



# Stony Brook Children's

## PATIENT REGISTRATION

### PATIENT INFORMATION

Name: (Last, First, MI)			
Address:			
City:	State/Province:	Zip:	Country:
Mailing Address (if different from above):			
Home Phone:		Work:	Mobile:
Email:	SSN:	Birth Date:	Sex: M <input type="checkbox"/> F <input type="checkbox"/>
Race: White <input type="checkbox"/>	Hispanic <input type="checkbox"/>	Black/African American <input type="checkbox"/>	Other Pacific Islander <input type="checkbox"/>
Other <input type="checkbox"/>	Asian <input type="checkbox"/>	Native Hawaiian <input type="checkbox"/>	American Indian <input type="checkbox"/>
Ethnicity: Hispanic/Latino <input type="checkbox"/>	Not Hispanic/Latino <input type="checkbox"/>	Other <input type="checkbox"/>	<b>Preferred Language for communication:</b>
Contact Preferred: Home <input type="checkbox"/>	Work <input type="checkbox"/>	Mobile <input type="checkbox"/>	
Allow Appointment Reminder: If Yes, please choose one method Call <input type="checkbox"/> Text <input type="checkbox"/> No <input type="checkbox"/>			Leave Message: Yes <input type="checkbox"/> No <input type="checkbox"/>
Primary Care Physician:		Referring Physician:	

### If parents are divorced or separated please fill out this section:

Who has custody?	
Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please explain and provide a copy of any legal paperwork that supports this restriction.	

### EMERGENCY CONTACT INFORMATION

Name:	Relationship to Patient:
Phone:	Email:

**CONTACT/POLICY INFORMATION**

Parent 1 Name:		Relationship to Patient:		Insurance Policy Holder Yes No (circle one)	
Parent 1 Address:					
City:		State:	Zip:		Country:
Home Phone:		Work:		Mobile:	
Birth Date:		Sex: M <input type="checkbox"/> F <input type="checkbox"/>		SSN:	
Employer Name:			Phone Number:		
Address:					
City:		State:	Zip:		Country:
Parent 2 Name:		Relationship to Patient:		Insurance Policy Holder Yes No (circle one)	
Parent 2 Address: (if different than above)					
City:		State:	Zip:		Country:
Home Phone:		Work:		Mobile:	
Birth Date:		Sex: M <input type="checkbox"/> F <input type="checkbox"/>		SSN:	
Employer Name:			Phone Number:		
Address:					
City:		State:	Zip:		Country:
<b>Primary Insurance</b>			<b>Policy Holder</b>		
Policy Number:		Insurance Company Group Name:			
Effective Date:		Expiration Date:		Policy Copay:	
<b>Secondary Insurance</b>			<b>Policy Holder</b>		
Policy Number:		Insurance Company Group Name:			
Effective Date:		Expiration Date:		Policy Copay:	

## NOTICE OF PRIVACY PRACTICES

Purpose of this notice: To describe how your medical information is used, whom it is disclosed to and how you gain access to it.

Stony Brook Community Medical as a healthcare provider is permitted by law to collect, use and disclose your “protected health information” or medical record for the purpose of treatment, payment, internal business operations or as required by law for reporting purposes.

You have certain rights including access to your information and some control over who has access to your information.

Stony Brook Community Medical, PC agrees to abide by the terms of this notice but reserves the right to change the terms at any time. Should we do so, we will notify you in writing.

Use and Disclosure of Protected Health Information (PHI): When you sign a consent form to be treated, your protected health information is used to treat you, to bill you or your insurance company for your care and to make decisions on how to provide healthcare services for you, your family and the community we take care of. Your physician, office staff and others outside of Stony Brook Community Medical i.e. your insurer are allowed access to this information.

Some examples of uses and disclosures of your protected health information are for:

- Treatment by your doctor
- Law enforcement
- Workers compensation
- Appointment reminders
- Payment for your treatment by you or your insurance
- Reporting adverse events of medication or medical devices to the FDA
- Reporting health risks
- Response to legal proceedings
- Organ or tissue donation
- Coroners, funeral directors
- Stony Brook Community Medical to determine if we meet the needs of our patients

Any other uses and disclosures not specified require an authorization, including for marketing purposes and disclosures that constitutes the sale of PHI.

