Tuscany Children Clinic

Phone: (928) 366-1026
Fax: (928) 366-1028

www.TuscanyChildrenClinic.com

2525 W 28th St, Ste A
Yuma, AZ 85364

Registration Form

Patient Information:

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Gender: ❑ Male ❑ Female Social Security # _____

Marital Status (Adult Patients): ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated

Address: _____

City: _____ State: _____ Zip: _____

Mailing address: (if different than above) _____

City: _____ State: _____ Zip: _____

Preferred Phone: _____ ❑ Cell ❑ Home ❑ Work

Other Phone: _____ ❑ Cell ❑ Home ❑ Work

Parent/Legal Guardian (if under 18 years old):

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Gender: ❑ Male ❑ Female Social Security # _____

Is this person the primary member/sponsor in insurance? ❑ Yes ❑ No

Emergency Contact:

Name: _____ Phone: _____ Relation: _____

Insurance Information:

Primary Insurance Company: _____ Effective Date: _____

Subscriber ID: _____ Group No: _____ Plan Name: _____

Primary Insured Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Gender: ❑ Male ❑ Female Social Security # _____

Address (if different than the patient's): _____

City: _____ State: _____ Zip: _____

Relation to Patient: ❑ Self ❑ Parent ❑ Spouse ❑ Other _____

Secondary Insurance Company: _____ Effective Date: _____

Subscriber ID: _____ Group No: _____ Plan Name: _____

Primary Insured Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Gender: ❑ Male ❑ Female Social Security # _____

Address (if different than the patient's): _____

City: _____ State: _____ Zip: _____

Relation to Patient: ❑ Self ❑ Parent ❑ Spouse ❑ Other _____

Patient's Name: _____ Date of Birth:_____

Consent for Treatment & Immunizations

I authorize and consent Tuscany Children Clinic licensed healthcare providers to examine my person, perform any medical diagnostic studies, give any medical treatment which is consistent with quality medical care, and to provide all immunizations as needed.

Signature of Patient or Responsible Party: _____ Date: _____

Lifetime Authorization to Release Information & Assignment of Benefits

I request that payment of authorized benefits be made on my behalf. I assign the payment of those benefits to which I am entitled, including private insurance and other health plans, to Tuscany Children Clinic.

I also hereby authorize payment of medical benefits directly to Tuscany Children Clinic of benefits due for services rendered to me or my dependents.

I understand that should I agree to the medical services which are not covered benefit under my medical insurance plan (s), that I am responsible for all of those non-covered procedures or services.

I further authorize Tuscany Children Clinic to release any information required to process and pay my insurance claims.

Signature of Patient or Responsible Party: _____ Date: _____

HIPPA

I _____ acknowledge that I have read a copy of the "Notice of Privacy Practices". My signature means that I agree and consent to allow Tuscany Children Clinic to use and disclose my protected health information to carry out treatment, payment, and healthcare operations.

A copy of the HIPAA Guidelines is available in our office. If you would like a copy to take home, please ask at the front desk.

Financial Policy

We emphasize that as medical care providers, our relationship is with you, not your insurance company. As a courtesy, we will file your insurance claim for you. If your insurance company does not respond or pay within a reasonable length of time (60 days), you will be expected to follow-up with your insurance company. You are responsible for any amount that your insurance does not pay.

You are responsible for any amounts not paid by your insurance company for coinsurance and/or deductible or any other out of pocket expenses.

As a patient in our office, it is your responsibility to inform us of any changes on your account regarding your insurance or address information. Acceptable insurance identification is required if you change insurance companies. This is defined as a valid insurance card updated when you receive a new insurance card.

No Insurance: If you do not have insurance: The total should be paid at time of service.
Returned Checks: Checks returned for non-sufficient funds will be charged $35.00 service fee.
Collections: If you have not made payments to your account and if there has been no attempt to contact our office with financial arrangements, it may be assigned to a collection agency after 90 days of no payment on account. You will be responsible for all collection & interest fees assigned by the collection agency. Please note that after your balance has been sent to collections, you may be dismissed as a patient in our office. Your balance will need to be paid at our collection agency in full prior to receiving services in our office.

Signature of Patient or Responsible Party: _____ Date: _____

I certify that the information I have reported with regard to my insurance coverage and personal information is correct.

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QUESTIONS ABOUT YOUR CHILD

Your pediatrician would like to know your child as a person, and not only treat one specific problem. Many of the questions below may not have anything to do with today's visit, but they will help your pediatrician to know your child better. They may help to prevent other problems before they get worse. Your answers will remain confidential.

	No	Yes
1. Was the pregnancy of the child's mother more than 2-3 weeks shorter or longer than normal?	_____	_____
2. Did the child's mother have any serious problems during the pregnancy?	_____	_____
3. Did she smoke during the pregnancy?	_____	_____
4. Did she drink or use any street drugs before or after she learned that she was pregnant?	_____	_____
5. Was the pregnancy unplanned ("oops")?	_____	_____
6. Was the pregnancy vaginal ____ or C-section ____? What was the child's birth weight, if you remember it? _____	_____	_____
7. Did the child have any complication at birth and did he/she stay in the hospital longer than the mother?	_____	_____
8. Did the child have to be admitted to the hospital (not just seen in the emergency room) in the first month after birth or any time during childhood?	_____	_____
9. Did the child have any operations? If yes, what type, what year or how old? _____	_____	_____
10. Did the child have any serious chronic illness? If yes, which one, and starting at what age? _____	_____	_____
11. Did the child fall behind in the things that children do (sitting, standing, walking, talking, etc…) or in his/her intelligence?	_____	_____
12. Are you worried about the child not talking, hearing or seeing well?	_____	_____
13. Does the child wet the bed at night, if older than 4 years?	_____	_____
14. Does the child have trouble pooping (constipation)?	_____	_____
15. Does someone on either side of the family have asthma, convulsions, or other serious illness?	_____	_____
16. How many children are there in the family (total)? _____ Are they from different father or mothers?	_____	_____
17. Are the parents of the child separated or divorced?	_____	_____
18. Does the mother or the father of the child smoke?	_____	_____
19. Has the mother or the father of the child had any problem with drinking, drugs or violence? (ex. Father hitting mother)?	_____	_____

Name of Child	Date of Birth	Today's Date