

DOWD MEDICAL ASSOCIATES

PEDIATRICS

FAMILY REGISTRATION

PARENT-GUARDIAN-RESPONSIBLE PARTY

DATE:

Names _____

Address _____ Hm# _____

_____ Cell# _____

_____ Zip _____ Work# _____

CHILDREN

Name _____ DOB _____ PCP _____

Name _____ DOB _____ PCP _____

Name _____ DOB _____ PCP _____

Name _____ DOB _____ PCP _____

Name _____ DOB _____ PCP _____

PRIMARY INSURANCE NAME _____ *DOB-*

CARDHOLDER _____ ID# _____ GROUP# _____

SECONDARY INSURANCE NAME _____

CARDHOLDER _____ ID# _____ GROUP# _____

PLEASE MAY WE COPY YOUR INSURANCE CARD TO BE ACCURATE IN OUR CLAIMS SUBMISSION.

I authorize the release of medical information necessary to process claims for medical benefits. I authorize payment of medical benefits to Dowd Medical Associates for services provided. I acknowledge that any payment due is my responsibility and that co-payments are due at the time of the visit.

Signature _____ Date _____

Acknowledgement of Receipt of Notice of Privacy Practices

I _____ acknowledge that I have read or received a copy of Dowd Medical Associates Notice of Privacy Practices. This notice describes how Dowd Medical Associates may use and disclose my protected health information, and rights, I may have regarding my protected health information.

Signature _____ Date _____

01/07

IDENTIFICATION SHEET

Please leave this side blank; office use

Family name:

Family Health History

Mother:

Occupation:

Father:

Occupation:

Address:

Phone:

Cell/business:

Children's names

Date of birth

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

Others living at home:

- | | | |
|----------------|---------------|---------------|
| 1) MI | 7) Hayfever | 13) Vision v |
| 2) Angina | 8) Asthma | 14) DES |
| 3) BP | 9) Excema | 15) Bleeding |
| 4) Smoking | 10) Allergies | 16) Rx anesth |
| 5) Cholesterol | 11) Ear info | 17) Drug Rx |
| 6) Diabetes | 12) Hearing | 18) |

Pharmacy (name & phone)

Source of referral:

Medical Insurance:

Emergency phone number:

WHAT THINGS ARE IMPORTANT TO YOU IN YOUR CHILD'S HEALTH CARE?

NOTES



**MASSACHUSETTS IMMUNIZATION PROGRAM
VACCINES FOR CHILDREN PROGRAM
MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH**

Patient Eligibility Screening Form

Date _____

Child's full name _____

Date of birth _____

Parent, guardian, or legal representative's full name _____

Health care provider's full name _____

This form must be completed for all children under 19 years old and kept in the child's medical record or on file in the office. The form may be completed by the parent, guardian, or legal representative, or by the health care provider. This form should be completed only once, unless the child's insurance status changes. Verification of responses is not required.

Check only one box below

This child:

- is enrolled in Medicaid (includes MassHealth and HMOs, etc., if enrolled through Medicaid)
- does not have health insurance (also check this box for children enrolled in the Children's Medical Security Plan)
- is Native American (American Indian) or Alaskan Native
- has health insurance and is not Native American (American Indian) or Alaskan Native

Please note that all children seen in Massachusetts practices get the same free vaccines. This form tells us which children get vaccines paid for by the federal VFC Program (first three boxes) and which get vaccines paid for by state and other federal funds (last box).

Only children deemed to have increased risk of exposure to persons with TB (ie Tuberculosis) should be considered for TB skin testing. Please answer the questions below so we may appropriately assess your child's risk to TB.

YES NO

1) Is your child in contact with anyone with confirmed or suspected TB? _____

2) Is your child a recent immigrant from an endemic country (Asia, Middle East, Africa, Latin America) or in significant contact with people from these countries or with people who repeatedly travel to endemic countries? _____

3) Is your child regularly exposed to anyone who is immunocompromised and therefore at potentially greater risk for contracting TB? _____

4) Is your child in regular contact with any of the following persons:
Homeless, Nursing Home Residents, Institutionalized persons, Drug abusers, Migrant Farm workers, Persons currently imprisoned or imprisoned within the last 5 years, Foster children with exposure to adults in the preceding high risk groups? _____

If your answer is YES to any of the above, your child will be given a Mantoux TB skin test in accordance with the American Academy of Pediatrics guidelines.

I have read and answered or reviewed previous answers to the above questions to the best of my ability:

PARENT

REVIEWED BY:

DATE:

