Ravalli Family Medicine
Patient Registration/Financial Agreement (Child)

Thank you for taking the time to complete this form. This information is necessary for the preparation of your clinical records. You are responsible for all charges billed. Our credit office personal will be happy to discuss a payment schedule that is most convenient for you.

PLEASE PRINT AND COMPLETE ENTIRE FORM.
WE ARE UNABLE TO BILL INSURANCE WITHOUT BIRTHDATES AND SS#.

Patient information:

Patient Name: _____
First Middle Last

Mailing address: _____ City: _____ Zip_____

Home address: _____ City: _____ Zip _____

Home phone #:_____ ☐ Male ☐ Female Birthdate: _____ SS#: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline

Email address: _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Other ☐ Decline

What is your preferred spoken language? _____

MOTHER'S NAME: _____

Address: ☐ same as above _____City: _____ Zip: _____
Work phone #: _____ Cell phone #: _____
If you cannot reach me at home it is OK to try me at: ☐ Work ☐ Cell ☐ It is not OK to call other numbers

FATHER'S NAME: _____

Address: ☐ same as above _____City: _____ Zip:_____
Work phone #: _____ Cell phone #: _____
If you cannot reach me at home it is OK to try me at: ☐ Work ☐ Cell ☐ It is not OK to call other numbers

Emergency Contact (other than parents):

Name: _____ Relationship: _____

Address: _____ Phone: _____

Person responsible for account:

Name: _____ Address: _____

Phone #: _____ Birthdate: _____ SS#:_____

Employer name: _____ Phone #: _____

Insurance Information: (We cannot bill insurance without this information)

Primary Insured's name: _____

Birthdate: _____ SS#: _____

I authorize the release of any medical information which may be requested to process claims for payment of medical services through my insurance carrier, prepaid medical plan, or government agency. I authorize payments to be made to the clinic or providers.

If no insurance: □ Cash □ Credit/Debit card

Ravalli Family Medicine
411 W Main Street
Hamilton, MT 59840

I assume liability for all non-covered charges and deductibles. By signing this form I acknowledge that I have received a copy of the Notice of Privacy Practices and payment policy of Ravalli Family Medicine.

PATIENT CONSENT TO BE TREATED
I consent to being treated as a patient at Ravalli Family Medicine, by the providers and their nursing staff to include the examinations, treatments, diagnostic tests, injections and medications which they believe are advisable and necessary for my care. If I need to be referred to a subspecialty physician, I hereby authorize Ravalli Family Medicine to make my medical information available to the appropriate consultant.

Patient Notification:
I agree that medical information may be left on my answering machine (circle one): Yes No

I agree that medical information may be given to:

Name: _____Relationship:_____

Phone:_____

Signature of Responsible Person Date Relationship

Pediatric Health History Form

Ravalli Family Medicine

Child's Name: _____ Date of Birth: _____ Age:___

Child's Previous Doctor/Provider: _____

Present Health Concerns: _____

_____

Medicines/Vitamins: _____

Herbs/Home remedies: _____

Allergies/Reactions to Medicines or Vaccines:_____

Pregnancy and Birth

This child is yours by (please check one): __birth __adoption __stepchild __other: _____

Medical problems during pregnancy: ___none or specify: _____

Delivered by (check one): __ vaginal birth __ C-section (and why):_____

Birth weight:_____ Birth Length: _____ If premature, how many weeks:_____

Nutrition and Feeding

Was your child breastfed? ___ yes ___ no If so, how long? _____

Has your child had any unusual feeding/dietary problems? ___ yes ___ no If yes, please specify:_

_____

Development

At what age did your child: sit alone:_____ walk alone: _____ say words:_____

toilet train (daytime): _____ Girls only, age of first menstrual period: _____

Medical History

Date of last dental visit: ___none or date: _____

Any concerns about lead exposure? (old home/plumbing/peeling paint): ____yes ____ no

Do any household members smoke? (even if they go outside to smoke) ____yes _____ no

Please describe any major medical problems:_____

_____

_____

Hospitalizations/Operations (with dates):_____

_____

Broken bones or severe sprains: _____

Has your child had immunizations: ___yes ____no, If yes, Is he/she up to date: ___yes ____no

--PLEASE COMPLETE BOTH SIDES OF THIS FORM--

Family History (Please circle any that apply)

Alcoholism/drug abuse	Heart disease/stroke before age 60	Seizures
Psychiatric	Thyroid	Kidney disease
High Blood Pressure	Bleeding/clotting problems	Birth defects
Asthma/hayfever/eczema	Inherited/genetic diseases	

Social History

Birth city: _____ Current (or upcoming) grade: _____

Who lives at the child's home:

Name	Age	Relationship	Highest education level

Child's parents are (check one): ____married ____unmarried ____separated ___divorced

Mother's occupation: _____ Father's occupation: _____

Does the child attend daycare? ____ yes ____ no

Is violence at home a concern? ____ yes _____ no Are there guns in the home? ___yes ____no

Does your child wear a seatbelt or is in an appropriate car/booster seat? ____yes ____no

Does your child wear a bike helmet? ____yes ____no

To the best of my knowledge, the above information is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my child's health. I understand that I am solely responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my doctor if my minor child has a change in health.

_____ _____ Date: _____

signature of parent/guardian print patient's name

--PLEASE FILL OUT BOTH SIDES OF THIS FORM--