Patients Information

Name _____ Date of Birth ____/____/____ Sex M F

Likes to be called/Nickname:_____ SSN:_____

Home Address _____APT#_____

City _____ State _____ Zip Code _____

Home Phone _____ Cell/Alt. Phone # _____ Text? Yes No

Hobbies _____Referred by_____

Parents/Guardian Information

Father's Name _____ **Mother's Name**_____

Occupation/Employer: _____ Occupation/Employer: _____

DOB ___/___/____ SSN ____-____-____ DOB ___/___/____ SSN ____-____-____

Address: _____ Address: _____

Cell# _____ Text? Yes No Cell# _____ Text? Yes No

Email# _____ Email# _____

In case of emergency Information

Notify: _____ Relation_____ Phone #_____

Pharmacy Information

Preferred Pharmacy: _____ Pharmacy Phone #: _____

Pediatrician Information (If other than Practical Approach Pediatrics)

Physician: _____ Phone#:_____

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true, and accurate

_____

Signature Relationship Date

Patient Name:_____ DOB:_____

Dental Insurance Information (If applicable)

Primary Insurance _____ Insurance Phone # _____

Name of Subscriber _____ Relationship to Patient _____

Subscriber's DOB ____/____/____ Subscriber's Employer _____

Member/Policy Number _____ Group Number _____

Secondary Insurance _____ Insurance Phone # _____

Name of Subscriber _____ Relationship to Patient _____

Subscriber's DOB ____/____/____ Subscriber's Employer _____

Member/Policy Number _____ Group Number _____

Medicaid # _____ Effective Date _____

Medical Insurance Information (If applicable)

Primary Insurance _____ Insurance Phone # _____

Name of Subscriber _____ Relationship to Patient _____

Subscriber's DOB ____/____/____ Subscriber's Employer _____

Member/Policy Number _____ Group Number _____

Secondary Insurance _____ Insurance Phone # _____

Name of Subscriber _____ Relationship to Patient _____

Subscriber's DOB ____/____/____ Subscriber's Employer _____

Member/Policy Number _____ Group Number _____

Medicaid # _____ Effective Date _____

I, the undersigned authorize payment of medical benefits to Practical Approach Pediatrics and Pediatric Dentistry for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

_____

Signature Date

Patient Name:_____ DOB:_____

MEDICAL HISTORY

Are you currently or have you been under the care of a healthcare provider in the last 3 years? Yes No

If yes, please state reason: _____

Name of health care provider: _____

Provider's Address _____ Provider's Phone#(_____)_____

Medications

Please list prescription medications you are taking.

Name	Dosage	Frequency

Please list over-the-counter medications, vitamins or herbal supplements you are taking.

Name	Dosage	Frequency

Allergies

Please list drug/substance and adverse reactions.

Name	Reaction (hives, rash, swelling, etc.)

Hospitalizations & Surgeries

Please list past surgeries and hospitalizations.

Reason	Date

Has your child ever received general anesthesia? YES NO

If YES, were there any complications (explain)? _____

_____

Signature Date

Patient Name:_____ DOB:_____

Review of Systems

Indicate if you have or have EVER had the following:

Allergy/ENT
- ☐ Hay Fever
- ☐ Seasonal Allergies
- ☐ Sinus Problems
- ☐ Hearing loss
- ☐ Otitis media (ear infections)

Cardiovascular
- ☐ Artificial Heart Valve
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Attack or MI
- ☐ Heart Surgery (CABG, Heart Catheterization, etc.)
- ☐ High Blood Pressure-Hypertension
- ☐ Pacemaker
- ☐ Swollen Ankles

Endocrine
- ☐ Diabetes
- ☐ Polycystic Ovarian Syndrome
- ☐ Thyroid Disorders
- ☐ Hirsutism-Excessive Hair

Gastrointestinal
- ☐ Liver Problems
- ☐ Ulcers
- ☐ Reflux-GERD

Hematology
- ☐ Abnormal Bleeding
- ☐ Bruise Easily
- ☐ Anemia
- ☐ Blood Diseases
- ☐ Blood Transfusion
- ☐ Hemophilia
- ☐ Sickle Cell Disease
- ☐ Spider or Varicose Veins

Infections
- ☐ Rheumatic Fever
- ☐ Hepatitis A B C
- ☐ HIV Positive
- ☐ AIDS
- ☐ Measles
- ☐ Scarlet Fever

Musculoskeletal
- ☐ Arthritis (Rheumatoid Arthritis/Osteoarthritis)
- ☐ Artificial Joints (hip, knee, etc.)
  If yes, when? _____
- ☐ Orthopedic problems

Neurologic
- ☐ Epilepsy/Seizures
- ☐ Fainting/Dizzy Spells
- ☐ Frequent Headaches
- ☐ Stroke or TIA
- ☐ Other Neurological Disorders _____
- ☐ Cerebral Palsy
- ☐ Spina Bifida
- ☐ Developmentally Delayed

