Atlantic Pediatrics
Drs. Concannon & Vitale LLC
1145 Reservoir Avenue, Suite 124
Cranston, RI 02920-6055

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

Phone: (401) 943-7337 **Fax:** 401.942.1509 **Web:** AtlanticPediatricsRI.com

Patient Registration-1

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

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: (Concannon & Vitale) or _____

Pharmacy Name: _____ Address: _____ City/State: _____

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 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 _____

Medical Insurance Company: _____

Policy Holder's Last Name: _____ First Name: _____ Initial: _____

BirthDate: MM / DD / YYYY Policy #: _____-_____-_____ Sex: M F

Relationship to Insured (Circle one): Child Step-Child Foster-Child Grandchild Niece/Nephew Other: _____

Second Insurance Company (if any): _____ Policy # _____

Second Policy Holder's Name: _____ BirthDate: MM / DD / YYYY

I hereby consent for my child to be treated by Atlantic Pediatrics (Drs. Concannon & Vitale), and I present that I have the authority to do so. I authorize the release of any information relating to claims for benefits submitted on behalf of my children, and I authorize Atlantic-Pediatrics 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. I have received or been offered a copy of the Notice of Privacy Practices for Atlantic Pediatrics. 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.

_____ Date: ____/____/_____

Parent Signature-
Additional Information (if any):

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Patient Registration-2

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

Child's Name: _____

Current Medicines: (*Daily or as needed)* ☐ None _____

Allergies to Medicines or Foods: ☐ None _____

Long-term illnesses, such as asthma, diabetes, etc.: ☐ None _____

Medical specialists your child currently uses: ☐ None _____

Other specialists your child has seen in the past 5 years (*example*: *skin doctors*, *heart doctors*, etc) ☐ None _____

Child's hospitalizations overnight: ☐ None _____

Child's Surgeries or Operations: ☐ None _____

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

Anything else? _____

Thank You!

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Patient Registration-3

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

Child Name: 1._____ Date of Birth:____/_____/_____

Child Name: 2._____ Date of Birth:____/_____/_____

Child Name: 3._____ Date of Birth:____/_____/_____

Child Name: 4._____ Date of Birth:____/_____/_____

Your Best Phone Number: _____-_____-_____ **Text (Cell) Number:** _____-_____-_____

Your preferred e-mail address: _____ □ None

Do you allow Atlantic Pediatrics 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

Do you allow us to leave a message on your home answering machine and cell voicemail? *Circle One:* Yes No

Do you allow us to leave a message on your work voicemail? *Circle One:* Yes No

Do you allow us to contact you via videoconference either through your cell-phone or computer? *Circle One:* Yes No
Note: You may be responsible for any applicable CoPays or Deductible payments, depending on your health insurance plan.

Please Excuse Us……

The Federal government now requires doctors to collect all sorts of personal information on their patients. This is part of regulations for health care reform and equity, 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".

Your child's residence type: *Circle One*: Private home, house, condo or apartment Group Home Homeless Refuse to Answer

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

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Transfer Records IN

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

Request for Transfer of Medical Records from:

Please transfer my child's/children's medical records to Atlantic Pediatrics via fax to **401.942.1509** (preferred) or at the above address if by mail.

Previous provider & Address

Child Name: 1._____ Date of Birth: ____/_____/_____

Child Name: 2._____ Date of Birth: ____/_____/_____

Child Name: 3._____ Date of Birth: ____/_____/_____

Child Name: 4._____ Date of Birth: ____/_____/_____

_____ _____ _____ _____
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: