PEDIATRIC PARTNERS OF STAFFORD REGISTRATION FORMS

INCOMPLETE FORMS CANNOT BE ACCEPTED AND WILL BE RETURNED TO YOU.

Patient Information **Date Completed: ____/____/_____**

Last Name: _____ **First Name:** _____ **Middle initial:** _____

Date of Birth: _____/_____/_____ **Sex:** ☐ **Male** ☐ **Female** **Nickname:** _____

Child Resides With: ☐ **Both Parents** ☐ **Mother** ☐ **Father** ☐ **Other:** _____

Childs Primary Address: _____ **City** _____ **State** _____ **Zip** _____

TELEPHONE NUMBERS

1.) _(_____)_____ ☐ Home ☐ Cell ☐ Work ☐ Other Name: _____

2.) _(_____)_____ ☐ Home ☐ Cell ☐ Work ☐ Other Name: _____

3.) _(_____)_____ ☐ Home ☐ Cell ☐ Work ☐ Other Name: _____

PARENT / GUARDIAN INFORMATION

Father / Guardian information

First Name: _____ Middle Initial: _____ Last Name: _____

DOB: _____/_____/_____ SSN: _____-_____-_____ Relationship ☐ Father ☐ Foster ☐ Legal Guardian ☐ Step ☐ other

Marital Status ☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Remarried ☐ Widowed

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Phone: _____ Occupation: _____

Mother / Guardian information

First Name: _____ Middle Initial: _____ Last Name: _____

DOB: _____/_____/_____ SSN: _____-_____-_____ Relationship ☐ Mother ☐ Foster ☐ Legal Guardian ☐ Step ☐ other

Marital Status ☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Remarried ☐ Widowed

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Phone: _____ Occupation: _____

Step Parents Name(s), if applicable: _____

Custodial Parent, if applicable: _____

EMERGENCY / ALTERNATE CONTACT

Full Name:

Relationship: _____ Phone Number: _____

Insurance Information

Entire form must be completed to ensure proper billing

Patient Name: _____	**DOB:** ____/____/_____
Primary Insurance: _____	**Secondary Insurance:** _____
Policy ID: _____	**Policy ID:** _____
Group Number: _____	**Group Number:** _____
Insurance Address: _____	**Insurance Address:** _____
_____	_____
Insurance Phone Number: _____	Insurance Phone Number: _____
Subscriber Name: _____	Subscriber Name: _____
Relationship to Patient: _____	Relationship to Patient: _____
SSN: _____/_____/_____DOB: ____/____/____	SSN: _____/_____/_____ DOB: ____/____/____
Employer Name: _____	Employer Name: _____
Employer Address: _____	Employer Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____

PAYMENTS AND INSURANCE AUTHORIZATION / ASSIGNMENT OF BENEFITS

It is the policy of this office that all payments for medical services be made *at the time of visit, or before in some cases.* This payment is required regardless of who brings the child in to be seen.

Initial _____ I understand and agree that I am ultimately responsible for any deductible, co-insurance, copays, or any balance not paid by my insurance company. This includes services provided that the insurance company deems not medically necessary.

Initial _____ I understand that I must pay my copay at the time of service, regardless of who accompanies my child to his / her appointment.

Initial _____ I understand a fee will be assessed for all forms needing to be reviewed and signed by a provider.

Initial _____ I understand I must have proof of insurance at every visit or I will have to pay in full to be seen. If I have a newborn, I will have to present proof of application by the 30 day mark if I do not have my baby's proof of insurance by then.

Initial _____ I understand that well and sick benefits may be handled differently by my insurance company, and if during a well visit, my child is sick, or has an issue needing treatment and / or medical attention, my provider may bill for both services. Regardless of what the well visit benefits are, I am responsible for any charges my insurance passes on to me for the sick portion.

Initial _____ I understand **that I am financially responsible for all amounts payable with regards to fees for healthcare services rendered now or in the future at this practice. In the event of non-payment by me of any amount due to this practice after 90 days, I agree that in addition to the original amount due, I am fully responsible to pay collection fees of 33 and 1/3 percent of the amount due, court cost, and reasonable attorney's fee incurred by this practice.**

Initial _____ I understand and hereby authorize payment to this practice for any benefits payable to me for healthcare services provided to the patient at this practice.

