Patient Information Sheet

Last Name: _____ **First Name:** _____ **MI:** _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Email Address: _____

Home #: _____ **Work #:** _____

Cell #: _____ **Fax #:** _____

DOB (MM/DD/YYYY): _____ **SS #:** _____

Sex: ☐ Male ☐ Female ☐ Unknown **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other

Race: __ American Indian or Alaskan Native __ Asian __Black __Caucasian __Pacific Islander __Other __Declined

Ethnicity: __Hispanic __Non-Hispanic __Declined **Primary Language:** __English __Spanish __Other

Pharmacy Name/Address: _____ **Phone:** _____

Emergency Contact Information:

Name: _____

Home #: _____ **Cell #:** _____

Patient Employment Information: ☐ Full Time ☐ Part Time ☐ Student

Employer Name/Address: _____

Phone #: _____ **Fax #:** _____

RESPONSIBLE PARTY INFORMATION:

Billing Information: ☐ Same As Patient or ☐ If different please fill out the following information.

Last Name: _____ **First Name:** _____ **MI:** _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Email Address: _____

Work #: _____ **Cell #:** _____

DOB (MM/DD/YYYY): _____**Sex: ☐ Male ☐ Female SS #:** _____

Relationship to Patient: _____

Responsible Party Employment Information: ☐ Full Time ☐ Part Time ☐ Student

Employer Name/Address: _____

Phone #: _____ **Fax #:** _____

Patient's or Authorized Person's Signature:

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits or other medical benefits to be assigned to _____ (Physician Name) for procedures and/or services render.

_____ _____

Authorized Signature **Date**

_____

Relationship to Patient

NEW PATIENT HISTORY

Patient Name: _____ DOB:_____ Sex: ___M ___ F

PREGNANCY AND BIRTH HISTORY

Birth weight: ___pounds ___ounces
Birth length: _____inches
Term: _____ weeks
Delivery: ___Vaginal ___C-section
Any birth defect: ___No ___Yes, _____
History of maternal complications during delivery/pregnancy: ___No ___Yes, _____
Mother: Age at time of birth: _____
Number of Pregnancies: _____
Number of Children: _____
Hospital: _____

PEDIATRIC PAST MEDICAL HISTORY:

___No Active Major Problems
Cancer:_____

___Autism
___ADD/ADHD
___Anemia
___Anorexia
___Anxiety
___Asthma
___Behavior Problems
___Blood disease
___Bone Problems
___Bronchitis, chronic
___Bulimia
___Cerebral Palsy
___Chronic Cough
___Cleft palate
___Constipation, chronic
___Depression
___Diabetes Mellitus
___Diarrhea, chronic
___Down's Syndrome
___Injury/Injuries
___Ear infection, recurrent
___Epilepsy
___Feeding Problems
___Hearing Problems
___Heart Murmur
___Heart Problems, other
___Mononucleosis
___Obesity
___Pneumonia
___Problems Developing
___RSV
___Rotavirus
___Seizures
___Skin Rash
___Sore Throat
___Spina Bifida
___Tonsillitis,chronic
___Undescended testis
___ Urinary Tract Infections
___ Vision Problems

Describe: _____

Allergies to Medications? _____

List of Current Medications? _____

Period started at age: ____years old
Sexually active? _____Yes _____No
STD: ___No ___Yes, _____
Pregnancies: ___No ___Yes, _____

Past Hospitalizations/Past Surgeries (List Date/Reason/Procedure) _____
_____
_____
_____
_____

Childhood Disease(s): ___None ___Chicken Pox ___Measles ___Mumps ___Polio ___Rheumatic Fever
___Scarlet Fever ___Typhoid Fever ___Whooping Cough
Other Major/Chronic Problems:_____

SOCIAL HISTORY:
Who all lives in home with child? _____
Is this child in daycare? ___No ___Yes
Are there pets in the home? ___No ___Yes, ___Cat(s) ___Dog(s) Other(s)_____
Current grade if in school: ___N/A ___grade
Any problems at school? ___No ___Yes, _____
Is this child involved in sports activities? ___No ___Yes, _____
Special skills or hobbies? ___No ___Yes, _____
Does he/she get along with other children? ___No ___Yes, _____
Any other information of note? ___No ___Yes, _____
Any smokers in the home? ____No ____Yes, _____

FAMILY HISTORY: ___ No Significant Family History ___Unknown
Mother: Height _____
Father: Height _____
___Arthritis/Gout: __mother __father __grandmother __grandfather __sibling
___Asthma/Hay Fever/Emphysema/Bronchitis: __mother __father __grandmother __grandfather __sibling
___Birth Defects: __mother __father __grandmother __grandfather __sibling
___Blood Clots: __mother __father __grandmother __grandfather __sibling
___Bone Disorders: __mother __father __grandmother __grandfather __sibling
___Cancer:_____ __mother __father __grandmother __grandfather __sibling
___Chemical Dependency: __mother __father __grandmother __grandfather __sibling
___Degenerative Disc Disease: __mother __father __grandmother __grandfather __sibling
___Diabetes: __mother __father __grandmother __grandfather __sibling
___Glaucoma: __mother __father __grandmother __grandfather __sibling
___Hearing Loss: __mother __father __grandmother __grandfather __sibling
___Heart Disease/Stroke: __mother __father __grandmother __grandfather __sibling
___High Blood Pressure: __mother __father __grandmother __grandfather __sibling
___High Cholesterol: __mother __father __grandmother __grandfather __sibling
___Kidney Disease: __mother __father __grandmother __grandfather __sibling
___Liver Disease: __mother __father __grandmother __grandfather __sibling
___Psychiatric/Emotional Problems: __mother __father __grandmother __grandfather __sibling
___Seizures/Epilepsy: __mother __father __grandmother __grandfather __sibling
___Sickle Cell Anemia: __mother __father __grandmother __grandfather __sibling
___Thyroid Disorders: __mother __father __grandmother __grandfather __sibling
___Tuberculosis: __mother __father __grandmother __grandfather __sibling

Other:_____ __mother __father __grandmother __grandfather __sibling

AUTHORIZATION AND RELEASE OF MEDICAL INFORMATION

I hereby authorize you to release any information, including diagnosis, labs and records of any treatment or examination rendered to me or my child, during the period of such care, to third party payers and/or other health care practitioners. I authorize and request my insurance company to pay insurance benefits, otherwise payable to me directly, to the physician. I understand that my carrier may pay less than the actual amount charged by the provider and may not pay for non covered services. I agree to be responsible and pay those described unpaid fees on my behalf or my dependents. Should I not pay these amounts in full and my account is turned over to an outside agency for collection, I understand I will be responsible for all cost of collections and attorney fees.

Signature of Patient/Guarantor:_____ Date:_____

AUTHORIZATION TO RELEASE INFORMATION

I authorize release of information (including facsimile transmission) relative to my medical records and/or lab results to my referring physician, _____, my spouse, _____, and the following names only, _____, _____, _____, _____, _____.

Signature:_____ Date:_____

NOTICE OF PRIVACY ACKNOWLEDGEMENT

We keep a record of all healthcare services we provide to you. You may ask to see and receive a copy of those records at any time. Any errors you discover on said records, you may request for corrections to be made. If it is found to be in fact an error, corrections to those records will be made.

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 our Privacy Office Administrator. Our Notice of Privacy describes in more detail how your health information may be used and disclosed and how you access your information.

By your signature below, you acknowledge receipt of this Notice of Privacy Practices.

Signature:_____ Date:_____

Consent to Treat

I**, _____** do hereby authorize River's Edge Pediatrics to treat my child _____. In the event of my inability to bring my child in to the office myself, I give the following person(s) permission to bring my child in for treatment. Additionally, the person listed below will also have access to my child's medical information. I give River's Edge Pediatrics permission to discuss medical information with person(s) listed below.

_____

Name and Relationship

_____

Name and Relationship

The treatment received in the office would include, but not limited to: Treatment of symptoms, Necessary laboratory or radiographs, and immunizations as required.

_____

Parent or Legal Guardian

Dated this _____day of _____, 20

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date: August 12, 2013

If you consent, the provider is permitted by federal privacy laws to make uses and disclosures of your health information for purpose of treatment, payment and health care operations. Protected health information is the information we create and obtain in providing our service to you. Such information may include documenting your symptoms, examination, test results, diagnosis, treatment and applying for future care or treatment. It also includes billing documents for those services.

Examples of the uses of your health information for treatment are:

- An employee of the provider's office obtains treatment information about you and records it in a health record.
- During the course of your treatment, the provider determines that he/she will need to consult with another specialist in the area. He/She will share the information with such specialists and obtain his/her input.

An example of use of your health information for payment purpose:

- We submit a request for payment to your insurance company. The insurance company requests information from us regarding services rendered. We will provide that information to them about you and the care you receive.
- We verify an insurance coverage prior to your first appointment and obtain prior authorization and pre-certification when required to do so by your policy coverage.

An example of using this information for health care operations:

- The state licensing authority wants to review records to assure that we have acted consistent with state laws regarding your care. In doing so, it wants to take sampling, which includes review of your chart. At the licensing authority's request, we will provide it with a copy of your chart.

Your health information rights:

The health record and billing records we maintain are the physical property of this office. The information in it, however, belongs to you.

You have the right to:

- Request a restriction on certain uses and disclosures of your protected health information. By delivering the request in writing to our office, we are required to grant the request.
- Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information by making a request at our office.
- Request that you be allowed to inspect and receive a copy of your health record and billing record. You may exercise this right by delivering the request in writing to our office.
- Appeal a denial of access to your protected health information except in certain circumstances.
- Request that your health care record be amended or correct incomplete or incorrect information by delivering a written request to our office.
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in our office. The accounting will not include internal uses of information for treatment, payment or operations, disclosures made to you and made at your request.
- Request that communication of your health information be made by alternative means or at the alternative location by delivering the request in writing to our office.
- Revoke any authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

You have the right to review the Notice before signing the consent authorizing use and disclosure of your protected health information.