

PATIENT REGISTRATION

Tammy Maschino, M.D.
Susan White, M.D.
Jessica Yocum, M.D.
Lauren Adams, APRN-CNP

Patient Information

First Name: _____ Middle Name: _____ Last Name: _____
Birthdate: _____ Sex: _____ Email: _____
Address: _____ City: _____ State: _____ Zip: _____

Parent Information

Mother: ☐ **Biological** ☐ **Step** ☐ **Foster** ☐ **Grandparent** ☐ **Adoptive** ☐ **Legal Guardian** ☐ **Other**

Mothers Name: _____ Middle Initial: ____ Birthdate: _____ SS#: _____
Address: _____ City: _____ State: _____ Zip: _____
Occupation: _____ Employer: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Email: _____

Father: ☐ **Biological** ☐ **Step** ☐ **Foster** ☐ **Grandparent** ☐ **Adoptive** ☐ **Legal Guardian** ☐ **Other**

Fathers Name: _____ Middle Initial: _____ Birthdate: _____
Address: _____ City: _____ State: _____ Zip: _____
Occupation: _____ Employer: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Email: _____

Insurance: _____
Subscriber Name: _____ Subscriber Birthdate: _____

Family Members

Sibling Name: _____ Birthdate: _____
Sibling Name: _____ Birthdate: _____

In Case of Emergency Notify (Please list someone living outside of home)

1. _____ Relationship: _____ Phone: _____
2. _____ Relationship: _____ Phone: _____

Other

How did you hear about our clinic? _____
Who was your child's previous pediatrician? _____

Insurance Authorization Assignment:

I hereby authorize Dr. Tammy Maschino, Dr. Susan White, Dr. Jessica Yocum and/or Lauren Adams, APRN-CNP to furnish information to insurance carriers concerning my child's illnesses and treatments and hereby assign to the doctor all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Parent/Guardian Signature **Date**

Tammy Maschino, M.D.
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Lauren Adams, APRN-CNP

VILLAGE CENTER PEDIATRICS

CHILD REGISTRATION AND HISTORY RECORD

To be filled out by parent or guardian

Child's name_____ **Date of Birth** _____

Sex ____M ____F City of birth/delivery hospital _____

Pregnancy and Birth

		Yes	No
1.	Were there any problems during the mother's pregnancy? *If yes, what problems?*_____	☐	☐
2.	Mother's age at birth _____		
3.	Did the mother use any cigarettes, alcohol, recreational drugs or mediations during pregnancy?	☐	☐
4.	Did the baby come more than 2 weeks early or 2 weeks late? *If yes, how many weeks (early or late)?* _____	☐	☐
5.	What was the baby's birth weight? _____		
6.	Were there any problems during labor or delivery? Vaginal ☐ C-Section ☐	☐	☐
7.	Anesthesia_____		
8.	Were there any problems during the nursery stay? *If yes, what problems?* _____	☐	☐
9.	Other problems_____		
10.	Number of days in the hospital _____		

Development and Behavioral Issues

		Yes	No
1.	Does your child go to a sitter, attend daycare or preschool? If yes, where? _____	☐	☐
2.	Did the child sit alone by 7 months?	☐	☐
3.	Did the child walk alone by 14 months?	☐	☐
4.	Did the child say 3 words by 15 months?	☐	☐
5.	Is the child doing well in school?	☐	☐
6.	Does the child get along well with other children?	☐	☐
7.	Check off any of the following problems which the child has: ☐ Nightmares/sleep problems ☐ Irritable/bad temper ☐ Discipline problems ☐ Speech problems ☐ Thumb sucking ☐ Bed wetting ☐ Toilet training problems ☐ Breath holding		

Feeding and Digestion

		Yes	No
1.	Has the child had any unusual feeding problems?	☐	☐
2.	Have there been any problems with diarrhea or constipation?	☐	☐
3.	Is your drinking water fluoridated?	☐	☐
4.	Does the child ever eat dirt, plaster, or paint?	☐	☐
5.	How many meals does the child eat per day? _____		
6.	Does the child take vitamins, fluoride, iron, or other supplements?	☐	☐
7.	Was/is the child breast ☐ or bottle☐ fed? If discontinued, when? _____		
8.	Has the child ever required oxygen? IV?	☐ ☐	☐ ☐

Health and Safety Issues

		Yes	No
1.	Are there any guns in the child's house?	☐	☐
2.	Does the child use a toothbrush daily?	☐	☐
3.	Does the child use a car seat or seat belt at all times?	☐	☐
4.	Are there smoke detectors in the child's home?	☐	☐
5.	Is the hot water temperature less than 125°?	☐	☐
6.	Do you have rules/limits for television viewing?	☐	☐
7.	Are medicines and potential poisons out of reach?	☐	☐
8.	Do you know child resuscitation or chocking management?	☐	☐

Name of current school_____

Current grade in school_____ Usual grades made in school _____

SEE BACK ⟶

Family History

Illnesses - Check □ where the child or members of the child's family (parents, siblings, grandparents, aunts, uncles) have had the following illnesses or problems.

	Child	Child's Family	Family Member		Child	Child's Family	Family Member
Bone Disease	□	□	_____	Developmental delay/ learning disorder	□	□	_____
Birth Defects	□	□	_____				
Frequent ear infections	□	□	_____	Kidney/bladder problems or infections	□	□	_____
Cystic fibrosis	□	□	_____				
Croup	□	□	_____	Seizures/convulsions	□	□	_____
Mumps, measles, chicken pox	□	□	_____	Heart disease	□	□	_____
Wheezing/asthma	□	□	_____	High blood pressure	□	□	_____
Pneumonia	□	□	_____	High cholesterol	□	□	_____
Eye problems	□	□	_____	Lung disease/tuberculosis	□	□	_____
Dental problems	□	□	_____	Sexually transmitted diseases/HIV	□	□	_____
Hearing problems	□	□	_____	Alcohol/drug problems	□	□	_____
Hay fever/allergies	□	□	_____	Mental/emotional disorders	□	□	_____
Eczema/skin problems	□	□	_____	Thyroid disease	□	□	_____
Anemia/blood problems	□	□	_____	Cancer	□	□	_____
Arthritis	□	□	_____	Migraines	□	□	_____
Ulcers/stomach problems	□	□	_____	Other_____	□	□	_____
Diabetes	□	□	_____	Other_____	□	□	_____

General Health				**Health**		
	First Name	Year of Birth	Sex	Good	Poor	(Explain)
Mother						
Father						
Brothers And Sisters						

Have any of the child's brothers or sisters died? No □ Yes □ (explain) _____

Hospitalizations or Serious/Unusual Illnesses

Identify any serious and/or unusual illnesses or injuries which your child has experienced.

Date Serious/Unusual Illness/Injuries

_____ _____

_____ _____

_____ _____

_____ _____

Allergies

List allergies, including any allergic reactions to drugs.

Parent/Guardian Comments

Village Center Pediatrics, LLC

Tammy Maschino, MD
Susan White, MD Jessica Yocum, MD
Lauren Adams, APRN-CNP

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I, _____ acknowledge that I have received a copy and/or
(Print Parent Name)
read the poster of Village Center Pediatrics Notice of Privacy Practices located on the waiting room door. This notice describes how Village Center Pediatrics may use and disclose my child's protected health information, certain restrictions on the use and disclosure of my child's health care information; and rights I may have regarding my child's protected health information.

We may release protected medical information about your child to a friend or family member who is involved in your child's medical care, or who helps pay for your child's care; as directed by law.
We cannot withhold medical information from a legal guardian.

Our office policy is patients who miss scheduled appointments without 24 hours advanced notification may be dismissed from our practice after three such incidents.

_____ _____
Child's Name Date of Birth

_____ _____
Parent Signature Date

ATTENTION

It is the patient's responsibility to know which lab, diagnostic facility, or specialist is in their insurance network. If the patient does not provide the office staff with the correct information, all lab will be sent to **Diagnostic Laboratory of Oklahoma** (DLO). Any additional charges will be the responsibility of the patient.

Patient Name: _____

Date of Birth: _____

Name of Lab: _____

Parent/Guardian Signature: _____

SEE BACK →

Village Center Pediatrics

Tammy Maschino, MD

Susan White, MD Jessica Yocum, MD

Lauren Adams, APRN-CNP

AUTHORIZATION FOR TREATMENT OF MINOR

Child's Name: _____ Date of Birth: _____

I _____ (Parent/Guardian), do hereby give permission for medical treatment from Tammy Maschino, MD, Susan White, MD, Jessica Yocum, MD and /or Lauren Adams, APRN-CNP to the above named child.

The following person(s) have my permission to bring the child listed above:

Name	Phone Number	Relationship
1. _____		
2. _____		
3. _____		

Parent Signature: _____ Date: _____

Village Center Pediatrics

2820 N Kelly, Ste 200 Edmond, OK 73003
Ph: 405-726-8000 **Fx:** 405-726-8101
Email: vcpforms@hushmail.com

www.villagecenterpediatrics.com

REQUEST FOR MEDICAL RECORDS

I,_____ hereby authorize your facility to release my child's entire medical record, including the diagnosis, prognosis, treatment, immunizations and any other pertinent information related to my child's healthcare for all dates of service to Dr. Tammy Maschino, Dr. Susan White, Dr. Jessica Yocum and Lauren Adams, APRN with Village Center Pediatrics.

Please release records for the following children: **Date of Birth:**

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

Records Requested From:

Name: _____
Address: _____
Phone: _____
Fax: _____

Send Records Via:

Secure Email
Mail
- OR -
Fax *Please mail records over 50 pgs*

Email, Mailing Address, Fax & Phone Number listed top of request.

I understand:

- I may void this authorization at any time, in writing. My void will not apply to information already retained, used or disclosed in response to this authorization.
- Unless the purpose of the authorization is to determine payment of claim or benefits, Village Center Pediatrics, LLC may not use this as a cause of change in the provision of treatment or payment for my care on my signing this authorization.
- Information used or disclosed under this authorization may be subject to re-disclosure by the recipient and no longer protected by the federal privacy regulations.
- The information authorized for release also may include drug/alcohol abuse treatment records. This category of medical information/records is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit anyone receiving this information or records from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CRF Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol drug abuse patient. As a result, by signing below I specifically authorize any such records included in my health information to be released.
- The information authorized for release may include information which may indicate the presence of a communicable disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency virus also known as acquired immune deficiency syndrome (AIDS).

Signature: _____

Parent/Legal Guardian or Patient if over 18 ***Relationship*** ***Date***

Processed & Documented By: _____

Date