Initial _____ I understand that my insurance provided, in no way relieves me of my financial responsibility for services rendered now or in the future.

SIGNATURE _____ **PRINT NAME:** _____ **DATE:** ____/____/____

RELATIONSHIP: _____

HEALTH HISTORY FORM

Patient Name: **DOB:** **Sex:**

Pregnancy and Birth History ☐ Birth history unknown

Birth Weight:_____ was baby born full term? _____ Or _____ weeks

Was the baby ☐ Breech ☐ Headfirst(Vortex)

Were there any prenatal or neonatal complications:

☐ Yes ☐ No Explain:_____

_____

Was NICU stay required: □ Yes □ No If yes explain:_____

_____

Was the delivery ☐ Vaginal ☐ Cesarean

If Cesarean, Why?_____

Is the child yours by ☐ Birth ☐ Adoption ☐ Step child

☐ Other

During pregnancy, did mother

Use tobacco ☐ Yes ☐ No drink alcohol ☐ Yes ☐ No

Use prenatal vitamins ☐ Yes ☐ No

Use drugs or medications ☐ Yes ☐ No □

What:_____ When:_____

Did the baby go home with mother from hospital?

☐ Yes ☐ No Explain if no: _____

Development and nutrition

At what age did your child: Sit alone _____ Walk alone_____

Say Words _____ Toilet train _____

Was child breast fed? ☐ Yes ☐ No How long? _____

Formula ☐ Yes ☐ No What brand: _____

Any unusual feeding / dietary problems? _____

Explain:_____

Is child's appetite usually good: ☐ Yes ☐ No

Please check if child has problems in the following areas:

☐ bad temper ☐ hyperactivity ☐ discipline ☐ school

☐ nightmares ☐ sleeping ☐ toilet training ☐ speech

Does he / she get along with other children? ☐ Yes ☐ No

Are your child's vaccines up to date: ☐ Yes ☐ No

Medical history infancy / childhood / adolescence

Last physician:_____ Date of last Check up: _____/_____/_____ last dental check up ____/____/_____

Any problems with:		Explain	Any problems with:		Explain
Asthma or reactive airway disease	☐ Yes ☐ No	_____	Anemia	☐ Yes ☐ No	_____
Wheezing, bronchitis, pneumonia	☐ Yes ☐ No	_____	Seizures	☐ Yes ☐ No	_____
Seasonal allergies	☐ Yes ☐ No	_____	Vision prob	☐ Yes ☐ No	_____
Food allergies	☐ Yes ☐ No	_____	Dental prob	☐ Yes ☐ No	_____
Recurrent ear infections	☐ Yes ☐ No	_____	Skin prob.	☐ Yes ☐ No	_____
Urinary tract infections	☐ Yes ☐ No	_____	Broken bones	☐ Yes ☐ No	_____
Genetic syndromes	☐ Yes ☐ No	_____			
Developmental delays	☐ Yes ☐ No	_____			
Speech delays	☐ Yes ☐ No	_____			
Depression / anxiety	☐ Yes ☐ No	_____			
Heart murmurs / problems	☐ Yes ☐ No	_____			
History of anemia	☐ Yes ☐ No	_____			
Frequent cold or sore throats	☐ Yes ☐ No	_____			

List of current medication:

_____

_____

_____

Allergies to: medicines / vaccines list/describe

_____

_____

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

Does your child have any serious illness or medical condition ☐ Yes ☐ No if yes:_____

_____

Has your child ever been hospitalized ☐ Yes ☐ No _____

Any previous surgeries or procedures ☐ Yes ☐ No _____

List any other physicians your child is currently seeing and reason: _____

_____

Social History

Number of people living in household:_____

Who is in household: ☐ Mom ☐ Dad ☐ Siblings ☐ Step Parent ☐ Extended family ☐ Other

Does your child attend daycare or is cared for by babysitter, family, friend:_____

List age, sex, and general health of child's siblings:_____

Does any member of household smoke: ☐ Yes ☐ No

How many hours per day does child spend:

