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Denver Pediatrics, PC
Gita Sikand, M.D.
Patient Registration

Date_____

PATIENT INFORMATION

Legal Name _____
Last First M Initial

Street Address _____Apt/Unit #_____

City _____ State _____ Zip Code _____

Birth Date _____Age _____ SS# _____ (Will be collected First Visit) Male _____ Female __ _

Responsible Party: Name _____SS#_____ (Collected First Visit)

Home Phone _____ Cell Phone _____ Work Phone _____

Siblings_____ Siblings _____

Mother's Name _____DOB: _____ S.S.#: _____ (Collected at first visit)

Father's Name _____DOB: _____S. S.#: _____ (Collected at first visit)

INSURANCE INFORMATION

Primary Insurance _____Type (HMO/PPO, etc) _____

Insured's Name _____Relationship to insured _____

ID# _____Group _____ Insured's Date of Birth _____

Secondary Insurance _____ Type (HMO/PPO, etc) _____

Insured's Name _____ Relationship to insured _____

ID # _____Group _____ Insured's Date of Birth _____

ADDITIONAL INFORMATION

Emergency Contact _____Relationship to Patient _____

Home Phone _____Work Phone _____ Cell _____

Whom may we thank for referring you?

MEDICAL INFORMATION AUTHORIZATION: I authorize release of any medical information necessary to process my/my child's claim

Signed _____ (You will sign at first visit) Date _____

Medical Information Authorization: I authorize medical benefits to the above named provider/s. I understand that I am financially responsible for charges not covered by this authorization. I agree to pay all non-covered fees incurred within 30 days or my account may incur interest at the rate of 18% ANNUAL PERCENTAGE RATE. I further agree to pay all costs including actual attorney fees incurred for collection of my account.

_____

Responsible Party/Parent or Legal Guardian Name Date

Submit completed forms at the end

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GITA S. SIKAND, M.D.

Fellow American Academy of Pediatrics Diplomat of the American Board of Pediatrics

PARENTAL PRE-AUTHORIZATION FOR MEDICAL CARE TO CHILDREN

For families who are ongoing patients of DENVER PEDIATRICS it may be more convenient to have prior authorization for medical care delivered directly to minors without a parent having to be present for treatment. Please review the following authorization form for treatment and complete the information if you want to authorize such treatment in advance.

AUTHORIZATION

I request and authorize Denver Pediatrics and its personnel to deliver medical care to my children listed below:

PLEASE PRINT

_____ _____
CHILD'S NAME DATE OF BIRTH

_____ _____
CHILD'S NAME DATE OF BIRTH

_____ _____
CHILD'S NAME DATE OF BIRTH

_____ _____
CHILD'S NAME DATE OF BIRTH

I authorize the following person(s) to bring my children in for medical care in my absence:

_____ _____
NAME RELATIONSHIP

_____ _____
NAME RELATIONSHIP

_____ _____
NAME RELATIONSHIP

NOTE: If there is any special parental or custodial relationship custody of one parent only, legal custody/guardianship with non-parents, etc. please explain on space below with your signature and telephone number where you can be contacted.

_____

_____

_____ _____
SIGNATURE DATE

9141 Grant Street, Suite 115 Thornton, CO 80229 Phone: (303) 920-9000 Fax: (303) 920-4000

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PRIVACY PRACTICES ACKNOWLEDGEMENT

DENVER PEDIATRICS
9141 GRANT STREET, SUITE 115
THORNTON, CO 80229
303-920-9000
303-920-4000 Fax

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Parent/Legal Guardian Name/Print: _____
Parent Legal Guardian Signature: _____

For Child's Name: _____
Date of Birth: _____

For Child's Name: _____
Date of Birth: _____

For Child's Name: _____
Date of Birth: _____

For Child's Name: _____
Date of Birth: _____

☐ I have read and understand the 3-page Notice of Privacy Practices.

