PATIENT INFORMATION SHEET

Patient Name________________________ Date of Birth__________ Sex_____

Address________________________ City __________ State_____ Zip Code________

Patient Cell # ________________ Religion__________ Race _________ Ethnicity________
*ONLY IF 16 OR OLDER

Pharmacy Name ________________________ **Phone #**________________

Mother's Name________________________ Date of Birth________________

Address________________________ City __________ State_____ Zip Code________

Employer________________ Job Title______________ Work Phone #____________

Cell # ______________ **Email**________________ **Home #** ______________

Father's Name________________________ Date of Birth________________

Address________________________ City __________ State_____ Zip Code________

Employer________________ Job Title______________ Work Phone #____________

Cell # ______________ **Email**________________ **Home #** ______________

Primary Insurance Name__________________ Subscriber's Name________________

Member ID #________________________ Group # ____________________

Claim Address________________________ City ______________ Zip Code________

Secondary Insurance Name________________ Subscriber's Name________________

Member ID #________________________ Group # ____________________

Claim Address________________________ City ______________ Zip Code________

Please Read and Sign Below

I will be financially responsible for any medical services not covered by my health insurance company. I authorize the payment of medical benefits to Westchester Pediatrics LLC. I authorize the release of any information needed to provide documentation for the amount billed.

SIGNATURE________________________________ **DATE**______________

HOJA DE INFORMACION DEL PACIENTE

Nombre del Paciente______________________________ Fecha de Nacimiento____________ Sexo____

Dirección______________________________ Ciudad ____________ Estado____ Código Postal________

Celular del Paciente # ______________________ Religión____________ Rasa _______ Étnico________
*SOLO PARA PACIENTES MAYORES DE 16 AÑOS

Nombre del Farmacia_______________________________________ **Teléfono**____________________

Nombre del Madre____ Fecha de Nacimiento____________

Dirección______________________________ Ciudad ____________ Estado____ Código Postal_______

Empleador_______________________ Título_________________ Teléfono de Trabajo______________

Celular ______________**Correo Electrónico**___________________ **Teléfono de Casa** ______________

Nombre del Padre____ Fecha de Nacimiento____________

Dirección______________________________ Ciudad ____________ Estado____ Código Postal_______

Empleador_______________________ Título_________________ Teléfono de Trabajo______________

Celular ______________**Correo Electrónico**___________________ **Teléfono de Casa** ______________

Nombre del Seguro Primario___________________________ Nombre de Titular____________________

Numero de Miembro______________________________ Numero de Grupo ________________________

Dirección del Reclamante___________________________ Ciudad _____________Código Postal________

Nombre del Seguro Secundario___________________________ Nombre de Titular__________________

Numero de Miembro______________________________ Numero de Grupo ________________________

Dirección del Reclamante___________________________ Ciudad _____________Código Postal________

Por favor Lea y Firme Abajo

Seré financieramente responsable por los servicios médicos no cubiertos por seguros de salud. Autorizo el pago de las prestaciones médicas a Westchester Pediatrics LLC. Autorizo la publicación de cualquier información necesaria para presentar documentación para la cantidad facturada.

FIRMA____ **FECHA**__________________

New Patient Questionnaire

Mother's Name ______________________

Occupation ______________________

Mother's health ______________________

Marital Status ______________________

Father's Name ______________________

Occupation ______________________

Father's Health ______________________

Marital Status ______________________

Do the child's parents live together? Yes No

Does the patient have any siblings? Yes No

If so, please give siblings' names, ages and health status ______________________

____

Whom does the patient live with?

____

Who cares for the child while you are at work?

____

Pregnancy and Birth History

Mother's age at time of birth ______________________

Any problems during the pregnancy? Yes No

Type of Delivery? Vaginal C-section

Any problem with delivery? Yes No

Baby's birth weight ______________________

Did the baby have any problems while in the hospital- such as jaundice, infection? Yes No