### Patient Rights:

- A. You have the right to inspect and to obtain a copy of your protected health information for as long as the group maintains your record.  
\*We are permitted by NYS law to charge you a fee of 75 cents per page
- B. You have the right to restrict or to limit the use of your protected health information that we use for treatment, payment or operations.  
\*Stony Brook Community Medical reserves the right to deny you treatment should you restrict the use of your protected health information for treatment, payment or operations, unless the requested restriction relates to disclosures to a health plan and the Protected Health Information relates to a health care service or item which you have paid for in full and out of pocket.
- C. You can restrict the release of your health information to family or friends unless they have your written or verbal permission.
- D. You have the right to request an accounting of disclosures made of your health information.  
\*Your request must be submitted in writing, specifying dates and time periods as far back as six years from today, as long as the events in question happened after April 12, 2003.
- E. You have the right to amend your protected health information.  
\*To amend your health information, your request must be given in writing along with a reason for doing so. Your request can be denied if the information originated outside Stony Brook Community Medical, PC.
- F. You have the right to request confidential communications as long as it is done in writing  
\*For example, you can specify that we only contact you at work, at home or by mail, etc.
- G. You have the right to receive notifications whenever a breach of your unsecured PHI occurs.

*If you feel your privacy rights have been violated, you may file a complaint, which will be forwarded to our Compliance Officer.*

**Acknowledgement of Receipt of  
Stony Brook Community Medical's Privacy Practices**

I, the undersigned, acknowledge that I have received a copy of Stony Brook Community Medical's Notice of Privacy Practices. Should I have any questions about the policy, I will discuss them with my Physician or the group's *Compliance Officer*.

Print Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Authorization for the Release of Patient Health Information to a Second Party**

I authorize the release of my Patient Health Information to my  
*(Fill in name(s) of all that apply.)*

Spouse, _____	Ph: _____
Family Member, _____	Ph: _____
Friend, _____	Ph: _____
School/College Health Services, _____	Ph: _____
Other, _____	Ph: _____

By signing below, I acknowledge that this authorization is valid until it is revoked by me.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature (if patient a minor): \_\_\_\_\_

Print name of Parent/Guardian: \_\_\_\_\_

Group # \_\_\_\_\_ : Patient Name: \_\_\_\_\_ MR#: \_\_\_\_\_ Date: \_\_\_\_\_

**CLINICAL PRACTICE MANAGEMENT PLAN**

Patient's Name: \_\_\_\_\_  
Last First Middle

**RELEASE OF INFORMATION**

I hereby authorize and direct Stony Brook Children's Services, University Faculty Practice Corporations having treated me, to release to governmental agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

X \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Patient or Authorized Representative

**UNIFORM ASSIGNMENT**

I hereby assign, transfer and set over to Stony Brook Children's Services, University Faculty Practice Corporations sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my medical care, to cover the cost of care and treatment rendered to myself or my dependent.

In addition, I also assign, transfer and set over to all of the other University Faculty Practice Corporations from which I may require medical care, sufficient monies and/or benefits to which I may be entitled. These other University Faculty Practice Corporations are as follows: Stony Brook Anaesthesiology, Stony Brook Dermatology, Stony Brook Family Medical Group, Stony Brook Internists, New York Spine and Brain Surgery, Neurology Associates of Stony Brook, University Associates of Obstetrics and Gynecology, Stony Brook Preventative Medicine Services, Stony Brook Ophthalmology, Stony Brook Orthopaedic Associates., Stony Brook Children's Services, Stony Brook Psychiatric Associates., Stony Brook Radiation Oncology, Stony Brook Radiology, Stony Brook Surgical Associates, and Stony Brook Urology.

X \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Patient or Authorized Representative

Account Representative: \_\_\_\_\_

Group #: \_\_\_\_\_ Name: \_\_\_\_\_ MR#: \_\_\_\_\_  
Date: \_\_\_\_\_

**Stony Brook Children's Services**  
**P.O. Box 1559**  
**Stony Brook, NY 11790**

**GUARANTEE OF PAYMENT**

Many insurance companies, including managed care organizations, require prior written authorization for treatment and follow-up visits. It is your responsibility as a patient to obtain all necessary authorizations from your insurance company prior to receiving medical services. If you have not received prior approval for the service or authorization has been denied, you are fully responsible for all charges if your insurance company does not agree to pay. In addition, you will be responsible for all deductibles, co-insurance, co-payments, any service that is not covered by your insurance plan, and any service that your insurance company has determined not to be "medically necessary".



