KIDSTRONG MEDICAL GROUP INC.

220 LAGUNA RD. SUITE #5
FULLERTON, CA. 92835
714-879-2980

PATIENT REGISTRATION

(PLEASE FILL OUT COMPLETLEY)

PATIENT NAME ____

LAST FIRST MIDDLE

BIRTHDATE__________________________AGE____________________SEX___________________________

HOME ADDRESS____

STREET ADDRESS CITY ZIPCODE

PHONE NUMBER____CELL#______________________________

EMAIL MOM:____DAD:__________________________________

IF DIVORCED/SEPERATED WHO HAS CUSTODY:_____________________________________JOINT/SEPERATE

FATHER NAME:____D.O.B.______________

EMPLOYER NAME____PHONE#___________________

CELL #____S.S.N_____________________

MOTHER NAME____D.O.B.______________

EMPLOYER NAME____PHONE#___________________________

CELL #____S.S.N.____________________________

EMERGENCY CONTACT______________________________________PHONE#__________________________

(NOT LIVING WITH YOU)

INSURANCE CARRIER:____ID#_____________________________

PHARMACY
NAME:_____________________________CITY______________________STREETS________________________

I HEREBY AUTHORIZE DR. AHLUWALIA TO FURNISH INFORMATION TO INSURANCE CARRIERS THAT PERTAIN TO MEDICAL SERVICES RENDERED. IT IS MY RESPONSIBILITY FOR ALL PAYMENTS AND ALL OUTSTANDING BILLS MUST BE PAID IN FULL.

SIGNATURE____DATE:___________________

Kidstrong Medical Group Inc.
220 Laguna Rd. Suite 5
Fullerton, Ca 92835
Ph: 714-879-2980 Fax: 714-879-5134

Request for Release of Medical Records

Date:______________

To:

____
(Physician Name)

____
(Address)

____
(Phone #) (Fax #)

I request my child's records be released to:

____
(Physician Name)

____
(Address)

____
(Phone #) (Fax #)

Patient Name: ____________________________________D.O.B: ____________________________

Patient Name: ____________________________________ D.O.B: ____________________________

Parent Name:____

Parent Signature: ____ Date:__________________

CHILD

HEALTH HISTORY

DATE: ______________________

Child's Name: ___________________________________ M__F__ Date of Birth: ___________

Child lives with ___________________________________ Place of Birth: __________________

Language spoken at home__________________________ Name of Dentist ________________

FAMILY HISTORY How many children have you (mother)had? __________________________

Mother's age now _____________ Height ___________Weight_________

Father's age now ______________ Height ___________ Weight_________

Has any family member had any of the following?

____ Allergies (Food, medicine, etc)

____ Birth Defects

____ Anemia, leukemia

____ Bleeding tendency

____ Bone, joint disease

____ Cancer

____ Lung Disease

____ Ear or eye disorder

____ Stroke

____ Diabetes

____ Thyroid Disease

____ Heart Disease

____ Kidney or Bladder problems

____ Developmental Delays

____ Muscle Disease

____ Epilepsy, Cerebral Palsy

____ Tuberculosis

____ High Blood Pressure

Has your child ever had any injuries or serious illnesses? _______ If Yes, please explain: ______

____

Is your child allergic to any medication? ________ If Yes, please list: _______________________

CHILD'S BIRTH HISTORY: Complete if your child is under 6yrs of age

Name of Obstetrician: __________________________Did you see a Doctor? ________________

Starting which month ______________ Any illnesses: _________Explain: __________________

Did you take any medication? _______ Please list ______________________________________

Any complications? ________________________________Length of labor: _________________

Type of delivery: Vaginal_____ C-Section______ Headfirst? _____________

Birth Weight _______________length ______________concerns at birth__________________

Age baby sat up alone_________ Pulled to stand ___________ Walk alone_________________

Breast or formula fed? ___________________ Any feeding/digestive problems ______________

Any other questions or concerns about your child? ______________________________________

KIDSTRONG MEDICAL GROUP INC.

220 LAGUNA RD. SUITE #5

FULLERTON, CA. 92835

714-879-2980

I ____
(Parent or Legal Guardian)

Who reside at ____
(Address) (City) (State)

Do hereby state that I am the Parent or Legal Guardian of the following minor children who reside with me:

Name	Age	Date of Birth
______________________________	__________	________________
______________________________	__________	________________
______________________________	__________	________________
______________________________	__________	________________

I authorize the following adult(s):

Name	Relationship	Phone Number
______________________________	________________	______________
______________________________	________________	______________

To secure medical treatment for the mentioned minor/children. I consent to the performance of such medical and/or surgical procedures which are necessary or advisable from this day _________________
(Date)

This document shall be kept in my child's chart during the effective time. I agree to be financially responsible for services rendered at providers office. I authorize the release of the information to my insurance company and my personal physician.

Signature of Parent or Legal Guardian: ____

Date Signed: __________________________ Daytime phone number:____________________

This is a legal document

KIDSTRONG MEDICAL GROUP INC.

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714-879-2980

I hereby acknowledge that I received a copy of this medical practice Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

□ I would like to receive a copy of any amended Notice of Privacy Practices by email at

____

Signed:____ Date:__________________

Print name____ Telephone:______________

Relationship to patient: ____

Name and address of Patient: ____

____

Por la presente reconozco que he recibido una copia del Aviso de esta Practica Medica de Practicas de privacidad. Ademas, reconozco que copia del aviso actual sera fijada en la zona de recepcion, y que una copia de la Notificacion de Practicas de Privacidad modificado estra disponible en cada cite.

□ Me gustiaria recibir una copia del Aviso de Practicas de Privacidad modificada por e-mail a:

____

Firmado:____ Fecha__________________

Impirmir Nombre:_______________________________________ Telefono________________

La relacion al paciente____

Nombre y direccion el paciente:____

____

KIDSTRONG MEDICAL GROUP INC.
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FULLERTON, CA. 92835 714-879-2980

FINANCIAL RESPONSIBILITY POLICY

We are dedicated to providing the best possible care for your family, and we want you to completely understand our financial policies.

1. Co-payments are due at the time of service. We accept Visa, Mastercard, Discover and American Express. We do not accept cash or checks sorry for this inconvenience.
2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a courtesy to you, we will file a claim with your insurance if you assign the benefits to the doctor-in other words, if you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If later we receive a check from your insurance, we will refund you any overpayment.
3. Not all insurance plans cover all services. In the event that your insurance plans determines a service to be “Not Covered”, you will be responsible for the complete charge. In addition, many plans have deductibles which you will be financially responsible for. **Payment is due upon receipt of a statement from our office.**
4. To provide you with the best possible services, you are responsible to update our office with any address, insurance and phone number changes, along with coordination of benefits with your insurance in case of dual insurances.
5. At your newborn’s initial visit of eligibility cannot be verified a $120.00 charge will apply at the time of the visit. Once claims are paid by insurance, the credit will be applied to future co-payments.

I have read and understand the practice’s financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

____ ____________________

Signature of responsible party Date

____

Patient Name