If yes, what kind? ______________________

____

Patient's Name ______________________

DOB: ______________________

Previous Doctor ______________________

Date of last check up ______________________

Past Medical History Review of Systems

Question		
Has your child had any surgery?	Yes	No
Has your child ever been hospitalized?	Yes	No
For what? ______________________		
Has your child had any serious injuries?	Yes	No
What? ______________________		
Has your child had an allergic reaction to any medication or food?	Yes	No
To what? ______________________		
Has your child had a severe reaction to an insect bite? (e.g. shortness of breath, tongue swelling)	Yes	No
Has your child had a any reaction to immunizations?	Yes	No
Has your child had chickenpox?	Yes	No
Has your child had asthma?	Yes	No
Does your child have a frequent cough?	Yes	No
Has your child had pneumonia?	Yes	No
Do you own an aerosol machine?	Yes	No
Does your child have any heart problems?	Yes	No
Does your child have any kidney problems?	Yes	No
Any problems with diarrhea or constipation?	Yes	No
Does your child have seizures?	Yes	No
Does your child have any skin conditions?	Yes	No
Has your child ever had anemia?	Yes	No
Any other medical problems? ______________________		

____

Are your child's immunizations up to date? Yes No

Do you have an immunization record? Yes No

Patient Name ______________________________

DOB ______________________________

Family History

Please circle any diseases that are present in parents, grandparents, siblings, aunts or uncles.

Alcoholism   Anemia   Respiratory allergies
Asthma   Diabetes   Heart Disease
High Blood Pressure   High Cholesterol
Inherited Illnesses   Mental Illness   Skin Disease

Have any of your children died?   Yes   No

Feeding and Nutrition

Were there any unusual feeding problems in the first 6 months of life?   Yes   No

Was the child breast or formula fed? __________

If still on formula, which one? ______________

Does your child have any food allergies?   Yes   No

Does your child take vitamins?   Yes   No

Development and Behavior

At what age did your child walk alone? ________

Does your child enjoy playing with other children?   Yes   No

Does your child have any problems with bed wetting or speech?   Yes   No

What school does your child attend?

____

Safety / Environment

Yes   No

Do you know the hottest temperature of the water in your pipes?

Yes   No

Is there a working smoke alarm on each floor of the house?

Yes   No

Does your child always use a car seat or seat belt (if over 5) when riding a car?   Yes   No

Are there any smokers in the household?

Yes   No

Are there any problems with the condition of your home? (peeling paint, rats or mice)?

Yes   No

Does your child always wear a helmet when riding a bicycle?   Yes   No

Does your child know how to swim?

SECONDARY INSURANCE

Name______________________________

Claim Address____

City__________________________ State__________ Zip______________ Phone__________________

Insured's Name____________________ ID/Policy #____________________ Group# __________________

CONSENT

I give permission for my child ______________________________ to receive medical service by the physicians at Westchester Pediatrics, LLC in the event that I am not available to bring my child to the office and he or she is brought in by a relative, medical services may be performed.

RELEASE OF MEDICAL RECORDS

I authorize payment of medical benefits to the physicians of Westchester Pediatrics, LLC, for any medical services rendered.

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to the physicians of Westchester Pediatrics, LLC, for any medical services rendered.

OFFICE BILLING POLICIES

This office is willing to bill your insurance company for you, once benefits have been verified. You will be responsible for any deductibles, co-insurance, co-payment, or non-covered benefits due.

In the event that benefits or member edibility cannot be verified, you will be responsible for all charges and balances incurred.

If my child is a newborn, I understand that I have to contact my insurance company to enroll the baby (most insurance companies will give you thirty days to enroll your newborn, check with your carrier). If enrollment is not completed within thirty days, I will be responsible for any charges incurred since birth.

If contracted with an HMO I must give them the name of the patient's primary care physician at Westchester Pediatrics, LLC. If Westchester Pediatrics, LLC physician was not chosen, I am aware that I will be responsible for all charges incurred.

I HAVE READ, UNDERSTAND AND AGREE TO ALL OF THE ABOVE MENTIONED INFORMATION.

SIGNATURE____ DATE____________________________________

PRINT NAME_______________________________________

Bad Check / Bounced Check Policy

PARENTS OR LEGAL GUARDIANS ARE RESPONSIBLE FOR THE FULL AMOUNT OF ANY CHECK RETURNED FOR INSUFFICIENT FUNDS PLUS A SERVICE CHARGE DEPENDING ON THE CHECK AMOUNT.

PAYMENT FOR A BAD CHECK IS DUE WITHIN 15 DAYS OF NOTIFICATION. IF PAYMENT IS NOT RECEIVED, THE UNPAID CHECK WILL BE REPORTED TO THE STATE ATTORNEY'S OFFICE.

