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

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

Patient Registration-1

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 <u>$20 fee</u> for missed appointments not cancelled 3 hours ahead, and a <u>$20 fee</u> for processing bounced checks.

_____ Date: ____/____/_____
Parent Signature

Additional Insurance Information *(if any)*:

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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

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

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: