ☐ Mental Health *(Other than Psychotherapy Notes)*

V. I understand that I may revoke this authorization in writing submitted at any time to the organization, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or *expiration event* is stated.

_____

(Specify new date)

I understand that Peacock Pediatrics will not condition treatment or eligibility for care on my providing this authorization except if such care is (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party. I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164].

Signature of Patient or Personal Representative *(State relationship to patient)*	Date
Signature of Witness	Date

PATIENT IDENTIFICATION

Name (Last, First, MI):_____ Date of Birth: _____

Peacock Pediatrics

An Affiliate of Children's Mercy

PROUDLY PROVIDING PERSONALIZED CARE FOR CHILDREN OF EVERY AGE AND EVERY STAGE

PATIENT INFORMATION

Patient's Name:_____ Date of Birth:_____

Do you consider your child to be in good health? ☐ Yes ☐ No

Do you have any concerns about your child's health? ☐ Yes ☐ No

If yes, please explain:_____

PAST MEDICAL HISTORY (PLEASE CIRCLE ALL THAT APPLY)

Asthma	Bed Wetting	Constipation	Seasonal Allergies
Crossed Eyes	Migraines	ADHD	Multiple Ear Infections
Preterm Infant	Bronchiolitis	Eczema	Urinary Tract Infection
Seizures	Concussion	Reflux	Other (please list):

SURGICAL HISTORY (PLEASE CIRCLE ALL THAT APPLY)

Adenoids removed	Hernia repair	PE (ear tubes)	Pyloric stenosis repair
Appendix removed	Hypospadias repair	Tonsillectomy	Circumcision
Nasal Cauterization	Strabismus repair	Other (please list):	

BIOLOGICAL FAMILY HISTORY (Please only provide the family members listed below)

Parents (M = Mother F = Father), *Siblings* (S = Siblings), and *Grandparents* (M = Maternal & P = Paternal)

ADHD	M	F	S	MG	PG	*Chron's Disease*	M	F	S	MG	PG	*High Cholesterol*	M	F	S	MG	PG
Alcoholism	M	F	S	MG	PG	*Cystic Fibrosis*	M	F	S	MG	PG	*Hypothyroidism*	M	F	S	MG	PG
Allergies (seasonal)	M	F	S	MG	PG	*Depression*	M	F	S	MG	PG	*Learning Disability*	M	F	S	MG	PG
Anemia	M	F	S	MG	PG	*Developmental Disability*	M	F	S	MG	PG	*Leukemia*	M	F	S	MG	PG
Anxiety	M	F	S	MG	PG	*Diabetes*	M	F	S	MG	PG	*Migraine*	M	F	S	MG	PG
Arrhythmia	M	F	S	MG	PG	*Drug Allergy*	M	F	S	MG	PG	*Seizures*	M	F	S	MG	PG
Asthma	M	F	S	MG	PG	*Eating Disorder*	M	F	S	MG	PG	*Sickle Cell Trait*	M	F	S	MG	PG
Bleeding Disorder	M	F	S	MG	PG	*Hearing Loss*	M	F	S	MG	PG	*SIDS*	M	F	S	MG	PG
Celiac Disease	M	F	S	MG	PG	*Heart Attack (<50 y/o)*	M	F	S	MG	PG	*Tuberculosis*	M	F	S	MG	PG
Congenital hip dysplasia	M	F	S	MG	PG	*High Blood Pressure*	M	F	S	MG	PG	*Ulcerative Colitis*	M	F	S	MG	PG
Other:	M	F	S	MG	PG	☐ **Adopted Family – history unknown.**											

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