

Name		DOB	Sex
<i>Last</i>	<i>First</i>	<i>(mo/day/yr)</i>	<i>M/F</i>

Birth History

Birth Weight	Type of Delivery	Hospital/OB
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Medical problems during pregnancy, delivery or the newborn period

Family

Child lives with the following adult(s): *(Check person responsible for bills.)*

<input type="checkbox"/> Name	Relationship to child
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Address

Home telephone	Weekend telephone
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Occupation	Employer
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Work telephone	Other telephone
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<input type="checkbox"/> Name	Relationship to child
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Occupation	Employer
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Work telephone	Other telephone
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Parent not living with child:

Check if custody is shared.

<input type="checkbox"/> Name	Relationship to child
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Address

Home telephone	Weekend telephone
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Occupation	Employer
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Work telephone	Other telephone
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Who else lives with the family?

Family Medical History

	Year of Birth	Medical Problems including Allergies or asthma Bleeding problems Deafness Juvenile Diabetes Onset of heart disease less than age 50 in men, age 60 in women
Mother		
Maternal Grandmother		
Maternal Grandfather		
Father		
Paternal Grandmother		
Paternal Grandfather		
Brothers and Sisters (Name)		

Please give medical details of biologic parents if different from above.

Are there any unusual illnesses in other family members?

School

Past Medical History

Allergic reactions to drugs, experienced by the patient. *Include date and type of reaction.*

Serious injuries, hospital stays, surgery: *Include hospital, approximate date, diagnosis*

Does the child have, now or in the past, a history of: *Give details, by number, in the space below.*

	Yes	No
1. Headaches		
2. Vision problems		
3. Severe nasal congestion		
4. Sinus infections		
5. Recurrent sore throat		
6. Recurrent ear infections		
7. Asthma		
8. Pneumonia		
9. Other lung problems		
10. Heart problems		
11. Fainting		
12. High Blood Pressure		
13. Chronic abdominal illness		
14. Nausea or vomiting		
15. Constipation		

	Yes	No
16. Intestinal bleeding		
17. Other intestinal illness		
18. Kidney disease		
19. Urine infection		
20. Joint swelling		
21. Unusual rashes		
22. Other skin problems		
23. Seizures		
24. Tics		
25. Neurologic problems		
26. Developmental or school problems		
27. Psychological problems		
28. Other significant illnesses		



Pediatric & Adolescent Medicine, LLP

FINANCIAL POLICY

We have direct financial relations with a limited number of insurance companies. We accept patients for Cigna Healthcare, Physician Health Services, Oxford and United Healthcare. We will bill these insurance companies directly for those patients enrolled with these plans. Please note, however, that all arrangements with insurance companies are subject to change at any time.

We **MUST** have your insurance information at the time of your visit in order to ensure our participation. If your insurance is a plan with which we do not participate, **YOU ARE RESPONSIBLE FOR PAYMENT AT THE TIME SERVICES ARE RENDERED.** Upon complete payment of services, we will provide you with a detailed summary of charges to submit to your insurer for your reimbursement.

You are responsible for any co-insurance, deductible and co-payments based on your plan. If your insurance requires you to pay a co-payment, this **MUST** be done at the time services are rendered in order to avoid an administration fee of \$5.

We will also charge a \$25 administration fee to your account for all outstanding balances over sixty days to cover the costs of billing. Any appointment(s) missed or not cancelled at least 24 hours prior to appointment arrival time will incur a \$40 cancellation fee.

You agree to provide accurate and prompt information concerning your health care plan. You agree to provide prompt notification of any changes to your insurance plan or coverage such as increased co-payment amounts, change of policy number, etc.

You understand that you are financially responsible for any services that are not covered by your insurance plan.

I have read the above information and understand my financial obligations.

Signed: _____

Print Name: _____ Date: - _____

Patient
Name: _____

Child's Name

**RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM**

Pediatric and Adolescent Medicine, LLP

I, _____, have received a copy of the Notice
Patient, Parent or Guardian's Name – PLEASE PRINT

of Privacy Practices followed by Pediatric and Adolescent Medicine, LLP.

Signature of Patient, Parent or Guardian

Date