DR. LOCKNANE
ATHLETIC AND PROCEDURAL MEDICINE

Timothy D. Locknane MD

NEWBORN PATIENT REGISTRATION

Patient Name:____ **M** or **F**

Last First Middle Initial Gender

Birth Date: _____ / _____ / _______ **SS#:** ______________________________

Home Address: ____

Street Apt. #

____

City State Zip

Parent/Legal Guardian 1:____
Home Phone: (   ) _________________ **Other Phone**: (   ) _________________

Parent/Legal Guardian 2:____
Home Phone: (   ) _________________ **Other Phone**: (   ) _________________

Primary Care Physician: ____

Primary Care Physician Phone#:__________________________________

Referred to LAM by: ______________________________ (Dr. / Patient / Friend)

BILLING INFORMATION

PRIMARY INSURANCE	**SECONDARY INSURANCE**
Ins. Co. Name: __________________	**Ins. Co. Name:**__________________
Subscriber Name: __________________	Subscriber Name:__________________
Date of Birth: __________________	Date of Birth:__________________
Group #: __________________	Group #: __________________
ID#:__________________	ID#:__________________
Employer: __________________	Employer:__________________

Does your insurance provide coverage of circumcision? YES NO UNSURE

I request that payment of authorized Medicare or insurance benefits be made to my physician on my behalf for any services provided to me by Timothy D. Locknane MD and Locknane Athletic Medicine. I authorize any holder of medical information about me to release to HCFA and its agents or to my insurance any information needed to determine these benefits. I authorize treatment of the person named above and agree to pay all fees and charges for such treatment, and I accept financial responsibility for non-covered services.

____________________________________ __________________

Signature Date

18518 Bothell Way NE, Suite C Bothell, WA 98011 ***Office*** *– 425.368.4242* ***Fax*** *– 425.368.4243*

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CONSENT AND RELEASE

NOTICE OF PRIVACY PRACTICES

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your records to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Locknane Athletic Medicine.

By my signature below I acknowledge access to and/or receipt of the Notice of the Privacy Practices

Patient or legally authorized individual signature | Date | Time

Printed name if signed on behalf of the patient | Relationship

CIRCUMCISION CONSENT

Circumcision is an elective, permanent procedure in which the penile foreskin is removed. This is not a medically necessary procedure, and is thus a family decision. We have been educated in relation to potential benefits of the procedure, not limited to a possibly decreased risk of male urinary tract infection, balanitis, penile cancer, and HIV infection and HPV infection; in the patient and in future sexual partners of the patient.

We understand that this procedure, even performed by a skilled physician, has risks. These include risk of local bleeding or hematoma (blood collection under the skin), infection, and even necrosis of the penis (tissue death). We also understand that most circumcision-related complications are very minor and easily treated. Major complications of the procedure are exceedingly rare.

We understand that absolute contraindications to this procedure include unusual or ambiguous genitalia, hypospadias (urethra does not exit the tip of the penis, but lower, on the ventral shaft), age less than 12 hours, severe illness, and prematurity (until the child is ready for appropriate hospital discharge).

I understand that there are risks associated and have decided to move forward with permanent removal of the foreskin on the above written newborn. I have received post circumcision care instructions and regarding this procedure, all questions have been answered to our satisfaction.

If both parents/legal guardians are not signed below or present at the appointment, the individual present at the procedure has received consent from the other parent/legal guardian.

Parent/Legal Guardian 1 | Date | Parent/Legal Guardian 2 | Date

ANESTHESIA CONSENT

I understand that studies have demonstrated that anesthetized infants, by way of dorsal penile nerve block or local or topical anesthesia, show less crying, lowered heart rates, less irritability, and fewer behavior changes during the 24 hours following the procedure, as well as lower post-procedure serum cortisol levels (stress hormone) than infants circumcised without anesthesia.

It is my desire that my healthy newborn infant receive anesthesia for his circumcision.

I understand that complications related to anesthesia for circumcision can include inadequate response despite one or more modes of anesthesia delivery, localized blood collection (hematoma) at injection site, local skin infection or necrosis, allergic reaction to lidocaine, and the theoretical chance of penile necrosis – though this latter, most serious consequence has never been reported.

Parent/Legal Guardian 1 | Date | Parent/Legal Guardian 2 | Date

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NEWBORN HEALTH HISTORY FORM

DATE:____________________

Patient Name: ____________________________________ D.O.B.: ___________________

TO BE FILLED OUT BY PARENT/LEGAL GUARDIAN:

BIRTH HEIGHT:________ **BIRTH WEIGHT:**____________

Birth Location:____

Birth Provider:____

Birth Provider Phone:____

Pre-Natal / Birth Complications:____

____

PRE-NATAL CARE (if different than above)

Pre-Natal Provider:____

Pre-Natal Provider Phone:____

Initiation Date of Pre-Natal Care:__________________ **Estimated # of visits:**_________________

Pre-Natal Complications:____

____

MATERNAL HISTORY:
- ☐ Cancer
- ☐ Heart Disease
- ☐ Diabetes
- ☐ Blood Clots
- ☐ Other _____________

PATERNAL HISTORY:
- ☐ Cancer
- ☐ Heart Disease
- ☐ Diabetes
- ☐ Blood Clots
- ☐ Other _______________

FAMILY HISTORY:
- ☐ Cancer
- ☐ Heart Disease
- ☐ Diabetes
- ☐ Blood Clots
- ☐ Other _______________

Other relevant medical history:____

____

NEWBORN MEDICATIONS (Please list medications, doses and frequency)

1. ________________________________ 2. ________________________________
3. ________________________________ 4. ________________________________

NEWBORN/FAMILY DRUG ALLERGIES:__________________________________ **None known** ______

Other notes or comments:

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