COLUMBIA UNIVERSITY MEDICAL CENTER

DEPARTMENT OF SURGERY

Registration Form

FOR OFFICE USE ONLY	
MRN:	Div:

Appointment w/:	Today's Date:

Patient Information:

Last Name		First Name		M
Date of Birth	Age	Sex	Marital Status	
Street Address		City/State		Zip Code
Home Phone # ( ) -	Mobile # ( ) -	Work# ( ) -	Email	
Mother's First Name:		Father's First Name:		

This is for medical record purposes only.

Employer Information:

Occupation	Employer's Name/Address

Emergency Contact Information:

Name	Relationship	Phone # ( ) -

Referral Source (From whom/how did you hear about this Provider?):

Name/Type: ☐ Physician ☐ Family or Friend ☐ Website/ Search ☐ Advertisement ☐ Other _____

Primary Care Physician	Address	Phone# ( ) -
Cardiologist	Address	Phone# ( ) -
Physician (Other) _____	Address	Phone # ( ) -

Insurance Information:

Patient Relationship to Guarantor (circle one) **SELF** **SPOUSE** **DEPENDENT CHILD** **STUDENT**	
Primary Insurance	Policy #
Guarantor Name	DOB
Secondary Insurance	Policy #
Guarantor Name	DOB

Pharmacy Information:

Circle One: **Retail Pharmacy** **Mail-Order Pharmacy**	Name
Address	Phone # ( ) -

Authorization for Treatment and Release of Information

I hereby authorize and direct the above named clinical practice having treated me, to release to governmental agencies, insurance carriers, or others financially liable for my medical care, all information needed to substantiate payment for such medical care; and to permit representatives thereof to examine and make copies of all records relating to such care and treatment. I furthermore authorize the treating physician/pracitce to take and use my photos for insurance predetermination and educational purposes.

Financial Responsibility (For Provider Indicated in the "Appointment w/" section of this form)

Medicare Patients: I request that payment of authorized health insurance benefits be made to me or on my behalf to the provider(s) for any services furnished to me by this provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration, and its agents, any information needed to determine these benefits or the benefits payable for related services.

Commercial/Other Insurance: I hereby authorize direct payment of surgical/medical benefits to my provider, for services rendered by him/her in person or under his/her supervision if I have not paid in advance. I understand that I am financially responsibly for all services. Additionally, I understand that all bills are my responsibility if not paid by the carrier.

Out of Network: I understand that the doctor is a **non-participating provider** of my insurance and therefore I will be responsible for any balances on this account.

Self-Pay: I agree to pay at the time the services are rendered.

I verify the accuracy of the above information and authorize treatment and release of information as indicated on this form.	**Patient (Guardian) Signature** X	**Date**
I understand and agree to terms of my financial responsibility as indicated on this form.	**Patient (Guardian) Signature** X	**Date**

COLUMBIA UNIVERSITY
MEDICAL CENTER

New York Presbyterian
Division of Plastic Surgery
161 Fort Washington Avenue
New York, NY 10032
Office 212-305-9612 Fax 212-305-9626

NewYork-Presbyterian
Plastic Surgery

Pediatric Intake Form

Our Philosophy of Patient Care

We thank you for taking the time to complete the following Medical History. We realize this may seem like a lot of information, especially if your condition does not seem related. However, we believe that it is important to have complete knowledge and understanding of your medical background in order to care for you and treat you properly. Many seemingly unrelated symptoms, points of family history, environmental exposures and many other factors can all contribute to your well-being. A thorough Medical History is also required by Medicare and Insurance companies, in accordance with government standards. This information will be compiled and entered into our electronic health record and will be available to other providers you may see in this facility. All patient information is kept confidential based on HIPAA Guidelines. It takes time to treat everyone properly and thoroughly. We ask for your patience while you are waiting to be seen.

Thank you.

Pediatric Intake Form Section 1

Child's Name_____ Date of Birth_____
First Last

Referring Physician_____ Today's Date_____

For specialist visits, list your child's pediatrician name and phone #:_____

_____

Preferred Pharmacy_____ Pharmacy Phone_____

Pharmacy Address_____

What is the reason for your child's visit today?_____

If your child's problem causes pain, where is it painful?_____ How long has it been present?_____

Description of pain_____ When does it occur? _____ Severity_____

Any other symptoms?_____ What makes it better or worse?_____

Please list ALL of your child's current medications below (use back of page if you need more room)

Medication Name	Dose	When is it given?	Approximate start date of medication

Does your child take any non-prescription medications? Yes___No___ If yes, list:_____

Pediatric Intake Form Section 2

Patient Name:_____

BIRTH HISTORY

Which pregnancy is this child? _____Did the mother have health problems during the pregnancy? Yes__No__

Describe:_____

Born by vaginal delivery or c/section?_____ If c/section, reason_____

How many months' gestation at birth?_____Birth weight_____

Please list problems, if any, after birth (jaundice, feeding problems, infections, etc)_____

_____

Is your child adopted? Yes__No__ If Yes,_ *please describe the above to the best of your knowledge.*

MEDICAL HISTORY: HAS YOUR CHILD EVER HAD (been diagnosed or treated for) ANY OF THE FOLLOWING

Anemia:	Yes__No__	_____
Asthma/Breathing Problems:	Yes__No__	_____
Allergies:	Yes__No__	_____
Arthritis:	Yes__No__	_____
Behavioral Problems:	Yes__No__	_____
Bleeding Tendency:	Yes__No__	_____
Bowel Problems:	Yes__No__	_____
Cancer/Leukemia:	Yes__No__	_____
Chicken Pox/Shingles:	Yes__No__	_____
Developmental Disorder:	Yes__No__	_____
Diabetes:	Yes__No__	_____
Ear/Nose/Throat (ENT) Disorder:	Yes__No__	_____
Eczema/Skin Disorder:	Yes__No__	_____
Eye Disorder :	Yes__No__	_____
Growth Disorder:	Yes__No__	_____
Heart Disorder/Defect:	Yes__No__	_____
High Blood Pressure:	Yes__No__	_____
High Cholesterol:	Yes__No__	_____
Immune Deficiency Disorder:	Yes__ No__	_____
Kidney/Urinary Disorder	Yes__No__	_____
Liver Disease:	Yes__No__	_____
Seizure:	Yes__No__	_____
Thyroid Disorder:	Yes__No__	_____
Any Other?	Yes__No__	_____

Pediatric Intake Form Section 3

Patient Name: _____

FAMILY HISTORY: Does your child have any family members with a history of major illness or conditions? List below:

RELATIVE CONDITION & DESCRIPTION LIVING (Y/N) IF DECEASED, AT WHAT AGE?

Mother: _____

Father: _____

Siblings: _____

Grandparent: _____

Grandparent: _____

Other: _____

SURGICAL HISTORY: List any surgeries your child has had and the approximate date:

_____

Has your child had a blood transfusion? Yes____No____? If yes, when? _____

SOCIAL HISTORY:

Legal Guardian if other than parents: _____

Other people living in the home: _____

Does anyone living in your home smoke? Yes___No____

Have you ever had problems with lead paint or contamination in your home? Yes_____No____

Do you have other children? Yes_____No____ If Yes, how many? _____What are their ages? _____

Parent/Guardian Signature_____**Date**_____

FOR OFFICE USE ONLY: *CROWN-04-29-09 intake*

The following sections were entered into CROWN by (sign initials next to the section(s) you entered):
*ALL*_____*Problems*_____*Allergies*_____*Birth Hx*_____*Medical Hx*_____
*Family Hx*_____*Surgical Hx*_____*Social History* _____
Physician Signature_____Date_____

COLUMBIA UNIVERSITY
MEDICAL CENTER

Health Insurance Portability and Accountability Act (HIPAA)
HIPAA Compliance/Columbia University Medical Center
601 West 168th Street, Apt. #22, 2nd Floor
New York, NY 10032/ T(212) 342-0059 F(212)342-5173
http://www.cumc.columbia.edu/hipaa/

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

DATE:_____

I acknowledge that I was provided with a copy of the Columbia University Medical Center Notice of Privacy Practices.

_____ _____
Patient Name (Print) Patient Signature

If completed by a patient's personal representative, please print and sign your name in the space below

_____ _____
Personal Representative (Print) Personal Representative's Signature

_____
Relationship

For Columbia University Medical Center use only.

Complete this section if this form is not signed and dated by the patient or patient's representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of Columbia University Medical Center's Notice of Privacy Practices but was unable to for the following reason:

- ☐ Patient refused to sign
- ☐ Patient unable to sign
- ☐ Other _____

_____ _____
Employee Name Date

This form should be placed in the patient's medical record

Revised October 2007

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Medication List (Please Print Legibly)

Medication	Dosage	# Times a day	Reason for Medication (e.g. High Blood Pressure)

Please fill out medications, dosages prescribed with, and how many times a day. Also include herbs, Vitamins, Minerals, and any other Supplements that you are currently taking.

Patient name (print) _____ Date_____

Signature _____