

PATIENT REGISTRATION

Date: \_\_\_\_\_

ROCKY MOUNTAIN PEDIATRIC SURGERY

Patient First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_ Home phone: \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Male \_\_\_\_\_ Female \_\_\_\_\_ SSN \_\_\_\_\_

**\*\*About the Mother:**

Name (First, Last) \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ SS# \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Employer \_\_\_\_\_ Employer phone \_\_\_\_\_

**\*\*About the Father:**

Name (First, Last) \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ SS# \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Employer \_\_\_\_\_ Employer phone \_\_\_\_\_

**\*\*\*\*\*Referring/Primary Care Physician Information:\*\*\*\*\***

Physician - Name: \_\_\_\_\_

Name of Practice \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_ Fax Number: \_\_\_\_\_

**Group Health Insurance Information )**

Primary Insurance Name: \_\_\_\_\_ Customer Services Phone#. \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Policy Holder Employer: \_\_\_\_\_ Phone #: \_\_\_\_\_

Group/Policy #: \_\_\_\_\_ ID Number: \_\_\_\_\_

Secondary Insurance Name: \_\_\_\_\_ Customer Service Phone # \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Policy Holder Employer: \_\_\_\_\_ Phone #: \_\_\_\_\_

Group/Policy #: \_\_\_\_\_ ID Number: \_\_\_\_\_

**ROCKY MOUNTAIN PEDIATRIC SURGERY  
Patient Consent Form**

*(Please Read and Sign)*

I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that Rocky Mountain Pediatric Surgery may include consent at satellite offices under common ownership.

I, the undersigned, acknowledge that Rocky Mountain Pediatric Surgery will use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

I acknowledge that I have been given the Rocky Mountain Pediatric Surgery Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official. Patient Initial:

\*\*\*\* \_\_\_\_\_ \*\*\*\*

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

\_\_\_\_\_  
**Patient (or Responsible Party) Signature**

\_\_\_\_\_  
**Date**

**General Information**

Patient Name \_\_\_\_\_

Reason for Visit \_\_\_\_\_

Pediatrician of Family Doctor \_\_\_\_\_

How much does your child weigh currently? \_\_\_\_\_

**Birth History**

How much did you child weigh at birth? \_\_\_\_\_ pounds \_\_\_\_\_ ounces

If you child was born early (premature), how many weeks? \_\_\_\_\_ weeks

Was the child born vaginally or by C-section?     Vaginally                       C-Section

Was the child jaundiced (yellow) as a newborn?                       Yes                                       No

Did the child require oxygen or a ventilator in the nursery?     Oxygen     Ventilation     None

How old was the child at discharge from the hospital? \_\_\_\_\_ (Age)

**Medical History**

Please list any hospitalizations                       None

Age \_\_\_\_\_ Reason for Hospitalization \_\_\_\_\_

Age \_\_\_\_\_ Reason for Hospitalization \_\_\_\_\_

Age \_\_\_\_\_ Reason for Hospitalization \_\_\_\_\_

Age \_\_\_\_\_ Reason for Hospitalization \_\_\_\_\_

**Surgical History**

Please list any operations (and approximate age). Please tell us if there were anesthetic problems.

Age \_\_\_\_\_ Operation \_\_\_\_\_

Age \_\_\_\_\_ Operation \_\_\_\_\_

Age \_\_\_\_\_ Operation \_\_\_\_\_

Age \_\_\_\_\_ Operation \_\_\_\_\_

Anesthetic problems? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies**

Please list all known allergies

Medications \_\_\_\_\_ Reaction \_\_\_\_\_

Medications \_\_\_\_\_ Reaction \_\_\_\_\_

Medications \_\_\_\_\_ Reaction \_\_\_\_\_

Foods \_\_\_\_\_ Reaction \_\_\_\_\_

Foods \_\_\_\_\_ Reaction \_\_\_\_\_

Other \_\_\_\_\_ Reaction \_\_\_\_\_

Latex       Yes       No

**Current Medications**

Please list all medications your child takes now.

Medication \_\_\_\_\_ Dose and frequency \_\_\_\_\_

Medication \_\_\_\_\_ Dose and frequency \_\_\_\_\_

Medication \_\_\_\_\_ Dose and frequency \_\_\_\_\_

Medication \_\_\_\_\_ Dose and frequency \_\_\_\_\_

**Health Problems**

Please check any of the following that apply to your child.       None

- |                                             |                                            |                                                |                                            |
|---------------------------------------------|--------------------------------------------|------------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Asthma            | <input type="checkbox"/> Croup                 | <input type="checkbox"/> Bronchitis        |
| <input type="checkbox"/> RSV/Bronchiolitis  | <input type="checkbox"/> Ear Infections    | <input type="checkbox"/> Strep throat          | <input type="checkbox"/> Sinus infections  |
| <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Thyroid Problems  | <input type="checkbox"/> Skin Problems         | <input type="checkbox"/> Hearing Loss      |
| <input type="checkbox"/> Vision Problems    | <input type="checkbox"/> Anemia            | <input type="checkbox"/> Broken Bones          | <input type="checkbox"/> Kidney Disease    |
| <input type="checkbox"/> Urinary Infections | <input type="checkbox"/> Seizures          | <input type="checkbox"/> Heart Murmur          | <input type="checkbox"/> Chronic Headaches |
| <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Frequent Constipation | <input type="checkbox"/> Reflux Disease    |

**Immunizations**

- Are all immunizations up to date?  Yes  No
- Has your child had Chicken Pox?  Yes  No
- Has your child had the Chicken Pox vaccine?  Yes  No

**Bleeding Problems**

- Does your child have hemophilia or von Willebrand's Disease?  Yes  No
- Does your child bruise easily?  Yes  No
- Does your child have chronic nose bleeds or bleeding gums?  Yes  No
- Is there any family history of bleeding disorders?  Yes  No

If yes who? \_\_\_\_\_ Relation \_\_\_\_\_

**Adolescent History**

- What age did menstruation begin? \_\_\_\_\_ Date of last period \_\_\_\_\_
- Are periods regular?  Yes  No
- Does the child smoke?  Yes  No

**Family History**

Please list ages of siblings and parents and describe medication allergies, problems with anesthesia, and chronic illnesses. (like asthma, diabetes, etc)

- Mother name \_\_\_\_\_ Age \_\_\_\_\_ Health information \_\_\_\_\_
- Father name \_\_\_\_\_ Age \_\_\_\_\_ Health information \_\_\_\_\_
- Sibling name \_\_\_\_\_ Age \_\_\_\_\_ Health information \_\_\_\_\_
- Sibling name \_\_\_\_\_ Age \_\_\_\_\_ Health information \_\_\_\_\_
- Sibling name \_\_\_\_\_ Age \_\_\_\_\_ Health information \_\_\_\_\_

Has anyone in the family had an abnormal reaction to general anesthesia?  Yes  No

**Is there anything else you want us to know about you child?**

Please describe any other concerns you want us to address or things you think we should know to protect you child during their clinic visit, operation, or hospitalization.

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