



Drs. Concannon & Vitale ^{LLC}
Pediatrics & Adolescent Medicine
 1145 Reservoir Avenue, Suite 124
 Cranston, RI 02920-6055

John Concannon, DO, FAAP
 Colleen C. Vitale, MD, FAAP

**Patient
 Registration-1**

Phone: (401) 943-7337 Fax: 401.942.1509 Web: DrConcannon.com or DrVitale.com

Parents, please fill out these forms to update important information for our new computers and electronic medical records. Please write clearly, and use only a BLACK INK PEN as this form will be scanned into our computer system.

Patient Information

Child's Last Name: _____ First Name: _____ Middle Initial: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext _____
 Child's BirthDate: MM / DD / YYYY Sex: M F Child's Social Security # (if available): _____
 Primary Doctor (Circle One): **Concannon & Vitale** Ohnmacht DeAngelis Nevola D'Alessandro Colantonio _____

Mother's or Guardian's Information

Mother's Last Name: _____ First Name: _____ Initial: _____
 Mother's BirthDate: MM / DD / YYYY Mother's Social Security #: _____
 Mother's Home Address: (Check box if same as child's) : _____
 Mother's City: _____ State: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext _____

Father's or Guardian's Information

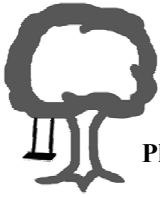
Father's Last Name: _____ First Name: _____ Initial: _____
 Father's BirthDate: MM / DD / YYYY Father's Social Security #: _____
 Father's Home Address: (Check box if same as child's) _____
 Father's City: _____ State: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext _____

INSURANCE INFORMATION MUST BE FILLED OUT COMPLETELY

Policy Holder's Last Name: _____ First Name: _____ Initial: _____
 BirthDate: MM / DD / YYYY Social Security #: _____ Sex: M F
 Medical Insurance Company: _____ Group (Employer) Name: _____
 Insurance ID#: _____ Group/Policy #: _____
 Certificate #: _____ Insurance Co-Payment Amount \$ _____
 Relationship to Insured (Circle one): Child Step-Child Foster-Child Grandchild Niece/Nephew Other: _____
 Second Insurance Company (if any): _____ Second Policy #: _____
 Second Policy Holder's Name: _____ BirthDate: MM / DD / YYYY

I hereby authorize the release of any information relating to claims for benefits submitted on behalf of my children, and I authorize Drs. Concannon & Vitale to submit claims for benefits for medical services rendered. I consent to allow their access to all other sources of medical records on my child. I give permission for medical information to be left on my personal voice mail, if necessary, when that voice mail is properly identified by name. I have received or been offered a copy of the Notice of Privacy Practices for Drs. Concannon & Vitale. If my child will be receiving any immunizations, I am offered standard vaccine information statements about the reasons and side effects of each vaccine. I understand there is a **\$20 fee** for missed appointments not cancelled 3 hours ahead, and a **\$20 fee** for processing bounced checks.

Parent Signature _____ Date: ____/____/____
 Additional Insurance Information (if any): _____ PatientRegistration.doc Rev 02/2012



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**Patient
Registration-2**

**Parents, please fill out these forms to update important information for our new computers and electronic medical records
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Child's Name: _____

Current Medicines: _____

None _____

Allergies to Medicines: _____

None _____

Current long-term illnesses, such as asthma, diabetes, etc.: _____

None _____

Medical specialists your child currently uses: _____

None _____

Child's hospitalizations overnight: _____

None _____

Child's Surgeries or Operations: _____

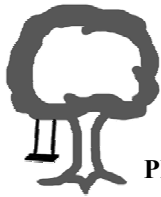
None _____

Usual Pharmacy: _____

Approximate Address & City: _____

New Patients Only: How did you hear about us?: _____

Thank You!



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**Patient
 Registration-3**

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Please Excuse Us.....

The Federal government is now requiring doctors to collect all sorts of personal information on their patients. This is part of regulations for health care reform, and may be used in reporting data for improvements in public health. If you prefer not to answer the questions, please select "Refuse to Answer".

Child Name: 1. _____ Date of Birth: ___/___/_____
 2. _____ Date of Birth: ___/___/_____
 3. _____ Date of Birth: ___/___/_____
 4. _____ Date of Birth: ___/___/_____

Your preferred e-mail address: _____ None

Do you allow Drs. Concannon & Vitale to look up your child's medication and health history from external sources? This will allow us in some cases to select the most appropriate and least costly medication for you child by cross-checking with data from your health insurance company. Circle One:

Yes No Refuse to Answer

Do you allow us to leave a message on your home answering machine and cell voicemail? Circle One:

Yes No Refuse to Answer

Do you allow us to leave a message on your work voicemail? Circle One:

Yes No Refuse to Answer

Your child's residence type: Circle One:

Private home, house, condo or apartment Group Home Homeless

Your child's race: Circle One:

White Asian Black/African-American Hispanic Native American Refuse to Answer

Your child's ethnicity: Circle One:

Non-Hispanic Hispanic Refuse to Answer

Primary language spoken at home:

English Spanish Cambodian Portuguese French Creole Other: _____

X _____ / / _____

Signature of Parent/Legal Guardian of all children listed above

Date

Mail, fax, or bring this 1 page form to your child's previous doctor



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**Transfer-IN
Records Request**

hone: (401) 943-7337 Fax: 401.942.1509 Web: DrConcannon.com or DrVitale.com

Please note that prior medical and immunization records MUST be received by our office at least 3 days before any appointment for your child with us, so that the records can be properly reviewed and entered. You may submit this one page directly to your previous physician. Any applicable fees are your responsibility.

From: Insert Name & Address of Previous Physician

To:

Drs. Concannon & Vitale ^{LLC}
1145 Reservoir Avenue, Suite 124
Cranston, RI 02920-6055

Fax: 401.942.1509

Name1:

Date of Birth:

Name2:

DOB:

Name3:

DOB:

Name4:

DOB:

Address

City

State

Zip

I hereby authorize the disclosure and/or transfer all medical records covering the period from birth to present, for the purpose of providing continuing medical care for my children or myself as listed above. This information to be disclosed will include all information, inclusive of alcohol, drug abuse, HIV testing, psychiatric notes, venereal disease and/or other sensitive information.

Medical information is protected under law and, except as provided by law, cannot be disclosed without written consent. Information released with this authorization must not be given, sold, transferred, or in any way relayed to any other person or entity not specified above. When medical information is transferred, the sender cannot necessarily prevent further disclosure by the recipient under HIPAA privacy rules. This authorization may be withdrawn at any time by submitting a written revocation to the sender.

Printed Name of Parent/Guardian/Patient

Relationship to Patient(s)

Parent/Guardian/Patient Signature

Date

Comments: