Registration Form
Eagan Valley Pediatrics, P.A.
****PLEASE RETURN COMPLETED FORM TO THE FRONT DESK ****

Today's Date: _____

Patient's Name:

First	MI	Last	DOB	M / F
				M / F

Parent #1 Name: _____ Relationship_____ DOB _____

Address: _____ City_____ State_____ Zip_____

Phone# Cell _____ Home _____ Work _____

Email Parent #1: _____

Parent # 2 Name: _____ Relationship_____ DOB _____

Address: _____ City_____ State_____ Zip_____

Phone# Cell _____ Home _____ Work _____

Email Parent #2:_____

Insurance Information

Primary
Insurance Company: _____
Subscribers Name: _____
Relationship_____DOB_____
Employer: _____
Policy#: _____
Group#_____StartDate: _____

Secondary
Insurance Company: _____
Subscribers Name: _____
Relationship_____DOB_____
Employer: _____
Policy#_____
Group#_____StartDate: _____

Whose address should we send your bill and/or mailings to? Parent #1 Parent #2
How did you hear about our clinic? Website Friend/Family Drive-By Other _____

Updated 4-21

Past Medical and Family History

Todays Date: _____

Patient Name: _____ DOB: _____

Mom's Name: _____ Dad's Name: _____

Child's Birth History:

Pregnancy Complications: _____

Smoking: _____

Alcohol: _____

Other Drugs: _____

Medications: _____

Infections: _____

Labor and Delivery Complications: _____

Gestation: _____weeks Delivery: _____

Birthweight: _____ lbs. _____ oz. Apgar's: _____ @1 min _____ @5 min

Child's Past Medical History:

Chronic Medical Conditions: _____

Medications: _____

Allergies: _____

Hospitalizations: _____

Surgeries: _____

Developmental Concerns: _____

Injuries: _____

Other: _____

Social History:

Lives With: _____

Parents: ____Married ____Separated ____Divorced ____Single ___Other

Dad's Occupation: _____ Mom's Occupation: _____

Exposure to tobacco smoke: Yes No Exposure to guns: Yes No

Family History

Is the child adopted? Yes No If yes, is any of the family history known? _____

Answer the following for child's parents, grandparents, aunts, uncles, first cousins.

Y	N		Affected Family Member(s)
☐	☐	Allergies	_____
☐	☐	Arthritis	_____
☐	☐	Asthma	_____
☐	☐	Cancer; type: _____	_____
☐	☐	Hearing Loss	_____
☐	☐	Recurrent ear infections	_____
☐	☐	Recurrent sinus infections	_____
☐	☐	Diabetes	_____
☐	☐	Juvenile	_____
☐	☐	Adult onset	_____
☐	☐	Substance/alcohol abuse	_____
☐	☐	Gastrointestinal disorders	_____
☐	☐	Gastroesophageal reflux disease	_____
☐	☐	Ulcers	_____
☐	☐	Celiac disease	_____
☐	☐	Inflammatory bowel disease	_____
☐	☐	Heart disease	_____
☐	☐	Hyperlipidemia (elevated cholesterol, elevated triglycerides)	_____
☐	☐	High blood pressure	_____
☐	☐	Kidney disease	_____
☐	☐	Recurrent urinary tract infections	_____
☐	☐	Ureteral reflux	_____
☐	☐	Other	_____
☐	☐	Mental health disorders	_____
☐	☐	Depression	_____
☐	☐	Anxiety	_____
☐	☐	Attention deficit disorder	_____
☐	☐	Other	_____
☐	☐	Neurologic disorders	_____
☐	☐	Seizures	_____
☐	☐	Developmental delays	_____
☐	☐	Developmental disorders	_____
☐	☐	Thyroid disease	_____
☐	☐	Vision problems	_____
☐	☐	Strabismus (lazy eye)	_____
☐	☐	Immune deficiencies	_____
☐	☐	Vascular disease	_____
☐	☐	Heart attacks or strokes in Individuals less than 55 years of age	_____
☐	☐	Overweight/obesity	_____
☐	☐	Sudden death	_____
☐	☐	Genetic disorders	_____

Eagan Valley Pediatrics
14135 Cedar Ave, S., Suite 100
Apple Valley, MN 55124
952-432-4373

Patient Name: _____

Date of Birth: _____

The State of Minnesota is asking healthcare providers to collect information on race, language and country of origin. This information will allow for the review of treatment patients receive to assure that everyone gets the highest quality of care and to evaluate for potential differences in the way health care is provided. Your answers will be confidential and will have no effect on the care you receive. Please respond to the following questions and return this form to the front desk staff.

From the list below, please identify the race(s) that best identify your child. You may choose more than one.