Oncology
- ☐ Cancer _____
- ☐ Chemotherapy
- ☐ Radiation Therapy

Ophthalmology
- ☐ Eye problems
- ☐ Glaucoma

Psychiatric Care
- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Schizophrenia
- ☐ Psychiatric Care
- ☐ Hyperactivity/ADHD

Renal/Urologic
- ☐ Kidney Stones
- ☐ Frequent Urination (day or night)
- ☐ Frequent Bladder Infections
- ☐ Blood in the Urine
- ☐ Prostate Problems (BPH)
- ☐ Kidney Problem

Respiratory
- ☐ Asthma
- ☐ Chronic cough
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Cystic Fibrosis
- ☐ Pneumonia
- ☐ Whooping Cough

Skin
- ☐ Cold Sores/Fever Blisters
- ☐ Change in moles

General
- ☐ Unplanned Recent Weight Gain/Weight Loss of 10 lbs or more
- ☐ Venereal Diseases or Sexually Transmitted Diseases
- ☐ OTHER:_____

Parent/Guardian Signature_____ Date_____

CONSENT FOR MEDICAL/DENTAL TREATMENT

Patient Name: _____ **DOB:** _____

I, _____ hereby consent to the following:

- Administration and performance of all treatment.
- Administration of any needed anesthetics.
- Performance of such procedures, as may be deemed necessary or advisable in the treatment of my child.
- Use of prescribed medication.
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees.
- Treatment for my child which in the judgment of my health care provider may be considered necessary or advisable while a patient at Practical Approach Pediatrics and Pediatric Dentistry, and it's health care providers, employees and agents.
- Photographs taken of my child to document and assist with care. I understand that Practical Approach Pediatrics and Pediatric Dentistry will own these images.

The healthcare providers at Practical Approach Pediatrics and Pediatric Dentistry are available to answer any questions concerning the potential risks and complications involved with specific procedures, and reasonable alternatives to the proposed treatment. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees or assurances have been made to me concerning the results of my child's treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing.

I certify that I have read and fully understand the above statements and consent fully.

_____ _____ Patient/Parent

Signature Date

Acknowledgement of Receipt

I have been provided with and fully understand and will comply with the following policies:

Patients Rights and Responsibilities
Privacy Notice (HIPPA)
Financial Policy
Office Policies

I, _____ have been provided with the above information either in the office or online. I understand that Practical Approach Pediatrics and Pediatric Dentistry reserve the right to change the above policies and prior to implementation will provide an updated copy either in person or online. I may request a copy of any of the above policies by calling my doctor's office or requesting a copy in person. The duration of this authorization is indefinite unless otherwise revoked in writing.

Patient's printed name _____ Date of Birth _____

Parent/Legal Representative Signature	Relationship to patient	Todays Date
_____	_____	_____

Patient Name:_____ Date of Birth_____

FINANCIAL POLICY

Thank you for selecting *Practical Approach Pediatrics and Pediatric Dentistry* as your healthcare provider. Our personnel will be happy to discuss our fees and this policy with you at any time. Please read and sign this financial policy prior to seeing the physician.

1. Payment for services is due at the time services are rendered, including any portion of your balance that is not covered by your insurance. We accept cash, check, VISA, Master Card, AMEX and Discover.

2. Your insurance policy is a contract between you, your employer, and the insurance carrier. We are NOT a party to that contract. We will follow their guidelines for submission of claims, co-pay amounts, and reimbursements. Any contractual provider discounts will be deducted from your balance.

3. All charges are your responsibility whether your insurance company pays or does not pay. Not all services are a covered benefit in all contracts. Some insurance companies and some employers decide what is and what is not a covered benefit. Please check your insurance plan for any questions.

4. Co-Payments not paid at the time of service are subject to a **$10 processing fee.** All balances more than 60 days past due are subject to a penalty of **$10 per month** to cover the cost of sending additional statements.

5. If your insurance company does not pay your claim within 30 days, it is your responsibility to contact your insurer to expedite payment. **If your insurance company does not pay within 60 days, you will be responsible for payment.**

6. Returned checks and balances older than 90 days may be subject to collection placement and collection fees which will be charged to the responsible party. If we are forced to send your account to collections, a **40% fee will be added to your balance**. There will be a **$35 non sufficient funds (NSF)** charge on all returned checks.

7. Occasionally, an insurance payment results in overpayment on your account and generally this balance remains on your account as a credit for use at a future visit. You may request a refund of overpayment by notifying the billing office.

8. We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to our billing office, so that we can assist you in management of your account with a payment plan.

9. Please note that all cancellations must be made at least 24 hours in advance. This allows us to care for other patients in need of our services. If you fail to cancel your appointment within 24 hours, you may be charged a $25 service fee.

10. **In an effort to care for our patients in a timely manner, we ask that you show up on time for appointments. Otherwise, we may have to reschedule your child. If you are running late, call us ASAP so we can advice you on the earliest available new appointment time.**

Again, thank you for choosing *Practical Approach Pediatrics and Pediatric Dentistry*. We appreciate the opportunity to serve you.

Guardian Name: _____ Signature: _____