CHILDREN'S HEALTHCARE ASSOCIATES, P.C.
PATIENT INFORMATION FORM

Patient Name:_____
Last Name **First Name** **Middle Initial**

Date of Birth:_____ **Birth Hospital**:_____

Sex_____ **Referred by**_____

Address:_____**Apt#**_____

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

Home Phone#_____ **Mobile#**_____

Emergency Contact: _____**Telephone#**:_____

Relationship to Child:_____

Parent # 1 Information

Parent Name:_____
Last Name **FIRST NAME**

Date of Birth:_____**Sex**_____ **Social Security#** _____

Maiden Name:_____

Address:(If Different from Child)_____

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

Employer:_____**Work#:**_____**Mobile#**_____

Parent # 2 Information

Parent Name:_____
Last Name **First Name** **Middle Initial**

Date of Birth:_____**Sex**_____ **Social Security #**_____

Maiden Name:_____

Address:(If Different from Child)_____

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

Employer:_____**Work#:**_____**Mobile#**_____

ASSIGNMENT OF MEDICAL BENEFITS

I authorize my insurance carrier to assign all medical benefits to Children's Healthcare Associates, P.C. I also authorize the release of medical information necessary to process all medical insurance claims. Please note we **DO NOT** accept assignment on secondary insurances under any circumstance. This includes and is not limited to private insurance or any state provided health plan such as ALL KIDS, MEDICAID or KIDCARE. Therefore, all copays/deductibles and coinsurance amounts are your responsibility.

_____Initial here

PAYMENT POLICY

Co-payments are due at the time services are rendered. We accept cash, checks and all major credit cards. Children's Healthcare Associates is contracted with many different insurance plans. **It is the Parents responsibility to check with their insurance plan for policy provisions and to check if their doctor is contracted with their specific plan.** Our physicians provide care according to the American Academy of Pediatrics and not based on what is covered by an Insurance plan. You will be responsible for any balance deemed patient responsibility/non-payable/non-covered by your insurance and billed accordingly. Payment is expected in full upon receipt of statement or payment arrangements must be made with our billing office. In the result your account is referred to an outside collection agency, our office will add an additional 33% to your account total for the service fees associated.

Please be advised that under state laws, both father and mother are responsible for the medical necessities of their dependent children, regardless of any separation or divorce agreements. Therefore, Children's Healthcare Associates observes the following guidelines.

- **Statements will be directed to the home where the child resides. It is that parent's responsibility to forward bills for payment**
- **We will assist you in filing insurance claims and providing duplicate copies of invoices as needed.**
- **Children's Healthcare Associates will not act as an arbitrator for a separation or divorce settlement with respect to determining responsibility for payment of bills**

_____Initial here

INSURANCE CARDS

It is **mandatory** that you inform the office when a change of insurance occurs. Due to timely filing limits if insurance is not updated in a timely fashion, the entire claim will become your responsibility. _____Initial here

CANCELLATION POLICY

Our office requests if an appointment needs to be cancelled, we receive notice no later than 24-hours prior to the appointment. We reserve the right to charge $30.00 for no show appointments or cancellations with less than 24-hour notification. This is to be collected on or before your next appointment.

_____Initial here

AFTER HOUR CALLS

ALL after hour calls will be assessed a $25 fee. This is **not covered** by Insurance and you will be billed directly. You are utilizing the physician's expertise outside of regular business hours and there are additional costs associated for handling patient calls when the office is closed.

_____Initial here

REFERRAL POLICY

If your Insurance company requires a referral it is your responsibility to contact our Care Coordinator to obtain the proper documentation. We require 72-hour notice for referrals.

_____Initial here

X_____

PRIMARY INSURANCE INFORMATION

Name of Insurance Company _____

Type of Plan: _____

Group# _____

ID#_____

INSURANCE COMPANY PHONE#_____

EFFECTIVE DATE:_____

NAME OF INSURED: _____

Please present a copy of your card to our receptionist.

Initial History Questionnaire

Name

ID NUMBER

FORM COMPLETED BY

DATE COMPLETED

BIRTH DATE

AGE

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names and ages and where they live. _____

If mother and father are not living together or if child does not live with parents, what is the child's custody status? _____

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home? _____

Birth History

Birth weight _____

Was the baby born at term? _____ Early? _____ Late? _____

If early, how many weeks' gestation? _____

Did mother have any illness or problem with her pregnancy?
☐ Yes ☐ No Explain _____

During pregnancy, did mother
Smoke ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No
Use drugs or medications ☐ Yes ☐ No
What _____ When _____

Was the delivery ☐ Vaginal? ☐ Cesarean?

