

**Shannon Scott Ellis, M.D.**

**Scott Gogulski, D.O.**

**3280 Henderson Drive Suite C, Jacksonville, NC 28546**

**Phone: 910-219-1713 Fax: 910-577-4984**

# Pediatric REGISTRATION FORM

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| (Please Print) | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Today’s Date: | | | | | | | | | | | | | | | | PCP: | | | | | | | | | | |
| PATIENT INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient’s full name: | | | | |  | | | | |  | | | | | Birth date: | | | | | Age: | | | | | Sex:  M  F | |
| Street address/ PO Box: | | | | | | | | | | | | | | | | | | | | | | | Social Security no. | | | |
| Home Phone:  (       ) | | | | | | | City: | | | | | | | | | | | State: | | | | ZIP Code | | | | |
| Father’s Name | | | Social Security no. | | | | | | | | | | | Date of Birth | | | | | | | Business Phone  (       ) | | | | | |
| Mother’s Name | | | Social Security no. | | | | | | | | | | | Date of Birth | | | | | | | Business Phone  (       ) | | | | | |
| Name of person not living with patient to contact for emergency | | | | | | | | | | | | | | | | | | | | | Phone: | | | | | |
| Chose clinic because/referred to clinic by (Please check one box): | | | | | | | | | | | | Dr. | | | |  | | | | | | | | Insurance plan | | Hospital |
| Family | Friend | Close to home/work | | | | | | | | Yellow Pages | | | | | | | | Other | | | | | | | | |
| Other family members seen here: | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| INSURANCE INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Primary Insurance Carrier Name | | | | | | | | Policy ID | | | | | | | | | | | | | Group# | | | | | |
|  | | | | | | | |  | | | | | | | | | | | | |  | | | | | |
| Insured’s Name: | | | | | | | | | | | Soc. Sec. No (if not listed above): | | | | | | | | | | Date of Birth (if not listed above) | | | | | |
|  | | | | | | | | | | |  | | | | | | | | | |  | | | | | |
| Patient’s relationship to subscriber: | | | | | | Self | | | Spouse | | | | Child | | | | Other | |  | | | | | | | |
| Secondary Insurance Carrier Name | | | | | | | | Policy ID | | | | | | | | | | | | | Group# | | | | | |
|  | | | | | | | |  | | | | | | | | | | | | |  | | | | | |
| Insured’s Name: | | | | | | | | | | | Soc. Sec. No (if not listed above): | | | | | | | | | | Date of Birth (if not listed above) | | | | | |
|  | | | | | | | | | | |  | | | | | | | | | |  | | | | | |
| Patient’s relationship to subscriber: | | | | | | Self | | | Spouse | | | | Child | | | | Other | |  | | | | | | | |
| Parental Pre-Authorization for medical care to children | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I give my permission for the physicians at Onslow Primary Care to provide any necessary medical care to my minor child whose name is: | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of legal guardian/parent ­­­­­­­­­­­­­­­­­­­­­ | | | | | | | | | | | | | | | Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | |
| Required signature | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I have been provided with the following documents from Onslow Primary Care: Your Rights and Responsibilities as a Patient, Notice of Privacy Practices. These documents are also available online at the practice’s website (www.onlsowprimarycare.org).  I authorize the release of information concerning my child’s healthcare, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits, otherwise payable to me, directly to Onslow Ambulatory Services, Inc. (For Medicare beneficiaries, this serves as a lifetime authorization assigning payment of Medicare benefits to Onslow Primary Care). I understand that I am personally responsible for all charges not covered by my insurance. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date ­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | |



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# Pediatric History form

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| |  |  |  |  | | --- | --- | --- | --- | | Name | DOB | Age | Sex  M  F |  |  |  |  |  | | --- | --- | --- | --- | | **BIRTH HISTORY** | | | | | Were there any complications during the pregnancy or at birth  No Yes-please explain:  jaundice  respiratory distress  feeding problems | | | | | If premature, born at how many weeks? | Delivery:  vaginal  c-section  breech | Length | Weight |  |  | | --- | | **ALLERGIES** to any medications, X-Ray dyes or other substances?  No  Yes (if yes, please the list the type of reaction) | |  |  |  |  |  |  | | --- | --- | --- | --- | | **MEDICATIONS-**names, dosages | | | | |  |  |  |  | |  |  |  |  |  |  | | --- | | **IMMUNIZATIONS** | | Are your child’s immunizations up to date?  Yes  No  Unsure |  |  |  |  |  |  | | --- | --- | --- | --- | --- | | **PAST MEDICAL HISTORY** | | | | | | Any delays in development?  No Yes-explain:  motor  speech  hearing | | | | | | ADD/ADHD | Anemia | Acid Reflux | Appendix removal | Asthma | | Blood Transfusion | Cancer | Chicken pox | Chronic ear infections | Diabetes | | Eczema | Epilepsy | Eye or vision problems | Heart Murmur | Hernia/Hernia repair | | Kidney/bladder problems | Liver disease/jaundice | Mono | Rheumatic fever | Tuberculosis | | Other: | | | | |  |  |  |  |  | | --- | --- | --- | --- | | **FAMILY HISTORY**  Adopted? Yes- you may skip this section | | | | | Illness | Father | Mother | Sibling (s) | | Bleeding/Clotting Disorder |  |  |  | | Cancer (list the type) |  |  |  | | Depression/Anxiety |  |  |  | | Diabetes |  |  |  | | Heart Attack |  |  |  | | High Blood Pressure |  |  |  | | High Cholesterol |  |  |  |  |  |  | | --- | --- | | **SOCIAL AND ENVIRONMENTAL HISTORY** | | | Who does the child live with? | Is the home tobacco free? |  |  | | --- | | **I attest that the above information is accurate to the best of my knowledge.**  Parent/Guardian Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |



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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

|  |  |  |  |
| --- | --- | --- | --- |
| Please note if your wish for anyone other than yourself to communicate with the doctor or our staff in regard to your care, appointments or account status. I understand that sensitive information, like STDs (including HIV/AIDS) results, pregnancy test results, mental health or substance abuse will not be shared unless specifically stated by me at the time.  Patient Name       Date of Birth  Do not release information about  Authorized contact name:  Relationship to patient:  Contact phone number:  Authorized contact name:  Relationship to patient:  Contact phone number: | | | |
| Authorized contact name:  Relationship to patient:  Contact phone number: | | | |
| Patient Signature: |  | Date Signed: |  |
| **Phone Release**  I authorize Onlsow Primary Care staff to leave messages with anyone that answers my phone or on my answering machine in regards to appointments, test results, or issues in regard to my care. | | | |
| Patient Signature: |  | Date Signed: |  |