Kansas City Pediatric Cardiology Associates

Patient Name: _____ Date of birth: _____ Chart # _____

Patient Review of Systems

Please circle any of the following symptoms that the patient has been experiencing:

CONSTITUTIONAL
Poor weight gain/growth
Fever/chills
Change in appetite

GASTROINTESTINAL
Vomiting
Diarrhea
Stomach Pain
Constipation

ENT
Sore throat
Cold symptoms
Earache
Hearing impairment
Mouth sores
Dry lips

☐ No positive findings for Review of Systems

RESPIRATORY
Shortness of breath
Difficulty breathing with feeding
Wheezing
Cough
Fast breathing
Labored breathing

MUSCLE/SKELETAL
Muscle pain
Joint pain or swelling
Back pain

SKIN
Recent rash
Skin discoloration
Birthmarks
Blueness (fingers/lips/toes)
Pale

NEUROLOGIC
Abnormal coordination/weakness
Motor/verbal delays
ADHD
Seizures

CARDIOVASCULAR
Chest pain
Irregular heart beat
Fast heart beat
Fluid retention
Slow feeding (>20 minutes to take a bottle
Palpitations
Murmur
Blueness

HEMATOLOGIC
Bruise/bleed easily
Swollen lymph node - "big glands"
Anemia

Any allergies to foods or medications? Yes _____ No _____ If YES, please list: _____

Medications taken daily: _____ **Dose** _____ _____ **Dose** _____

_____ **Dose** _____ _____ **Dose** _____

Are all immunizations up to date? Yes _____ No _____ Date and name of most recent vaccination _____

Family and Social History

Have the parents or siblings of the patient been diagnosed with heart disease, diabetes, high blood pressure, stroke, cancer, sickle cell anemia, or seizures?
Yes _____ No _____ If YES, please explain:

Is there any family history of heart disease in babies or children or sudden **unexplained** death? Yes _____ No _____
If Yes, please explain;

Do any other illnesses run in the family? Yes _____ No _____ If YES, please list illness and relative:

Who lives in the same house as the patient? _____

Does anyone in the home smoke? Yes _____ No _____ If YES, inside the house _____ outside the house _____

If the patient is in school, what grade is he/she in? _____ Performance: Satisfactory _____ Non-satisfactory _____

Is the patient involved in athletics? Yes _____ No _____ If YES, what sport/s?

_____ _____ _____/_____/_____
Signature of person completing form ***Relationship to patient*** ***Date***

Internal use only:

Chief Complaint: _____ PCP: _____

HT_____ WT_____ BP_____/_____ Resp_____ Pulse_____ O2_____ SG_____

_____ _____ _____/_____/_____
Documentation Review by **Title** **Date**

Kansas City Pediatric Cardiology

PATIENT REGISTRATION FORM

First Name	Middle Intl	Last Name	Nickname

Birth Date:_____ Male_____ Female _____ Primary Care Physician_____

Race: _____ Hispanic or Latino: Y or N Primary Language: _____

Primary Phone:( )_____Secondary Phone:( )_____

Address_____

City _____State _____ Zip _____

Status of Parents: Married ☐ Seperated ☐ Divorced ☐ Widowed ☐ Unmarried ☐

Mother or Guardian Information

_____ _____Primary Phone ( )_____

Last Name First Name

RELATIONSHIP TO PATIENT(S): ☐ Mother ☐ Step-Mother ☐ Grandparent ☐ Foster Parent ☐ Other_____

Email Address:_____ SSN#_____DOB:_____

Address:_____ City: _____ State: _____ Zip: _____

Employer:_____ Work Phone: ( )_____

Father or Guardian Information

_____Primary Phone ( )_____

Last Name First Name

RELATIONSHIP TO PATIENT(S): ☐ Father ☐ Step-Father ☐ Grandparent ☐ Foster Parent ☐ Other _____

Email Address:_____ SSN#_____DOB:_____

Address:_____City: _____ State: _____ Zip: _____

Employer:_____ Work Phone:( )_____

WITH WHOM DOES THE CHILD RESIDE? ☐Father ☐ Mother ☐ Legal Guardian ☐ Step Parent ☐ Foster Parent ☐Other_____

If child/children are living with step parent or other relative, please complete the following:

Name:_____ DOB:_____ Phone#( )_____

Primary Health Insurance:	Secondary Health Insurance:
1) Company Name:_____	2) Company Name:_____
Policy ID#:_____	Policy ID#:_____
Subscriber's Name:_____	Subscriber's Name:_____
Subscriber DOB: _____	Subscriber DOB:_____
RELATIONSHIP TO PATIENT: ☐MOTHER ☐ FATHER	RELATIONSHIP TO PATIENT: ☐ MOTHER ☐ FATHER
☐ STEP-PARENT ☐ OTHER:_____	☐ STEP-PARENT ☐ OTHER _____

I authorize Kansas City Pediatric Cardiology to release any and all medical records, pertaining to my child's health, to my insurance company for any requested additional information. I, _____, hereby acknowledge that Kansas City Pediatric Cardiology Associates has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me/my child may be used and disclosed, and how I can access this information. I also acknowledge that I was provided with Kansas City Pediatric Cardiology Associates financial policy and agree to the policy as stated. I understand that if I have questions or complaints I may contact KCPCA.

Signature_____ Date_____

CONSENT OF TREATMENT

The physicians of Kansas City Pediatric Cardiology have my permission to provide my child/children with any necessary treatment. The following persons have my permission to seek medical attention for my child/children in my absence.

1)_____(2)_____ (3)_____

Referring Provider: _____

Parent/Legal Guardian Signature_____ Date_____

Kansas City Pediatric Cardiology Associates
Office Financial Policy

We would like to thank you for choosing Kansas City Pediatric Cardiology. As one of our patients, we would like to keep you informed of our current office and financial policies. We require a signature to document that you have read and understand these policies.

Payment

- Payment is expected at the time of service. This is an insurance company rule. This includes co-payments participating insurance companies. Kansas City Pediatric Cardiology, accepts cash, personal checks, most major credit cards. There is a service charge of $25 for returned checks.
- Patients with an outstanding balance more than 90 days overdue must make arrangements for payment prior to scheduling appointments. Parents are ultimately responsible for any charges or portion thereof for which payment is denied by insurance for whatever reason, except where prohibited by law or prior contractual agreement.

Insurance

- It is the patient's responsibility to provide us with current insurance information and to present an active insurance care at each visit.

Referrals

- If your plan requires, you may need to receive a referral from your primary care physician. It is your responsibility to obtain this referral if it is required by your insurance company.

Canceled Appointments

- If you are unable to keep your scheduled appointment, please call our office 24 hours before your appointment to reschedule. This will allow time to provide that time slot to another patient.
- We reserve the right to charge $25 for appointments that are not canceled at least 24 hours in advance.

Past Due Accounts

- If this account is not paid when due, and Kansas City Pediatric Cardiology has to retain an attorney or collection agency for collection, I/we agree to pay all late fees, costs of collection including reasonable interest, reasonable attorney's fees (even if suit is filed) and reasonable collection agency fees.

More Information

- Please call our office at (816) 584-0505 if you have a question about your bill. Most problems can be settled quickly and easily, and your call will prevent any misunderstandings.
- If you are having trouble paying you bill, please discuss the situation with us. Satisfactory arrangements can almost always be made.
- Financial considerations should never prevent children from receiving the care they need at the time they need it.

Signature _____ **Date** _____