MORNING STAR PEDIATRICS

3499 S. MERCY ROAD, SUITE103, GILBERT, AZ 85297, Tel: 480-355-8530 Fax: 480-591-3115

PATIENT INFORMATION

Patient Name: _____ **Sex:** M / F

Date of Birth: _____ **Appointment Date:** _____ **Time:** _____ **Provider:** _____

Mailing Address: _____ **Apt/Ste:** _____

City, State & ZIP: _____

Street Address (if different than mailing): _____ **SSN:** _____

Home Phone: _____ **Can we leave a message at home? (please circle)** Y N

Cell Phone: _____ **Can we leave a message on cell phone? (please circle)** Y N

Please rank as 1st and 2nd; your preference for our communications with you in the future:

____ Text Message **____ Phone Call**

I consent to receive calls, text messages, or emails from Morning Star Pediatrics for my protected healthcare and other services at the phone number(s) listed above, as indicated by circling the Y. I understand that such calls may be generated by an automated dialing system and that such calls to my cell phone may result in charges by my wireless carrier. I realize that consent is not required as a condition of being a patient and that I may revoke this authorization at any time and that the revocation does not have to be in writing.

Signature of Responsible Party: _____ Date: _____

What is your race? (please circle) American Indian or Alaskan Native Asian Native Hawaiian or other Pacific Islander

Black or African American White Hispanic Other _____ Other Pacific Islander Decline To Answer

What is your ethnicity? Hispanic or Latino **Preferred Language?** _____

Non-Hispanic or Latino Decline to Answer

Pharmacy Name: _____ **City:** _____ **Phone Number:** _____

Address or cross streets: _____

Emergency Contact Name: _____ **Relationship:** _____

Phone Number: _____

Second Emergency Contact Name: _____ **Relationship:** _____

Phone Number: _____

PAYMENT INFORMATION

Guarantor Name: _____ **Relationship to Patient:** _____

Address: _____

Gender: (please circle) M F **Social Security Number:** _____ **Date of Birth:** _____

Guarantor's Employer Name: _____ **Work Phone:** _____

Work Address: _____

Primary Insurance: _____

Address: _____ **Insured Relationship to Pt:** _____

Insured Name: _____ **Date Of Birth:** _____

Subscriber ID: _____ **Group Number:** _____

Secondary Insurance: _____

Address: _____ **Insured Relationship To Pt:** _____

Insured Name: _____ **Date Of Birth:** _____

Subscriber ID: _____ **Group Number:** _____

How did you hear about us? _____

Special Instructions:

If there is a special custody situation, please list details here:_____

_____

Benefits Assignment

I hereby authorize the assignment of benefits (payments) directly to Morning Star Pediatrics for all my insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance. **I understand that co-pays, co-insurance, deductibles and non-covered services are due at the time of service. I also understand that any lab services such as blood work and cultures are additional charges dependent on and invoiced by the lab vendor.**

Signature of Responsible Party: _____ Date: _____

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Patient Name: _____ Date of Birth: _____

Reason for Your Visit: _____

Medications (Name and Dosage):_____

Allergies: _____

Responsible Party Name _____ Signature _____ Date _____

Review of Systems

Please check those problems which apply to the patient:

GENERAL

Fever / Chills ____
Persistently Tired ____
Sweats ____
Loss of Weight ____

SKIN

Acne _____
Rash ____
Skin changes ____

HEAD,EYE,EAR,NOSE,THROAT

Vision problems _____
Excessive tearing ____
Loss of hearing ____
Earache ____
Nasal congestion ____
Mouth breathing ____
Snoring ____
Bleeding gums ____
Hoarseness ____
Sores in mouth/gums ____
Dental problems ____

RESPIRATORY

Unable to keep up with peers ____
Difficulty breathing ____
Wheezing ____

CARDIOVASCULAR

Chest Pain ____
Irregular heart beat ____

GASTROINTESTINAL

Food restriction / dieting ____
Stomach aches ____
Dark stools ____
Bloody stools ____
Constipation ____
Diarrhea ____
Nausea ____
Vomiting ____

GENITOURINARY

Unusual urine odor ____
Blood in urine ____
Discharge from vagina or penis ____
Frequent urination ____
Painful urination ____
Bed-wetting problems ____

MUSCULOSKELETAL

Back Pain ____
Painful joints ____
Swollen joints ____

NERVOUS SYSTEM

Speech problems ____
Dizzy / Fainting ____
Headaches ____
Seizures ____
Weakness ____

PSYCHIATRIC

Anxiety ____
Change in sleep pattern ____
Depression ____
Inability to concentrate ____

ENDOCRINE

Appetite change ____
Cold intolerance ____
Excessive thirst ____
Excessive urination ____
Heat intolerance ____

HEMATOLOGIC

Abnormal bleeding ____
Easy bruising ____
Nose bleeds ____

SIGNATURE _____ DATE _____