I AM AWARE OF THE ABOVE STATED OFFICE POLICY.

Signature: ______________________________ Name: ________________________________

Patient's Name: __________________________ Date Signed: ___________________________

Westchester Pediatric Associates, L.C.
Office Charges

Dear Parents:

The following are the office charges:

Charge	Fee
Form(s) not completed during appointment	$25
Letters	$25
Family Leave Forms	$25
Duplicate copy of School Entry Health Exam Form (DH3040)	$25
Any completed form, letter, school forms, referral, or prescription over 30 days from the requested date	$25
Duplicate of controlled substance prescription	$10
Bounced Check	$30 and up
Copy of the 1st 25 pages of a medical record each additional page .25¢/page	$1/page
Ear Piercing (not covered by insurance)	$55
Repeat of PPD test due to parent failure to return to recheck test within 48hrs-72hrs (not covered by insurance)	$30
Refusal of a prepared vaccine(s) or injectable medication after parent/legal guardian consent	charge depends on vaccine/injectable
Purchase of an aerosol mask	$15
Notary service (only for office related services)	$25
Cancellation or Rescheduling of an Appointment on day of/No Show Fee	$25

By means of my signature, I acknowledge and agree with each office policy charges for my child, _______________________, DOB ______________.

_______________________________   ____________________________

Signature of Parent or Legal Guardian   Date

NEWBORN

PLEASE REMEMBER TO CONTACT YOUR INSURANCE COMP ANY WITHIN THIRTY (30) DAYS TO ENROLL YOUR BABY!

THE BABY WILL NOT BE AUTOMATICALLY ENROLLED BY THE INSURANCE COMPANY. YOU MUST SUBMIT THE ENROLLMENT PAPERS.

INFORMED BY: ______________________

DATE: ______________________________

PARENTS SIGNATURE: ______________________________

ELIGIBILITY AND/OR ENROLLMENT STATUS MUST BE VERIFIED FOR THIS PATIENT ON THE NEXT VISIT AFTER FIRST INITIAL VISIT. THANK YOU.

Notice of Privacy Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Policy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

______________________________________ ______________________

Patient Name or Legal Guardian (print) Date

____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of Notice of Privacy Practices:

Date:______________ Attempt: ___________________________________

Staff Name: ____

Aviso De Privacidad Reconocimiento

Entiendo que bajo el Health Insurance Portability and Accountability Act (HIPAA), tengo ciertos derechos a la privacidad con respecto a mi información de salud protegida.Reconozco que han recibido o han tenido la oportunidad de recibir una copia de su aviso de prácticas de privacidad. También entiendo que esta práctica tiene el derecho de cambiar su aviso de prácticas de privacidad y que puedo contactar con la práctica en cualquier momento para obtener una copia actual de la notificación de prácticas de privacidad.

_____________________________________ _________________________

Nombre del paciente o la Legal de Guarda (impresión) Fecha

____

Firma

Uso de oficina solamente:

Hemos hecho el siguiente intento de obtener la firma del paciente reconoce el recibo de la notificación de prácticas de privacidad:

Fecha: __________________ Intento: ____

Nombre De Empleado: ____

YEARLY UPDATE

PATIENT INFORMATION SHEET

Patient Name________________________________ Date of Birth______________ Sex______

Address____________________________ City ____________ State______ Zip Code________

Patient Cell # ______________________ Religion__________ Race _________ Ethnicity________
*ONLY IF 16 OR OLDER

Pharmacy Name ________________________________ **Phone #**________________

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Employer____________________ Job Title________________ Work Phone #____________

Cell # ___________________ **Email**______________________ **Home #** ____________

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Employer____________________ Job Title________________ Work Phone #____________

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*SOLO PARA PACIENTES MAYORES DE 16 AÑOS

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Dirección____________________ Ciudad __________ Estado____ Código Postal________

Empleador__________________ Título______________ Teléfono de Trabajo______________

Celular ____________ **Correo Electrónico**______________ **Teléfono de Casa** ____________

Nombre del Padre____________________ Fecha de Nacimiento__________

Dirección____________________ Ciudad __________ Estado____ Código Postal________

Empleador__________________ Título______________ Teléfono de Trabajo______________

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FIRMA______________________________ **FECHA**________________