Signature: _____ Date: _____

Submit completed forms at the end

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Denver Pediatrics
Gita Sikand, M.D., FAAP
9141 Grant Street, Suite 115
Thornton, CO 80229

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

PATIENT NAME _____

BIRTHDATE _____ **SS #:** (Will be collected at First Visit)

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination, tests results, diagnosis, and treatment and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many healthcare professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

☐ **I request the following restrictions to the use or disclosure of my/my child's health information:**

_____

_____

_____

_____

PATIENT SIGNATURE: _____

OFFICE USE ONLY

☐ **ACCEPTED**

_____

Signature **Title** **Date**

☐ **DENIED**

Submit completed forms at the end

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Denver Pediatrics

Pediatric Questionnaire Completed By: _____

Child's name: _____
Reason for today's visit: _____
Any smokers in the house? ☐ Y ☐ N
Any guns in the house? ☐ Y ☐ N

Immunizations
Immunizations up to date? ☐ Y ☐ N
Do you have a shot record? ☐ Y ☐ N
Hospitalizations? ☐ Y ☐ N
Where: _____
When: _____
Why: _____
List serious injuries: _____
_____

Allergies
Allergic reaction to medicines? ☐ Y ☐ N
Allergic reaction to food? ☐ Y ☐ N
Allergic reaction to animals? ☐ Y ☐ N
Allergic reaction to insect bites? ☐ Y ☐ N
Medicines taken on a regular basis? _____

Medical History

Acid Reflux/GERD	☐ Y ☐ N	Environmental Allergies	☐ Y ☐ N
ADHD	☐ Y ☐ N	Food Allergies	☐ Y ☐ N
Anemia	☐ Y ☐ N	Fracture	☐ Y ☐ N
Asthma	☐ Y ☐ N	Hearing Problems	☐ Y ☐ N
Autism	☐ Y ☐ N	Heart Murmur	☐ Y ☐ N
Bladder Infection/UTI	☐ Y ☐ N	Obesity	☐ Y ☐ N
Cerebal Palsy	☐ Y ☐ N	Seizure/Epilepsy	☐ Y ☐ N
Developmental Delay	☐ Y ☐ N	Vision Problems	☐ Y ☐ N
Eczema	☐ Y ☐ N		

Other medical history: _____

Surgical History

Adenoids Removed	☐ Y ☐ N	G Tube	☐ Y ☐ N
Appendectomy	☐ Y ☐ N	Heart Surgery	☐ Y ☐ N
Circumcision	☐ Y ☐ N	Hernia Repair	☐ Y ☐ N
Ear tubes	☐ Y ☐ N	Nissen Fundoplication	☐ Y ☐ N
Eye Surgery	☐ Y ☐ N	Tonsillectomy	☐ Y ☐ N
Fracture Surgery	☐ Y ☐ N	VP Shunt	☐ Y ☐ N

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Family History

Please write the name of the person, their status (Alive or Deceased) and check the correct box that applies to that person.

Note: MGM: Maternal Grandmother, **MGF:** Maternal Grandfather, **PGM:** Paternal Grandmother, **PGF:** Paternal Grandfather

Relationship	Name	Status	Abnormal Lipids	Alcohol/Drug Abuse	Allergies	Arthritis	Asthma	Blood Disease	Cancer	Diabetes	Excema	Gastrointestinal (GI)	Genetic Disorder	Heart Disease	Hypertension	Lung Disease	Neurological Diagnosis	Psychiatric Disorder	Stroke	Thyroid Disease	Other
Mother																					
Father																					
Sister																					
Brother																					
MGM																					
MGF																					
PGM																					
PGF																					
Mat Aunt																					
Mat Uncle																					
Pat Aunt																					
Pat Uncle																					
Other																					

_____

_____

Birth History

Birth Length: _____ Birth Weight: _____ Gestational Age: _____

Delivery Method: _____ Feeding Method: _____

E-Cigarette/Cigarette/Vaping

Current Everyday User	☐ Y	☐ N	User – Current Status Unknown	☐ Y	☐ N
Current Some Day User	☐ Y	☐ N	Unknown If Ever Used	☐ Y	☐ N
Former User	☐ Y	☐ N	Never User	☐ Y	☐ N
Never Assessed	☐ Y	☐ N			

Passive Exposure	☐ Y	☐ N	Flavoring	☐ Y	☐ N
Counseling Given	☐ Y	☐ N	Disposable	☐ Y	☐ N
Nicotine	☐ Y	☐ N	Pre-filled	☐ Y	☐ N
THC	☐ Y	☐ N	Refillable Tank	☐ Y	☐ N
CBD	☐ Y	☐ N	Pre-filled Pod	☐ Y	☐ N

To submit this form, please choose the best option for you.

Option 1

Print forms using the button below, bring the filled out forms to your appointment

Option 2

Save the forms to your computer as a PDF. Email the forms as an attachment to **pformsdpeds@aol.com**

Thank you! We look forward to your appointment!

Print Forms