☐ 1 = American Indian or Alaska Native
(a person having origins in any of the original peoples of North and South America [including Central America], and who maintains tribal affiliation or community attachment)

☐ 2 = Asian
(a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam)

☐ 3 = Black or African American
(a person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American.")

☐ 4 = Hispanic or Latino
(a person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin. The term "Spanish origin" can be used in addition to "Hispanic or Latino")

☐ 5 = Native Hawaiian/Other Pacific Islander
(a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands)

☐ 6 = White
(a person having origins in any of the original peoples of Europe, the Middle East, or North Africa)

☐ 97 = Choose not to disclose/decline

☐ 98 = Unknown

Language:
From the list below, please identify the language in which we can best serve you and your child.

☐ 1 = Amharic	☐ 8 = English	☐ 15 = Karen	☐ 22 = Russian	☐ 29 = Tibetan
☐ 2 = Arabic	☐ 9 = French	☐ 16 = Korean	☐ 23 = Sign Language	☐ 30 = Tigrinya
☐ 3 = Bosnia	☐ 10 = German	☐ 17 = Laotian	☐ 24 = Somali	☐ 31 = Urdu
☐ 4 = Burmese	☐ 11 = Hearing Impaired	☐ 18 = Mandarin	☐ 25 = Spanish	☐ 32 = Vietnamese
☐ 5 = Cambodian	☐ 12 = Hindi	☐ 19 = Oromō	☐ 26 = Swahili	☐ 33 = Yoruba
☐ 6 = Cantonese	☐ 13 = Hmong	☐ 20 = Polish	☐ 27 = Tagalog	
☐ 7 = Chinese	☐ 14 = Japanese	☐ 21 = Romanian	☐ 28 = Thai	

☐ 97 = Choose not to disclose/decline ☐ 98 = Unknown ☐ 99 = Other Language not listed above

_____

Country of Origin:

From the list below, please identify the country where your child was born.