If cesarean, why? _____

Did your baby have any problems right after birth?
☐ Yes ☐ No Explain _____

Was initial feeding ☐ Breast? ☐ Bottle?

Did your baby go home with mother from the hospital?
☐ Yes ☐ No Explain _____

General

Do you consider your child to be in good health? ☐ Yes ☐ No Explain _____

Does your child have any serious illness or medical condition? ☐ Yes ☐ No Explain _____

Has your child had serious injuries or accidents? ☐ Yes ☐ No Explain _____

Has your child had any surgery? ☐ Yes ☐ No Explain _____

Has your child ever been hospitalized? ☐ Yes ☐ No Explain _____

Is your child allergic to any medicines or drugs? ☐ Yes ☐ No Explain _____

Development

Are you concerned about your child's physical development? ☐ Yes ☐ No Explain _____

Are you concerned about your child's mental or emotional development? ☐ Yes ☐ No Explain _____

Are you concerned about your child's attention span? ☐ Yes ☐ No Explain _____

If your child is in school:

How is his/her behavior in school? _____

Has he/she failed or repeated a grade in school? _____

How is he/she doing in academic subjects? _____

Is he/she in special or resource classes? _____

Family History

Have any family members had the following:

Deafness	☐ Yes	☐ No	Who _____	Comments _____
Nasal allergies	☐ Yes	☐ No	Who _____	Comments _____
Asthma	☐ Yes	☐ No	Who _____	Comments _____
Tuberculosis	☐ Yes	☐ No	Who _____	Comments _____
Heart disease (before 50 years old)	☐ Yes	☐ No	Who _____	Comments _____
High blood pressure (before 50 years old)	☐ Yes	☐ No	Who _____	Comments _____
High cholesterol	☐ Yes	☐ No	Who _____	Comments _____
Anemia	☐ Yes	☐ No	Who _____	Comments _____
Bleeding disorder	☐ Yes	☐ No	Who _____	Comments _____
Liver disease	☐ Yes	☐ No	Who _____	Comments _____
Kidney disease	☐ Yes	☐ No	Who _____	Comments _____
Diabetes (before 50 years old)	☐ Yes	☐ No	Who _____	Comments _____
Bed-wetting (after 10 years old)	☐ Yes	☐ No	Who _____	Comments _____
Epilepsy or convulsions	☐ Yes	☐ No	Who _____	Comments _____
Alcohol abuse	☐ Yes	☐ No	Who _____	Comments _____
Drug abuse	☐ Yes	☐ No	Who _____	Comments _____
Mental illness	☐ Yes	☐ No	Who _____	Comments _____
Mental retardation	☐ Yes	☐ No	Who _____	Comments _____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	Who _____	Comments _____

Additional family history _____

_____

_____

Past History

Does your child have, or has he/she ever had:

Chickenpox	☐ Yes	☐ No	When _____
Frequent ear infections	☐ Yes	☐ No	Explain _____
Problems with ears or hearing	☐ Yes	☐ No	Explain _____
Nasal allergies	☐ Yes	☐ No	Explain _____
Problems with eyes or vision	☐ Yes	☐ No	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	Explain _____
Any heart problem or heart murmur	☐ Yes	☐ No	Explain _____
Anemia or bleeding problem	☐ Yes	☐ No	Explain _____
Blood transfusion	☐ Yes	☐ No	Explain _____
Frequent abdominal pain	☐ Yes	☐ No	Explain _____
Constipation requiring doctor visits	☐ Yes	☐ No	Explain _____
Bladder or kidney infection	☐ Yes	☐ No	Explain _____
Bed-wetting (after 5 years old)	☐ Yes	☐ No	Explain _____
(For girls) Has she started her menstrual periods?	☐ Yes	☐ No	When _____
(For girls) Are there problems with her periods?	☐ Yes	☐ No	Explain _____
Any chronic or recurrent skin problem (acne, eczema, etc)	☐ Yes	☐ No	Explain _____
Frequent headaches	☐ Yes	☐ No	Explain _____
Convulsions or other neurologic problem	☐ Yes	☐ No	Explain _____
Diabetes	☐ Yes	☐ No	Explain _____
Thyroid or other endocrine problem	☐ Yes	☐ No	Explain _____
Any other significant problem	☐ Yes	☐ No	Explain _____
Use of alcohol or drugs	☐ Yes	☐ No	Explain _____