Watching tv:_____ Computer:_____ Video games:_____

Sports / exercise: type:_____

How often:_____ How long:_____

Biological Family History

Have any family members had the following

Aids	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent	
Allergies	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent	
Anemia	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent	
Asthma	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent	
Alcohol problems	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent	
Blood disorder	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent	
Cancer	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent	
Childhood hearing loss	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent	
Diabetes	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent	
Heart problems	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent	Age:_____
Stroke	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent	Age:_____
Sudden cardiac death	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent	Age:_____
High blood pressure	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent	
Cholesterol	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent	
Obesity	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent	
Thyroid disease	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent	
Kidney disease	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent	
Seizures	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent	
Migraines	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent	
Bed wetting after 10	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent	
Chronic recurring skin conditions	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent	
Tuberculosis	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent	
Depression / anxiety/ mood problems / ADHD	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent	
Learning disability	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent	

Additional family history:_____

Safety and environment

Is your water heater set at 120 degrees Fahrenheit?	☐ Yes ☐ No
Is there a working smoke alarm on each floor of your home?	☐ Yes ☐ No
Does your child always use a car seat or seat belt in the car?	☐ Yes ☐ No
Are there guns in the home?	☐ Yes ☐ No
If yes are they securely locked up?	☐ Yes ☐ No
Does your child always wear a helmet when riding a bike / skateboard / scooter?	☐ Yes ☐ No

PEDIATRIC PARTNERS OF STAFFORD

HIPAA Notice of Privacy Practical and Medical Treatment Authorization

Would you like to authorize anyone other than yourself to receive your child's health information? For example lab or test results, advice from a nurse, or general information. If so, please list who may receive this information (Please list anyone other than yourself). This may include grandparent, guardian, nanny, babysitter, friend, neighbor, or family relative. This person may also bring your child to an appointment in the event of your absence. **Please note information may not be given to parents if patient is 18 years or older, unless consent is given below.**

_____

Patient's Name

_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient

☐ **I do give consent to leave detailed message on voice mail. (Example labs)**

☐ **I do not give consent to leave detailed message on voice mail.**

Acknowledgement of Receipt of Notice of Privacy and Medical Treatment Authorization

The practice listed above reserves the right to modify the privacy practices outlined in the notice. I have received or been offered a copy of the Notice of Privacy Practices for the practice listed above. In the event of my absence, I hereby authorize the contacts above to bring the above named minor to an appointment and to give consent to any medical diagnosis or treatment for my child that is deemed advisable by physician or nurse practitioner at Pediatric Partners of Stafford. I certify that I have legal custody of the above named minor and are either the parent or legal guardian.

SIGNATURE OF PATIENT REPRESENTATIVE: _____

RELATIONSHIP TO PATIENT: _____

DATE: _____

COPY OF HIPPA AVAILABLE UPON REQUEST

CONSENT TO EMAIL AND / OR TEXT

PEDIATRIC PARTNERS OF STAFFORD

We now have the ability to email and / or text you, reminding you of your appointments. If you would like to receive this feature in the future please read and sign this consent. The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

_____ (Parental/guardian Initials) I consent to receive appointment reminders from Pediatric Partners of Stafford at my wireless number provided and any number forwarded or transferred to that number. I understand that this request to receive text message appointment reminders will apply to all future appointment reminders unless I request a change in writing (see revocation section below). I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

_____ (Parental/guardian Initials) I consent to receive appointment reminders from Pediatric Partners of Stafford by email provided. I understand that this request to receive e-mail message appointment reminders will apply to all future appointment reminders unless I request a change in writing (see revocation section below).

This consent applies to the following Children:

Name:	Birthdate:

LIST ONLY ONE FOR EACH & PRINT CLEARLY

Authorized Cell Phone Number:	Authorized Email:

Parent / Guardian Signature: _____ Date: _____

Printed Name: _____ Relationship: _____

Revocation/ Opt out

_____I hereby **have chosen to OPT OUT of email and / or text message appointment reminders**

_____I hereby revoke my request for future appointment reminders via email and / or text messages

Patient Name: _____ DOB:_____

Parent / Guardian signature:_____ Date:_____

Printed Name: _____

Pediatric Partners of Stafford

Dear Patient and Parents:

Welcome to our practice: At Pediatric Partners, we care for children from birth to age 18. We provide preventive care, acute sick visits, and also handle management of chronic problems and diseases. We currently have four physicians and three nurse practitioners on staff. Our doctors are board certified pediatricians and members of the American Academy of Pediatrics. The pediatricians and nurse practitioners are: Tamara Loving M.D., Haleh Rajaee M.D., Laura Walsh M.D., Lori VanHorn M.D., Bethanie Cooke C.P.N.P., Holly Frankel C.P.N.P., and Jessica Johnson C.P.N.P.

