



# high desert pediatrics

8650 Alameda Blvd NE  
Suite 101E  
Albuquerque, NM 87122

Phone: (505) 255-1866  
Fax: (505) 255-1852

## BILLING and REGISTRATION FORM

CHILD'S NAME: \_\_\_\_\_  
*(Last, First, Middle Initial)*

DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_ SEX ( M / F ) HOME PHONE #: \_\_\_\_\_

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

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

PARENT #1: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_ DOB: \_\_\_\_\_

PARENT #2: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_ DOB: \_\_\_\_\_

### PARENT'S EMPLOYER INFORMATION:

COMPANY NAME: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ EXT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

### BILLING/INSURANCE INFORMATION:

*(Please give your card to the receptionist to copy)*

Check if same as above

NAME OF RESPONSIBLE PARTY (Guarantor): \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ PHONE NUMBER \_\_\_\_\_

INSURANCE 1: \_\_\_\_\_ CO-PAY AMOUNT: WELL \$ \_\_\_\_\_  
SICK \$ \_\_\_\_\_

SUBSCRIBER NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

MEMBER ID # \_\_\_\_\_ GROUP # \_\_\_\_\_

INSURANCE 2: \_\_\_\_\_ CO-PAY AMOUNT: WELL \$ \_\_\_\_\_  
SICK \$ \_\_\_\_\_

SUBSCRIBER NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

MEMBER ID # \_\_\_\_\_ GROUP # \_\_\_\_\_

I authorize the release of any medical information necessary to process this claim. **(REQUIRED)**

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

I authorize payment of medical benefits to my physician for services provided. **(REQUIRED)**

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



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## Past Medical History Form

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

Please list allergies you may have: \_\_\_\_\_

Have you ever been hospitalized overnight?  Yes  No If so, when: \_\_\_\_\_

Are immunizations up to date? \_\_\_\_\_ (We would like a copy of your immunization records)

### Which of the following conditions are you currently being treated for or have been treated for in the past?

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Heart disease/murmur              | <input type="checkbox"/> Shortness of breath          | <input type="checkbox"/> Eye disorder            |
| <input type="checkbox"/> High cholesterol                  | <input type="checkbox"/> Asthma                       | <input type="checkbox"/> Seizures                |
| <input type="checkbox"/> Low blood pressure                | <input type="checkbox"/> Lung problems/cough          | <input type="checkbox"/> Stroke                  |
| <input type="checkbox"/> High blood pressure               | <input type="checkbox"/> Sinus problems               | <input type="checkbox"/> Headaches/migraine      |
| <input type="checkbox"/> Heartburn/ reflux                 | <input type="checkbox"/> Seasonal allergies           | <input type="checkbox"/> Neurological problems   |
| <input type="checkbox"/> Anemia/blood or bleeding problems | <input type="checkbox"/> Tonsillitis                  | <input type="checkbox"/> Depression/anxiety      |
| <input type="checkbox"/> Pregnancy (prior history)         | <input type="checkbox"/> Ear Problems                 | <input type="checkbox"/> Psychiatric care        |
| <input type="checkbox"/> Diabetes                          | <input type="checkbox"/> Kidney/bladder problem       | <input type="checkbox"/> Liver problem/hepatitis |
| <input type="checkbox"/> Arthritis                         | <input type="checkbox"/> Cancer                       | <input type="checkbox"/> Ulcers/colitis          |
| <input type="checkbox"/> Thyroid Problem                   | <input type="checkbox"/> Sexually transmitted disease | <input type="checkbox"/> Abnormal pap smear      |
| <input type="checkbox"/> Corrective lenses/glasses         | <input type="checkbox"/> Hearing loss                 | <input type="checkbox"/> Rheumatic fever         |
| <input type="checkbox"/> Hernia                            | <input type="checkbox"/> Kidney stones                | <input type="checkbox"/> Eating disorder         |

Please describe any current or past medical treatment not listed above:

\_\_\_\_\_  
Please list your past surgeries:

### Family History

	<u>Living</u>	<u>Age (or age at death)</u>	<u>List serious illnesses</u>
Mother	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Father	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Sisters	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Brothers	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

### Has any member of your family (including children and parents) had any of the following illnesses?

<u>Illness</u>	<u>Which family member?</u>
Anemia or blood disease	_____
Cancer	_____
Diabetes	_____
Glaucoma	_____
Heart disease	_____
High blood pressure	_____
Mental Illness/depression	_____
Stroke	_____
Other serious illness	_____