Mid-City Pediatrics, Inc.
Patient Registration Data
ALL INFORMATION IS CONFIDENTIAL

Date: _____

Patient Information

Patient's Name | Date of Birth | Gender (M/F) | Ethnic Origin | Social Security Number

Address | City | State | Zip

Home Phone Number | Emergency Phone Number

Responsible Parties

Legal Guardian | Relation to Patient | Date of Birth | Social Security Number

Address | City | State | Zip

Employer | Occupation | Work Phone Number | Email Address

Legal Guardian | Relation to Patient | Date of Birth | Social Security Number

Address | City | State | Zip

Employer | Occupation | Work Phone Number | Email Address

Insurance Information

Insurance | ID # | Group # | Effective Date

Subscriber Name | Subscriber Date of Birth

Insurance | ID # | Group # | Effective Date

Subscriber Name | Subscriber Date of Birth

Name (Please Print) | Signature

Mid-City Pediatrics

8250 Kenwood Crossing Way, Suite 205
Cincinnati, Ohio 46236

7777 University Drive, Suite D
West Chester, Ohio 45069

Phone: 513-948-8444 Fax: 513-948-0756 Email: mcp7710@aol.com

PARENTAL CONSENT TO TREAT

I, _____ bearing the relation of mother / father / legal guardian to _____

D.O.B. _____, do hereby permit the doctor(s) participating in the care of my child to use any treatment or procedure that may be deemed necessary in the medical and dental care that shall include the use of the following:

1. drugs
2. medicines
3. dietary procedures
4. laboratory procedures
5. x-ray procedures
6. diagnostic test
7. immunizations
8. preventative medicine

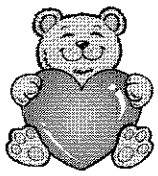
I will consent to immunizations, as they are needed for my child.

This consent does not include any surgical procedures of diagnostic tests that require general anesthesia.

Signed: _____

Date: _____

Witnessed By: _____



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NOTICE OF PRIVACY POLICY

PATIENT ACKNOWLEDGEMENT

I, _____, hereby acknowledge that I was given a copy of the
(print name)
Notice of Privacy Policy issued by Mid-City Pediatrics, Inc. on the date indicated below.

_____ _____
Signature Date

Name of child _____

Relationship to child:

- ❒ Custodial Parent
- ❒ Guardian
- ❒ Power of Attorney
- ❒ Health Care Proxy or Surrogate

_____ _____
Witness Date

Chart No. _____

Patient History

Child's name: _____ **Date** _____

How did you hear about Mid-City Pediatrics? _____

Family History (*please check all that apply for your extended family*)

- ☐ asthma
- ☐ bleeding problems
- ☐ seizures
- ☐ high blood pressure
- ☐ headaches
- ☐ substance abuse
- ☐ high cholesterol
- ☐ depression
- ☐ learning disability
- ☐ allergies
- ☐ birth defects
- ☐ diabetes
- ☐ heart problems
- ☐ kidney problems
- ☐ alcoholism
- ☐ menstrual problems
- ☐ vision problems
- ☐ hyperactivity
- ☐ anemia
- ☐ cancer
- ☐ hearing problems
- ☐ mental retardation
- ☐ sickle cell trait/disease
- ☐ thyroid problems
- ☐ tuberculosis
- ☐ domestic violence

Please explain any checked items:

_____

_____

_____

_____

_____

Mother's height _____ Father's height _____

Patient's Medical History (*check all that apply*):

- ☐ asthma
- ☐ bleeding problems
- ☐ diabetes
- ☐ attention deficit/hyperactivity
- ☐ seizures
- ☐ kidney problems
- ☐ poor appetite
- ☐ vision problems
- ☐ bone fractures
- ☐ allergies
- ☐ constipation
- ☐ hearing problems
- ☐ mental retardation
- ☐ sickle cell
- ☐ heart problems
- ☐ learning disability
- ☐ fatigue
- ☐ jaundice
- ☐ anemia
- ☐ birth defects
- ☐ speech problems
- ☐ headaches
- ☐ recurrent infections
- ☐ bedwetting
- ☐ depression
- ☐ physical disability
- ☐ smoke exposure

Please explain all checked items: _____

_____

_____

_____

_____

_____

Surgery/ hospitalization/ serious injuries: _____

_____

_____

_____

_____

Does your child need any special aids (*hearing aid, wheelchair, glasses etc.*)? _____

_____

_____

Does your child have any allergies to medications/foods? Has your child had any reactions to immunizations?

_____

_____

_____