☐ 2 = Afghanistan	☐ 52 = Ecuador	☐ 102 = Malawi	☐ 152 = Solomon Islands
☐ 3 = Albania	☐ 53 = Egypt	☐ 103 = Malaysia	☐ 153 = Somalia
☐ 4 = Algeria	☐ 54 = El Salvador	☐ 104 = Maldives	☐ 154 = South Africa
☐ 5 = American Samoa	☐ 55 = Equatorial Guinea	☐ 105 = Mali	☐ 155 = South Korea
☐ 6 = Angola	☐ 56 = Eritrea	☐ 106 = Malta	☐ 156 = Spain
☐ 7 = Argentina	☐ 57 = Estonia	☐ 107 = Marshall Islands	☐ 157 = Sri Lanka
☐ 8 = Armenia	☐ 58 = Ethiopia	☐ 108 = Mauritania	☐ 158 = Sudan
☐ 9 = Australia	☐ 59 = Fiji	☐ 109 = Mauritius	☐ 159 = Suriname
☐ 10 = Austria	☐ 60 = Finland	☐ 110 = Mexico	☐ 160 = Swaziland
☐ 11 = Azerbaijan	☐ 61 = France	☐ 111 = Micronesia	☐ 161 = Sweden
☐ 12 = Bahamas	☐ 62 = Gabon	☐ 112 = Moldova	☐ 162 = Switzerland
☐ 13 = Bahrain	☐ 63 = Gambia	☐ 113 = Mongolia	☐ 163 = Syria
☐ 14 = Bangladesh	☐ 64 = Georgia	☐ 114 = Montenegro	☐ 164 = Taiwan
☐ 15 = Barbados	☐ 65 = Germany	☐ 115 = Morocco	☐ 165 = Tajikistan
☐ 16 = Belarus	☐ 66 = Ghana	☐ 116 = Mozambique	☐ 166 = Tanzania
☐ 17 = Belgium	☐ 67 = Greece	☐ 117 = Namibia	☐ 167 = Thailand
☐ 18 = Belize	☐ 68 = Grenada	☐ 118 = Nepal	☐ 168 = Togo
☐ 19 = Benin	☐ 69 = Guam	☐ 119 = Netherlands	☐ 169 = Tonga
☐ 20 = Bhutan	☐ 70 = Guatemala	☐ 120 = New Zealand	☐ 170 = Trinidad and Tobago
☐ 21 = Bolivia	☐ 71 = Guinea	☐ 121 = Nicaragua	☐ 171 = Tunisia
☐ 22 = Bosnia Herzegovina	☐ 72 = Guinea-Bissau	☐ 122 = Niger	☐ 172 = Turkey
☐ 23 = Botswana	☐ 73 = Guyana	☐ 123 = Nigeria	☐ 173 = Turkmenistan
☐ 24 = Brazil	☐ 74 = Haiti	☐ 124 = North Korea	☐ 174 = Uganda
☐ 25 = Brunei	☐ 75 = Honduras	☐ 125 = Norway	☐ 175 = Ukraine
☐ 26 = Bulgaria	☐ 76 = Hungary	☐ 126 = Oman	☐ 176 = United Arab Emirates
☐ 27 = Burma	☐ 77 = Iceland	☐ 127 = Pakistan	☐ 177 = United Kingdom
☐ 28 = Burkina Faso	☐ 78 = India	☐ 128 = Palestinian State (proposed)	☐ **1 = United States**
☐ 29 = Burundi	☐ 79 = Indonesia	☐ 129 = Panama	☐ 178 = Uruguay
☐ 30 = Cambodia	☐ 80 = Iran	☐ 130 = Papua New Guinea	☐ 179 = Uzbekistan
☐ 31 = Cameroon	☐ 81 = Iraq	☐ 131 = Paraguay	☐ 180 = Vanuatu
☐ 32 = Canada	☐ 82 = Ireland	☐ 132 = Peru	☐ 181 = Venezuela
☐ 33 = Cape Verde	☐ 83 = Israel	☐ 133 = Philippines	☐ 182 = Virgin Islands, U.S
☐ 34 = Central African Republican	☐ 84 = Italy	☐ 134 = Poland	☐ 183 = Vietnam
☐ 35 = Chad	☐ 85 = Jamaica	☐ 135 = Portugal	☐ 184 = Western Sahara
☐ 36 = Chile	☐ 86 = Japan	☐ 136 = Puerto Rico	☐ 185 = Yemen
☐ 37 = China	☐ 87 = Jordan	☐ 137 = Qatar	☐ 186 = Yugoslavia (former)
☐ 38 = Colombia	☐ 88 = Kazakhstan	☐ 138 = Romania	☐ 187 = Zambia
☐ 39 = Comoros	☐ 89 = Kenya	☐ 139 = Russia	☐ 188 = Zimbabwe
☐ 40 = Congo, Democratic Republic of	☐ 90 = Kuwait	☐ 140 = Rwanda	
☐ 41 = Congo, Republic of	☐ 91 = Kyrgyzstan	☐ 141 = Saint Lucia	
☐ 42 = Costa Rica	☐ 92 = Laos	☐ 142 = Saint Vincent & the Grenadines	
☐ 43 = Cote D'Ivoire	☐ 93 = Latvia	☐ 143 = Samoa	
☐ 44 = Croatia	☐ 94 = Lebanon	☐ 144 = Sao Tome and Principe	
☐ 45 = Cuba	☐ 95 = Lesotho	☐ 145 = Saudi Arabia	
☐ 46 = Cyprus	☐ 96 = Liberia	☐ 146 = Senegal	
☐ 47 = Czech Republic	☐ 97 = Libya	☐ 147 = Serbia	
☐ 48 = Denmark	☐ 98 = Lithuania	☐ 148 = Sierra Leone	
☐ 49 = Djibouti	☐ 99 = Luxembourg	☐ 149 = Singapore	
☐ 50 = Dominican Republic	☐ 100 = Macedonia	☐ 150 = Slovakia	
☐ 51 = East Timor	☐ 101 = Madagascar	☐ 151 = Slovenia	

☐ 997 = Choose not to disclose/decline ☐ 998 = Unknown ☐ 999 = Other country of origin – not listed above

EAGAN VALLEY PEDIATRICS PA
General Consent

Patient Name: _____ **Date of Birth:** _____ **Date:** _____

Consent to Treat
I consent to and authorize the physicians, nurses and other healthcare providers at Eagan Valley Pediatrics, PA to perform appropriate healthcare examinations, treatment, diagnostic testing or medication administration as deemed medically necessary by their professional judgment. I know that there are some risks with all medical treatments and procedures and I understand that no one can guarantee how well treatments or procedures will work.

Assignment of Benefits/Payment for Services
I authorize payment of any and all benefits to Eagan Valley Pediatrics, PA. I know that I must pay for any charges for my care that are not covered by my insurance, health plan, or government programs. I realize I must cooperate with Eagan Valley Pediatrics, PA to get payment for my care. If I am eligible for payment from more than one type of coverage, Eagan Valley Pediatrics, PA will return any extra payments to the payor. If I have an unpaid bill at Eagan Valley Pediatrics, PA, any refunds due to me will be put on my unpaid bill. I further understand that future services may be denied with the non-payment of my account. If you No Show for more than one appointment in a 12 month period there will be a charge of $50 that you will be responsible for. Insurance does not cover this cost.

Lab Results
I give permission to Eagan Valley Pediatrics to leave a message for (Parent 1 name and phone) _____,

(Parent 2 name and phone)_____re: lab or test results.

