Bucci Lancer Pediatrics
Patient Registration

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Child 1: Last Name: _____ First Name: _____ MI: _____

D.O.B.: _____/_____/_____ Sex: Male / Female Primary Language: _____

Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White /Unknown

Insurance Information

Primary Policy: Policy Holder's Name: _____

Policy Holder's Birth Date: _____ Policy Holder's Sex: Male / Female

Insurance Carrier: _____ Policy ID#: _____

Group #:_____

Secondary Policy: Policy Holder's Name: _____

Policy Holder's Birth Date: _____ Insurance Carrier: _____

Policy ID#: _____ Group #:_____

Child 2: Last Name: _____ First Name: _____ MI: _____

D.O.B.: _____/_____/_____ Sex: _____

IF INSURANCE INFO or other data IS DIFFERENT THAN CHILD 1, PLEASE NOTIFY STAFF

Child 3: Last Name: _____ First Name: _____ MI: _____

D.O.B.: _____/_____/_____ Sex: _____

IF INSURANCE INFO or other data IS DIFFERENT THAN CHILD 1, PLEASE NOTIFY STAFF

Contact Information

Name: _____

Relation to Patient: _____

Home Phone: (_____) _____ - _____

Cell Phone: (_____) _____ - _____

Preferred Email: _____

Mailing Address: _____

(Street or PO Box) (City) (State & Zip)

Please note cell phone will be used as default contact number for calls and appointment reminders

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Additional Contact Questions:

Who should receive billing statements? _____

If address different than above please note: _____

If parents are divorced or separated please fill out this section:
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? Yes / No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

_____

Assignment of Benefits:

I understand that I am responsible for the accuracy of the information I have provided on this form. I authorize payment of medical benefits directly to Bucci Lancer Pediatrics, LLC for all services rendered. I authorize release of any medical and/or additional information necessary for the processing of claims. If for any reason payment is not be made by my insurance carrier, I will be responsible for all fees incurred with Bucci Lancer Pediatrics, LLC as well as late fees for unpaid balances and all costs associated with collection agencies and/or attorney fees. I acknowledge that I have reviewed the Practice's HIPAA Notice of Privacy Practices and a copy will be provided to me at my request.

I understand that the parent/Guarantor who brings the child to the office for medical services is responsible at the time of service for co-payments, deductibles, balances and for payment in full for services that are not covered by insurance.

Guarantor Name: _____ Relationship: _____

Guarantor Signature _____ Date: _____

Second Guarantor Name: _____ Relationship: _____

Second Guarantor Signature _____Date: _____

Interval History Information

Patient Name_____ Date of Birth_____

Completed by: _____ Date Completed: _____

Allergy / Reaction Information

Medication Allergies: No: _____ Yes: ____ (explain below)

1 _____

(Medication) (Reaction)

2:_____

(Medication) (Reaction)

Non-Medication Allergies:

None: ___ Yes (please list):_____

Vaccine Reactions:

None: ___ Yes (please list): _____

Current Medications

1. _____

(Medication) (Dose)

2. _____

(Medication) (Dose)

3. _____

(Medication) (Dose)

4. _____

(Medication) (Dose)

Current Problem List
(i.e. Asthma, Migraine, etc.)

1._____

(Diagnosis)

2._____

(Diagnosis)

3._____

(Diagnosis)

Pertinent Past Medical History
(Check if Yes and provide details)

___ Serious Injuries Please list: _____

___ Surgeries Please list: _____

___ Hospitalizations Please list: _____

Pertinent Family Medical History:

Diagnosis	If positive family history- please list whom (PATERNAL VS MATERNAL)
Allergies	
Asthma	
Lung Disease	
Cancer	
High Blood Pressure	
High Cholesterol	
Diabetes (Type I vs II)	
Headache/Migraine	
Seizure Disorder	
Neurologic Disorder	
Heart Disease (less than 55 yo)	
Autoimmune Disorder	
Gastrointestinal Disease	
Blood Disorders i.e. sickle cell/thalasemia	
Mental Illness	
Birth Defects	
Hearing Loss	
Kidney Disease	
Thyroid Disease	
Learning Problems/ADHD	

Pertinent Social History:
Who lives in the home (*Information used to link patient accounts-if siblings listed previously, please do not include below).*

Name:_____ Date of Birth:_____/_____/_____ Relationship:_____
Occupation:_____

Name:_____ Date of Birth:_____/_____/_____ Relationship:_____
Occupation:_____

Name:_____ Date of Birth:_____/_____/_____ Relationship:_____
Occupation:_____

Guns in Home (circle) : Yes or No **If yes, Are guns in a locked safe?** Yes or No
Tobacco Exposure (circle) Yes or No
Pets (circle) Yes or No Type:_____

HIPPA Notice of Privacy Practices:

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. The HIPAA Notice of Privacy Practices describes how we may disclose your protected health information (PHI) to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographics, that may identify you and related to your past, present, or future physical or mental health or condition and related health care services.

Signature below is only recognition that you agree, for all children listed, to the HIPAA Notice of our Privacy Practices. A copy of the document will be provided to you upon request.

Print Name: _____

Signature: _____

Date: _____

Policies & Procedures:

Form 03082017 (Bucci Lancer Pediatrics Office Policies and Procedures) summarizes the Practice's protocol on matters related to insurance, cancellations, vaccine schedules, and other pertinent office information. A copy is available for you to review in the front office and on our website: buccilancermd.com. A copy of the document (Form 03082017) will also be provided to you upon request.

Signature below indicates that you fully understand and agree to the office and financial policies set forth by the practice, for each child listed above. The Practice may amend the terms of these policies at any time without prior notification.

Print Name: _____

Signature: _____

Date: _____