## Las Vegas Pediatric Urology

# Pediatric Demographics Form

| | | |
|---|---|---|
| Patient's Name: | Preferred Name: | Age: |
| Patient's Social Security Number: | Date of Birth: | Sex: M / F |
| Home Address: Apt: | | |
| City: State: Zip: | | |

| | |
|---|---|
| **Mother's Name:** | **Father's Name:** |
| Social Security Number: | Social Security Number: |
| Address: | Address: |
| City: State: Zip: | City: State: Zip: |
| Cell phone #: | Cell phone #: |
| Home phone #: | Home phone #: |
| Email address: | Email address: |

| | | |
|---|---|---|
| If not birth parent, name of Legal Guardian: | | Relationship: |
| Emergency Contact: | Phone #: | Relationship: |

## Insurance Information

| | | |
|---|---|---|
| **<u>Primary Insurance</u>:** | Phone #: | |
| Claim Address: | City: State: Zip: | |
| Subscriber Name: | Policy #: | Group #: |
| Subscriber relationship to patient: | Subscriber DOB: | |
| Employer Name: | Phone #: | Occupation: |
| **<u>Secondary Insurance</u>:** | Phone #: | |
| Claim Address: | City: State: Zip: | |
| Subscriber Name: | Policy #: | |
| Subscriber relationship to patient: | Subscriber DOB: | |
| Employer Name: | Phone #: | Occupation: |

## Pediatric Patient Medical Information

Patient Name:_____

| | | |
|---|---|---|
| Pediatrician's Name: | | Referring MD name (if different): |
| Phone #: | Fax #: | Practice Name: |

**REASON FOR VISIT**:

_____

**UROLOGIC CONDITIONS**: [ ] Kidney issues [ ] Bladder issues [ ] Testicle issues
[ ] Penis issues [ ] Urinary tract infection [ ] Bedwetting / Urinary incontinence
[ ] _____

**ALLERGIES** to Medications: [ ] None _____ _____
Medication causing allergy Reaction

**CURRENT MEDICATIONS**: [ ] None _____ _____

_____ _____ _____ _____

**PHARMACY** Name: _____ Fax:_____

Street address: _____ City: _____ Zip Code:_____

**BIRTH HISTORY** (if patient less than 1 year old): [ ] Full Term
[ ] Premature--gestational age at birth:___wks [ ] NICU stay? If so, how long? _____

**MAJOR MEDICAL CONDITIONS**: [ ] None

| | | | |
|---|---|---|---|
| [ ] Congenital heart disease | [ ] Prematurity | [ ] Bleeding disorder | [ ] Asthma |
| [ ] Cerebral palsy | [ ] Spina bifida | [ ] Down Syndrome | |
| [ ] Diabetes (using insulin? Y / N ) | [ ] Autism | [ ] Other: _____ | |

**PRIOR SURGERIES**: [ ] None

_____ _____

**SOCIAL HISTORY**: [ ] Patient lives with parents, who are legal guardians.

[ ] Parents are divorced. Which parent has legal custody and can authorize medical care? _____

[ ] Patient is fully adopted. Adopting parents have full legal rights to authorize patient's medical care.

[ ] Patient is a foster child. Name of Foster Parent: _____

Name of Caseworker:_____ Phone#: _____

IMPORTANT: Please note that for surgery, a foster child will often need consent of the court. Moreover, the Caseworker may need to be present at the hospital on the day of surgery to sign consents, unless the foster parents are legally authorized by the court to sign all the legal consents. Please make all the necessary arrangements with the Caseworker when surgery is being scheduled to avoid delay and cancellation.

# Las Vegas Pediatric Urology

By signing below, I certify that I have reviewed and agree to the following:

- AUTHORIZATION AND AGREEMENT TO OFFICE POLICIES AND FEES
- NOTICE OF PRIVACY PRACTICES
- AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION
- PHYSICIAN-PATIENT ARBITRATION AGREEMENT

I understand that I may request to keep a copy of the above forms.
The forms are also available for review and download online at www.lasvegaspediatricurology.com.

I agree to mutual communication via regular mail, email, phone, fax, and text messages.

A photocopy of this authorization is as valid as the original.

_____ _____
Patient or Patient Representative Signature Date

_____ _____
Print Name of Patient or Patient Representative Social Security Number of signee

_____
Relationship to Patient (Self, Parent, or Legal Guardian)