CHILD REGISTRATION

PATIENT INFORMATION:

NAME: _____
FIRST MIDDLE LAST

ADDRESS: _____/ _____/_____/_____
MAILING ADDRESS CITY STATE ZIP CODE

BIRTHDATE: _____/_____/_____ AGE: _____ SEX: • M • F SOCIAL SECURITY#:_____

RELATIONSHIP WITH THE PATIENT: _____

• Biological • Adopted • Guardian' • Temporary • Permanent • Foster Parent

EMAIL ADDRESS: _____

MOTHER/GUARDIAN: NAME_____ SS#_____ BIRTHDAY_____

PHONE#: HOME_____/WORK_____/CELL_____

ADDRESS_____

_____
EMPLOYER SUPERVISOR

FATHER/GUARDIAN: NAME_____ SS#_____ BIRTHDAY_____

PHONE#: HOME_____/WORK_____/CELL_____

ADDRESS: _____

_____
EMPLOYER SUPERVISOR

REFERRING PHYSICIAN: _____ PHONE: _____ FAX:_____

ADDRESS:_____/_____/_____/_____
MAILING ADDRESS CITY STATE ZIP CODE

PEDIATRICIAN/PRIMARY CARE DOCTOR NAME:_____ PHONE:_____

PHARMACY_____ PHARMACY PHONE _____

EMERGENCY CONTACT: OTHER THAN PARENT OR GUARDIAN

_____/_____/_____
NAME RELATIONSHIP HOME PHONE #

_____/_____/_____/_____/_____
MAILING ADDRESS CITY STATE ZIP CODE WORK/CELL PHONE

_____
EMAIL ADDRESS

INSURANCE INFORMATION—PLEASE COMPLETE

INSURANCE SUBSCRIBERS NAME (Whose name is it in?)**:**_____ DOB: _____

SUBSCRIBERS ADDRESS_____

SUBSCRIBERS PHONE #_____

SUBSCRIBERS RELATIONSHIP TO PATIENT_____

Consent to Treatment
Cameron S. Schaeffer, MD, PSC

I voluntarily authorize Cameron S. Schaeffer, MD, PSC and/or its agents to provide medical and surgical care for me or for the person for whom I am a legal guardian or custodian. This includes medical and surgical care, as well as any necessary testing. I acknowledge that no guarantees have been made as to the effect of such examination and treatment on my condition or on the condition of the person for whom I am duly authorized to sign. I understand that I have the right to make the decisions concerning my health care or the health care of the person for whom I am duly authorized to make such decisions, including the right to refuse recommended medical or surgical care.

I understand that my medical record or the medical record of the person for whom I am duly authorized to sign is confidential. This information will be maintained by Cameron S. Schaeffer, MD, PSC and its agents. I understand that no information will be released from this record except as noted below. I authorize the release from my medical records or from the records of the person for whom I am duly authorized to so, of any medical or psychiatric information as may be required by:

1) Any health or accident insurance carrier, workman's compensation, or agency which is legally responsible (social, welfare, governmental), or which Cameron S. Schaeffer, MD, PSC has good cause to believe is legally responsible for all or any part of its professional fees.
2) Any physicians or health care facilities rendering professional care to the patient.
3) Any Peer Preview Organization responsible for reviewing medical care.

I authorize Cameron S. Schaeffer, MD, PSC to obtain medical records form other physicians, hospitals, or health care facilities that it deems necessary for my medical care or for the care of the person for whom I am duly authorized to sign. This consent will remain in effect until Cameron S. Schaeffer, MD, PSC is otherwise notified by me in writing.

I agree to be responsible to Cameron S. Schaeffer, MD, PSC for charges resulting from care rendered by Dr. Schaeffer and his agents not covered by my insurance, if any. All bills are due in full on demand. If I fail to honor this agreement, I agree to pay any collection cost or attorney fees resulting from the collection of my accounts. I agree that Cameron S. Schaeffer, MD, PSC is not party to any disputed claim or peer-review decision which affects payment of any claim filed on my behalf, and that upon my request for payment by Cameron S. Schaeffer, MD, PSC (by invoice, phone, or email), I agree to pay any outstanding balance.

I hereby assign all rights and privileges and authorize payment directly to Cameron S. Schaeffer, MD, PSC for any claim filed on my behalf or on the behalf for any of the person for whom I am duly authorized to sign for insurance benefits. I agree that I am financially responsible to Cameron S. Schaeffer, MD, PSC for charges not covered by this assignment or not paid on a timely basis by the insurance company.

I certify that I have read and understand the authorizations given above and I am the patient, or the person duly authorized by the patient to execute the above and accept its terms.

_____ _____

Patient
Date of Birth_____

Parent or Legal Guardian
Date_____

Cameron S. Schaeffer, M.D., PSC

Consent to Treat

I hereby authorize Cameron S. Schaeffer, M.D., PSC, and its employees, to provide medical care to my child, listed below, including examinations and treatments both within its office and at other locations. I certify that I am the legal parent or guardian, and I understand that Cameron S. Schaeffer, M.D., PSC assumes that a child's biological and/or legal parents are both legal guardians who have access to medical information and treatment options for that child. Any child brought to our clinic by someone other than the child's parents and or legal guardians for examination or treatment must have a signed authorization from the parents or legal guardians. This authorization gives Cameron S. Schaeffer, M.D., PSC the right to share the child's protected health information with the person(s) who accompany the child to our office.