I have read and understand this information. I understand that my insurance company may deny coverage and request that Stony Brook Children's Services perform this medical service anyway. I agree to be personally and fully responsible for all charges. I understand that the provider named above is relying on this promise and is rendering services without requiring payment at the time of service based on such reliance.

\_\_\_\_\_  
Signature of Patient or  
Legally Authorized  
Representative

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

### Pediatric Patient Medical History

Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

How did you hear about our practice? \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Pharmacy Address: \_\_\_\_\_

**Please briefly state in the box below the reason for your visit**

Family Medical History				
Condition / Disease	Mother	Father	Sister	Brother
<input type="checkbox"/> Alcohol Addiction				
<input type="checkbox"/> Allergies				
<input type="checkbox"/> Asthma				
<input type="checkbox"/> Blood Disorders				
<input type="checkbox"/> Cancer				
<input type="checkbox"/> Cholesterol				
<input type="checkbox"/> Convulsions				
<input type="checkbox"/> Dental Problems				
<input type="checkbox"/> Diabetes				
<input type="checkbox"/> Drug Addiction				
<input type="checkbox"/> Eczema/Skin Problems				
<input type="checkbox"/> Emotional Disorder				
<input type="checkbox"/> Eye Problems				
<input type="checkbox"/> HDL				
<input type="checkbox"/> Heart Disease				
<input type="checkbox"/> High Blood Pressure				
<input type="checkbox"/> Kidney				
<input type="checkbox"/> LDL				
<input type="checkbox"/> Lipids				
<input type="checkbox"/> Mental Retardation				
<input type="checkbox"/> Migraine				
<input type="checkbox"/> Sickle Cell				
<input type="checkbox"/> Stroke				
<input type="checkbox"/> Sudden Infant Death Syndrome				
<input type="checkbox"/> TB				
<input type="checkbox"/> Tobacco Use				
<input type="checkbox"/> Triglycerides				
<input type="checkbox"/> Other:				

Birth History			
Hospital of Birth		Term	
Type of Delivery		APGAR	
Birth Weight		Circumcision	
Length		Conditions	
Discharge Weight		Complications of Pregnancy	

Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_ Sex: \_\_\_\_

Feeding / Nutrition	
Feeding	
Formula	
Vitamins	
Meals / Day	

Past History			
	Month / Yr		Yes / No
Chicken Pox		Seizures	
Pertussis		Frequent Colds	
Measles		Scarlet Fever	
Mumps		Tonsillitis	
Rubella		Ear Infections	
		Asthma	
Injuries:			
Hospitalizations:			

Health and Safety			
	Yes / No		Yes / No
Are there guns in the house?		Is your child drinking fluoridated water?	
Does the child use a toothbrush daily?		Does the child ever eat dirt, plaster or paint?	
Does the child use a car seat or seatbelt all the time?		Does the child take vitamins, iron or other supplements?	
Are there smoke detectors in the home?		Does anyone in the house smoke?	
Do you have syrup of Ipecac?		What pets are in your home?	

\*\*\*\*THIS SECTION ONLY NEEDS TO BE COMPLETED IF CHILD IS 5+

Development and Behavior			
	Yes / No	Does your child have:	Yes / No
Did the child sit alone by 7 months?		Nightmares / Sleep Problems	
Did the child walk alone by 14 months?		Irritable / Bad Temper	
Did the child say 3 words by 15 months?		Discipline Problems	
Is the child doing well in school?		Speech Problems	
Does the child get along with other children?		Thumb Sucking	
How often do you read to your child?		Bed Wetting	
		Toilet Training Problems	
		Breath Holding	

Today's Date: \_\_\_\_\_

Completed By: \_\_\_\_\_



## Mid Island Pediatric Associates

### *Patient Portal*

*The Patient Portal allows you to view parts of your personal health record including results, visit summaries, immunizations and medications and also allows you to request medication refills.*

***The invitation for the portal will come to your email from IQHEALTH.***

Patient's First Name: \_\_\_\_\_

Patient's Last Name: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_

Gender:     Male     Female

Patient's Email address: \_\_\_\_\_

#### Security Question

Patient's Postal code: \_\_\_\_\_

If you are not interested in the patient portal, please check below:

Decline Patient Portal