*NASA PEDIATRICS-NEW PATIENT REGISTRATION*

PATIENT FULL NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SEX: M\_\_\_\_\_ F\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FATHER’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MOTHER’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FATHER’S PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MOTHER’S PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL ADRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PREFERRED PHARMACY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **NAME ADDRESS PHONE**

|  |  |
| --- | --- |
| WHO LIVES IN HOUSEHOLD WITH CHILD?*QUIEN VIVE CON EL PACIENTE* | 🗖MOTHER/MADRE 🗖FATHER/PADRE 🗖SIBLINGS/HERMANOS 🗖STEP-PARENT/PADRASTRO 🗖OTHERS/OTRO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| SINGLE PARENT HOUSEHOLD *PADRE/MADRE SOLTERO* | 🗖YES/SI 🗖NO 🗖N/A  |
| SPLIT CUSTODY/*CUSTODIA COMPARTIDA*DIVORCED/DIVORCIOSEPARATED/SEPARADOS | 🗖YES/SI 🗖NO **If YES, Divorce Decree is REQUIRED**.SPECIFY/SPECIFICAR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

**EMERGENCY CONTACT**: (PLEASE LIST AT TWO CONTACTS WHO DO NOT RESIDE IN THE SAME RESIDENCE IN CASE WE ARE UNABLE TO CONTACT PARENTS/GUARDIANS)

1. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to child:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to child:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIVACY PRACTICES AND CONSENT TO TREAT** \_\_\_\_\_\_\_\_\_\_\_\_\_ *(INITIALS)* I have reviewed the NASA Casa De Niños notice of privacy practices, which explains how my medical information may be used and disclosed. I understand that I am entitled to receive a copy of this document. I, Parent/Guardian of above-named child, give authorization to NASA Pediatrics to provide medical evaluation and treatment. I understand that my child must always be present with a parent/guardian during consultation. I authorize the following person(s) to consent for any/all medical treatment and/or procedures if I am unable to bring my child in. (Must be at least 18 years of age)

1. **Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PROVIDERS**\_\_\_\_\_\_\_\_\_\_\_\_\_ *(INITIALS)* Our providers rotate between offices to allow patients the opportunity to see them at both of our convenient office locations (Scarsdale and Pasadena). Our EMR system allows us to access your file from either location. Please make an appointment to see a specific provider. We cannot guarantee your preferred provider will be available if you walk in.

**NOTICE REGARDING RESULTS/REFERRALS**\_\_\_\_\_\_\_\_\_\_\_\_\_ *(INITIALS)* If you have not heard from our staff concerning your Lab/X-ray results or referral, I understand I share responsibility with the office to obtain the information. Please contact our office if you have not received a call within 7 business days.

**VACCINE INFORMATION** *\_\_\_\_\_\_\_\_\_\_\_\_\_ (INITIALS)* I have reviewed and understand the office Vaccine Policy.

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize NCNPC or Dr. Rivera to release information as needed to process my claim.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Name Parent Signature Date

**NO SHOW POLICY**

At *Nasa Pediatrics* it is imperative to provide the best quality medical care to all our patients. In order to accommodate all our patients with an appointment, we need to ensure we follow procedures to ensure your visit is conducted in a timely manner. Our office is requiring notification of at least 24 hours in advance if you need to cancel or reschedule your appointment.

Our **NO SHOW** Policy is as follows:

1. A minimum 24-hour notice is required to cancel or reschedule your appointment.
2. Late cancellations will be considered **“NO SHOW”**. Last minute cancellations or rescheduling is not acceptable.
3. First **NO SHOW** appointment: Will be documented and a courtesy call will be made regarding your missed appointment and the possibility of rescheduling at that time.
4. Second **NO SHOW** appointment: A warning letter will be sent to you to the address on file.
5. Third **NO SHOW**: It will be the Office Manager or Physicians discretion as to whether a letter notifying of a practice discharge will be sent out. If this is the case, this will notify you via certified letter we can no longer provide services and you will have 30 days to find another medical provider.

Nuestra Politica **NO SHOW**:

1. Se requiere notification de 24 horas mínimas para reprogramar o cancelar su cita.
2. Cancelaciones tardes serán consideradas **“NO SHOW”**
3. La primera “**NO SHOW**” cita: Sera documentada y haremos una llamada de cortesía notificando de su cita Perdida y la posibilidad de reprogramarla en ese momento.
4. La segunda “**NO SHOW**” cita: Se le enviara una carta de advertencia a la dirección que aparece en su expediente.
5. Tercera “**NO SHOW**”: Sera la discreción de la Manager de la Oficina o Medico si una carta dando al paciente de alta de la practica será enviada. Si este es el caso, se le notificará vía carta certificada que ya no podremos proveer servicios y tendrá 30 días para buscar otro proveedor médico.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name/Nombre de Paciente DOB/Fecha de Nacimiento

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Name/Nombre Padre/Madre Signature/Firma

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date