Medical Records/ Privacy

At Cameron S. Schaeffer, M.D., PSC, we are committed to protecting the security and privacy of your child's personal information. Medical records are our property, kept in a secure location, and are accessed only for purposes outlined by the **Notice of Privacy Practices**. Records may be released or shared with other health care providers or third party payers for treatment of your child. Patients are entitled to one free copy of their medical records only after an authorization for release is signed. Additional copies may be made for a fee.

- I understand that Cameron S. Schaeffer, M.D., PSC may contact me at home or at my place of employment by mail, phone, fax, or email for health care reasons, appointment reminders, or to resolve billing issues. Use of email will not include the provision of health care, but will be limited to appointment reminders and billing issues.
- I understand that Cameron S. Schaeffer, M.D., PSC may leave messages on my answering machine regarding appointments and limited lab information.
- I authorize Cameron S. Schaeffer, M.D., PSC to discuss my child's medical case with adults or other minors present during the visit regardless of whether I am present.
- I understand that if I send photograph(s) of my child(ren), Cameron S. Schaeffer, M.D., PSC may display them within the office.
- I understand that any signed artwork created by my child may also be displayed within the offices of Cameron S. Schaeffer, M.D., PSC.
- I understand that Cameron S. Schaeffer, MD., PCS will fax letters of consultation and other information to my PCP or Referring MD.

I acknowledge that I have been offered and have received a copy of Cameron S. Schaeffer, M.D., PSC's Notice of Privacy Practices and Consent to Treat information. I understand that I may edit any of the above items.

_____	_____	_____
Patient	**Parent**	**Date**

CAMERON S. SCHAEFFER, MD, PSC

PEDIATRIC UROLOGY/PLASTIC SURGERY
MEDICAL HISTORY

Dear Parent/Guardian:

Please take a few minutes to complete this form. This will help assure you of the best possible care for your child. The information you provide will be held in confidence as part of your child's medical record.

NAME OF PATIENT:_____ TODAY'S DATE_____
DATE OF BIRTH:_____ AGE:_____ SS#_____
Reason for visit:_____ Referring Physician:_____
Person completing this form:_____ Relationship to patient:_____

MEDICAL HISTORY/REVIEW OF SYSTEMS

Is your child currently having problems or has ever had problems with any of the following?:

(Please circle or write in symptoms)

GENERAL: Premature, "Failure to thrive", Recent weight changes, Weakness, Fatigue, Unexplained fever, Developmental delay — Y N

SKIN: Rashes, Dry/flaky skin, Jaundice, Discoloration of skin, Changes in hair or nails — Y N

EYES, EARS, NOSE, THROAT: Thrush, Ear infections, Sinus infections, Soreness/redness of gums, Difficulty swallowing, Difficulty hearing/deafness, Blindness — Y N

RESPIRATORY: Wheezing, Asthma, Bronchitis, Pneumonia, Chest Pain, Tuberculosis, Difficulty breathing, Reactive Airway Disease — Y N

NEUROLOGIC: Spina bifida, Seizures, Fainting, Paralysis, Tingling, Tremors, Sacral agenesis — Y N

CARDIOVASCULAR: Heart murmur, Rapid heart beat, High blood pressure, Dizziness, Swelling hands/feet, Rheumatic fever — Y N

ENDOCRINE: Thyroid trouble, heat or cold intolerance, Excessive sweating, Excessive thirst or hunger, Diabetes — Y N

GASTROINTESTINAL: Changes in appetite, Nausea, Vomiting, Indigestion, Food intolerance, Gastroesophageal reflux, Constipation, Diarrhea, Soiling pants, Hemorrhoids — Y N

GENITOURINARY: Abnormal prenatal ultrasound of bladder/kidneys, Blood in urine, Frequent urination, Painful urination, Bladder/kidney infections, Day or night wetting/leakage/dribbling, Protein in urine — Y N
MALE: Hernias, Testicular problems, Penis/foreskin problems, adhesions
FEMALE: Vaginal discharge, Yeast infections, adhesions

HEMATOLOGIC: Anemia, Easy bruising, Easy bleeding, Leukemia, Blood transfusion — Y N

MUSCULOSKELETAL: Coordination difficulties, Weakness, Pigeon toes, Broken bones — Y N

PSYCHIATRIC: Depression, Nervousness, Mood Swings, Nightmares, Insomnia, ADHD/ADD — Y N

ALLERGY/IMMUNOLOGIC: Latex allergy, Food allergy, Plant allergy, — Y N

DRUG ALLERGIES:_____
_____

IMMUNIZATIONS: Up to date Y N

MEDICATIONS your child is taking (please include over the counter medications and herbal products):
_____
_____

HOSPITALIZATION/SURGERY: Please list hospitalizations and/or surgeries your child has had:
_____ Year_____ _____ Year_____
_____ _____ Year_____ _____ Year_____
_____ Year_____ _____ Year_____

FAMILY HISTORY: Do you have any family history of:
Genitourinary System:
Daywetting N Y_____ Kidney Stones N Y_____
Bedwetting N Y_____ Blood in Urine N Y_____
Urinary Infections N Y_____ Kidney Failure N Y_____
Protein in Urine N Y_____
Abnormalities of Urinary Tract (i.e., reflux) N Y_____

Other:
Diabetes N Y_____
Cancer N Y_____
High Blood Pressure N Y_____
Hearing Loss (born with) N Y_____

SOCIAL HISTORY:
Child lives with: ___Mother ___Father ___Both ___Other_____
Grade in school_____
Are any of these products used in the home: ___Tobacco ___Alcohol ___Drugs

OFFICE USE ONLY:
I have reviewed the Medical History/Review of Systems with the patient and/or family.

_____
Cameron S. Schaeffer, MD, FACS