Appointments: At Pediatric Partners we see patients by appointment only. We strive to accommodate all of our sick patients with same day appointments. We do request that you provide us with at least 24 hours' notice when canceling or rescheduling an appointment so that we may make that time available for another patient. As a courtesy, our office will try to confirm your child/ children's appointment at least 48 hours prior, but it is still the parent's responsibility if an appointment that you scheduled is missed.

Missed Appointments: Our office will bill for any missed appointments not cancelled within 24 hours. **Three missed appointments with no notification are grounds for dismissal from Pediatric Partners of Stafford.**

Information Changes: If any of your personal information changes such as your address, phone number or insurance plan please inform our staff. We will have you complete a new patient information sheet and discard the old one to alleviate any future confusion. Please be advised you will have to complete a new patient information sheet every year, regardless of any changes.

Insurance: If your insurance changes please check with our office to ensure we are currently accepting that insurance coverage is a contract between you and your insurance company. You are ultimately responsible for payment of your account and knowledge of what your insurance policy covers.

Applicable Fees: All patients are subject to a $50 no call no show fee for missed appointments or appointments cancelled in less than 24 hours. Personal checks returned for non-sufficient funds or closed accounts will be subject to a $33 returned check fee which must be paid by cash or credit card. There is a processing fee for copying and/or mailing medical records which consists of a $10 administrative fee plus $0.25 per page**. All forms brought in for a physician to fill out are subject to a fee per form**.

After Hours: We share night and weekend call with a group of local pediatricians. There is always a doctor on call for this practice. The on call doctor has limited weekday, early evening, and Saturday morning appointments available for urgent sick visits. Please call our office number if you feel your child is in need of an urgent sick visit and our answering service will direct you to the on call doctor.

Telephone Calls: Our nurses are available to answer your healthcare questions during our office hours. All calls are returned as quickly as possible and all general questions are returned within a 48 hour period. When our office is closed, there is an after-hours advice nurse offered through Mary Washington Hospital for urgent medical needs which cannot wait until the next day. To access the after-hours advice nurse through MWH, call 540-741-1000. For all non-medical questions such as referrals, prescription refills, scheduling / rescheduling appointments, insurance questions and / or billing questions, please call us during our regular office hours Monday – Friday 8:30 AM – 12:30 PM and 1:30 PM to 5:00 PM.

Prescription Refills: We feel each child deserves the best medical care possible. We do not believe it is in your child's best interest to receive an antibiotic prescription over the telephone without proper evaluation first. All prescription refill requests take 48-72 hours to process.

Insurance Referrals: Your doctor may refer you to a specialist. If your insurance requires a referral, please contact our referral coordinator to have one processed. Each insurance company has its own referral process. Some are quite simple and others require many steps. To insure your referral is complete and ready for your appointment, we request at least 3-5 working days to process referrals.

Medical Records: If you are requesting a copy of your child / children's medical records please sign a release form. We request 7-10 business days to process records.

Billing and Claims: SA Medical of Virginia files all of our patient's insurance claims. If you should have any questions regarding your account, EOB, or bill you have received, please contact our billing service (SA Medical of Virginia) at 540-371-4488.

Privacy: Your child / children's medical record is strictly confidential. We do not release information regarding your child's health to your employer, friends, or relatives without written permission from a parent or legal guardian. We comply with the Health Insurance Portability & Accountability Act (HIPAA) guidelines and have a written privacy policy available in our office.

We look forward to assisting your with all your child's healthcare needs.

I have read and accept these policies:

Patient Name: _____

Signature of Parent / Guardian: _____

Date: _____

Office Staff Initial: _____

COPY AVAILABLE UPON REQUEST