Other Individuals Authorized to Consent to Treatment, and be Your Child's Designated Emergency Contact
In addition to the legal guardians of the patient, the following persons are authorized to consent to recommended medical care for my child: name and phone. Do we have permission to discuss care with this person in case of an emergency?

Name: (Other than parent(s)) **Phone:**

_____ _____

This contact will remain active unless we receive written notification from the parent or guardian requesting a change.

Release of Information

I consent to and authorize Eagan Valley Pediatrics, PA to use and disclose my protected health information for:

- Treatment
- Payment

Releases for these purposes may be made to insurance companies, health plans, government programs, e-prescriber databases, payer network organizations, including clinically integrated networks and/or accountable care organizations in which my provider participates, and other healthcare providers involved in my care and treatment. Additionally, I consent to and authorize my insurance company to share my protected health information for the purposes stated above to Eagan Valley Pediatrics, PA or a clinically integrated network or accountable care organization in which Eagan Valley Pediatrics, PA participates.

Patient Rights and Privacy Practices
You and your family's rights and our privacy practices are posted in main areas within Eagan Valley Pediatrics, PA. Your signature acknowledges receipt of our Notice of Privacy Practices. If you have any questions concerning your rights and/or our privacy practices, please contact your care provider or Eagan Valley Pediatrics, PA's Privacy Officer.

Reference Laboratory Services
I understand that Eagan Valley Pediatrics, PA utilizes the services of Health East Laboratory to perform some of the lab tests requested by our physicians. I further understand that Health East Laboratory will bill separately for its services. I consent to Eagan Valley Pediatrics, PA providing demographic information as necessary for billing purposes.

My signature here means I have read this information and understand it. This consent is valid until revoked in writing.

Signature: _____ **Print Name:** _____

Relationship to Patient: _____ **Parent Email:** _____

Name of Interpreter (if used): _____ **Telephone consent obtained by (Name/Date/Title):** _____

Updated 4-21

EAGAN VALLEY PEDIATRICS

14135 Cedar Ave So, Suite 100
Apple Valley MN 55124-4523
Phone 952-432-4373
Fax 952-997-5679

Eagan Valley Pediatrics Use Only
MRN _____
Completed By _____
Date _____

PATIENT AUTHORIZATION FOR RELEASE OF PROTECTED INFORMATION

Patient Information	Name:_____ DOB:_____ Address:_____ City:_____ State:_____ Zip:_____ Phone # 1:_____ Phone #2_____
Health Information Released **FROM**	◯ Eagan Valley Pediatrics ◯ Other Provider/Person/Organization_____ Address_____ City:_____ State:_____ Zip:_____
Health Information Released **TO**	Person/Organization: (Please include **COMPLETE** address) _____ _____ ◯ Eagan Valley Pediatrics
Purpose of Disclosure	◯ Transfer of Care ◯ Continuing Care ◯ Insurance ◯ Personal ◯ Legal/Attorney Other(Please Explain)_____
Health Information to be Released	Entire Health Record (includes all records listed) ◯ Office Notes ◯ Laboratory results ◯ Immunization Record ◯ Allergy records ◯ History and physical report ◯ X-ray/Imaging results ◯ Medication information ◯ Behavioral (Mental) Health ◯ Chemical Health Records ◯ Other described here:_____ Unless specifically excluded, behavioral/mental health information, HIV information, and/or alcohol/drug abuse information appearing in the information selected above will be disclosed. **Do not release records/information related to:** O Behavioral/Mental Health O HIV/HIV related illnesses O Alcohol and/or drug abuse **There may be a charge for copies of your records per Minnesota Statue 144.292.**
Method of Delivery	◯Mail to Recipient ◯ Pick up on __/__/__ ◯Fax (Less than 50 pages total) Fax to :_____ ATTN: _____ Other:_____
Authorization	•I understand that this consent expires within one calendar year of this date, or shall remain in effect for the period reasonably needed to complete the request for information, whichever date occurs first. **I understand that:** •I may revoke this authorization at any time by notifying, in writing, the healthcare facility listed in the FROM section. •Revoking this authorization does not apply to information that has already been released under this authorization. •I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed and no longer protected by these regulations •I release the above named healthcare provider from all legal responsibility and /or liability that may arise from the release of the records I have specified. I direct that only information prior to the date of my signature be honored and that a photocopy or fax copy of this authorization be granted the same authority as the original. •I do not have to sign this form. Treatment will still be provided to me if I do not sign this form. Payment for services is not contingent upon me signing this form, unless those services are for the sole purpose of creating personal information for a third party, such as a life insurance company. _____ _____ Signature of Patient or Patient's Representative Signature Date _____ _____ Print name of Representative Relationship to Patient

evp 2015