PEDIATRIC NEW PATIENT FORM

Please fill out completely.

Last Name _____ First Name_____ Middle Name _____

Preferred Name of Child _____

Date of Birth _____ Gender _____ SSN _____-_____-_____

Street Address _____ City _____ State _____ Zip _____

Primary Language _____ Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race ☐Black or African American ☐White ☐Asian ☐Other _____

Parental Information

Circle One: Mother Stepmother Guardian

Name _____

Date of Birth _____

Home Phone _____

Cell Phone _____

Work Phone _____

Address _____

Email Address _____

Employer _____

Occupation _____

Parental Information

Circle One: Father Stepfather Guardian

Name _____

Date of Birth _____

Home Phone _____

Cell Phone _____

Work Phone _____

Address _____

Email Address _____

Employer _____

Occupation _____

Emergency Contact_____ Phone (____) _____ Relationship _____

Pharmacy: _____ Pharmacy City: _____

Primary Insurance

Company _____ ID/Policy # _____ Group # _____

Policy Holder _____ Relationship to Child _____ SSN _____

Employer _____ Phone (_____) _____

Secondary Insurance

Company _____ ID/Policy # _____ Group # _____

Policy Holder _____ Relationship to Child _____ SSN _____

Employer _____ Phone (_____) _____

Insured's Signature _____ Date _____

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Patient Health History

Depending on your child's age, all of these questions may not be relevant. Please complete this form as fully as possible.

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Name of person completing this form: _____ Relationship to patient: _____

Name of child's previous physician: _____

Delivery and Birth History ____ Unknown Was your child adopted? Y / N Date of Adoption: _____

Place of birth: Name of Hospital _____ City and State: _____

Type of delivery: ____ Vaginal (If yes, breech/feet first? Y / N) ____ Caesarean (If yes, was it planned?: Y / N)

How old was the birth mother at time of delivery? _____ Was the child premature? Y / N days:_____ weeks:_____

Child's birth weight: _____ length: _____ head circumference: _____

Were there any significant medical problems during your pregnancy? Y / N

Were there any significant complications during labor? Y / N

Did the baby have a NICU stay after birth? Y/N

Were there any complications during the baby's newborn period? Y / N

If yes, to any of the above, please explain: _____

_____

Growth and Development

Have you or your child's previous physician ever had any concerns about your child's growth or development? Y / N
(speech/language, social skills, motor skills, etc.)

Please provide your child's age when they first:

Sat up without help _____ Crawled _____ Walked without help _____ Spoke their first words _____

Girls only: Age at first period: _____

List any developmental concerns or issues you would like to speak to Dr. Anderson about: _____

_____

Child's Medical History

Please indicate if your child has had any of the following conditions.

Been hospitalized overnight		Pneumonia		Eating Disorder/Anorexia or Bulimia	
Asthma/wheezing		Seizure/Epilepsy		Seasonal Allergies	
Used a nebulizer		Liver Disease/hepatitis		Learning Delay	
Surgery		Kidney Disease		Learning Disability	
Broken bones		Bladder infection		ADD/ADHD	
Frequent or severe sprains		Sexually Transmitted Infection		Lead Poisoning	
Mental or behavior challenges		*Skin problems*		*Obesity/overweight*	
Seen in the Emergency Room		Hearing problems		Emotional/Behavioral Challenges	

If yes to any of the conditions above, please describe: _____

_____

_____

Medications and Allergies

Please list current medications, vitamins, and supplements, even those used occasionally:

Medication	**Dosage**	**Directions**	**Prescribed By:**
Example: Cetirizine	**5mg**	**Once a day**	**Dr. Anderson**

Please list allergies or reactions to medications, vaccines or foods:

Allergy	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

Social History

Please list all others living in the child's household:

Name	Age	Relationship

Does your child attend school? Y / N Homeschool: Y / N Daycare: Y / N

Do you have pets in the home? Y / N If yes, type and number of pets: _____

Do you have guns/firearms in the home? Y / N If yes, are they locked _____

Does anyone in the home smoke? Y / N If yes, who _____

Approximately how many hours a day does your child spend in front of a screen? _____

Does your child play organized sports? Y / N If yes, what and for how long: _____

Family History

Please indicate if any family members have had any of the following diseases. If so, please write in their relation: mother, father, sister, brother, maternal aunt/uncle/grandmother/grandfather, paternal aunt/uncle/grandmother/grandfather

Disease	Family Member
ADD/ADHD	
Alcohol/Drug dependency	
Anemia	
Anxiety or depression	
Arthritis or Lupus	
Asthma/ Lung Disease	
Blood Clots	
Blood Transfusions	
Breast Disease or Cancer	
Cancer (list type)	
Dementia	
Diabetes	
Genetic disease or Birth defects	

Heart problems	
Hepatitis	
High Blood Pressure	
HIV	
Kidney disease	
Liver disease	
Mental Health Disorder	
Migraines	
Neurological disease	
Seizures	
Stomach problems	
Stroke	
Thyroid disease	
Tuberculosis	

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DESIGNATION OF AUTHORIZED ADULT REPRESENTATIVE(S)
AND EMERGENCY CONTACTS
(other than parents)

In my absence, I hereby give permission to the following person(s) to bring my child (or children) to Anderson Family Care to seek medical care.

Patient Name(s) _____ Birthdate _____

_____ _____

_____ _____

Name (First and Last)	Phone Number	Relationship to Child

I understand that care will be provided by Dr. Anderson and the staff, including the administration of any medications and/or vaccinations deemed necessary by Dr. Anderson at the time. I will make a good effort to call Anderson Family Care with any questions I have about my child's care following any visit where I am not present. I understand that unless and until I provide written notice to the practice of any changes to the designation of authorized adult representatives, Anderson Family Care may rely on the consent provided herein.

_____ _____

Signature of parent / guardian or assigned representative Relationship to child

_____ _____

Print Name Date

ANDERSON
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Policy for Divorced or Separated Parents

Anderson Family Care staff are dedicated to our patients and providing quality medical care to your child(ren). Our focus is on your child's medical, emotional, psychological and physiological health. We are not party to or to be involved in any legal issues involving divorce, separation or custody agreements. Please, read and agree to the following so that we may provide care to your child(ren).

1. The physician(s), medical assistants, office and billing staff will not be put in the middle of domestic issues or disagreement over the phone or in the office.
2. Please make decisions regarding appointments, vaccinating and/or any office procedures PRIOR to visiting our practice.
3. Only in situations where there is a confirmed, documented **Court Order** will one of the parents be denied access to the minor child's health records or visits at the office. Anderson Family Care must have a copy of this Court Order on file in the minor child's electronic chart.
4. If there is NOT a court order on file with our office, either parent or legal guardian can sign a "Designation of Authorized Adult Representatives" form that authorizes any named individuals (like grandparents, nannies etc.) to bring your child to our practice, be present during the visit and consent to any treatment during that visit. We will not be involved in any disputes regarding named individuals on the consent forms unless instructed by the court. Either parent or legal guardian can schedule an appointment for their child, be present for the visit and/or obtain a copy of the visit summary.
5. It is both parents' responsibility to communicate with each other about the patients' care, office visit dates and any other pertinent information relevant to the patient. It is not the responsibility of the staff to communicate visit information to each custodial parent separately. Our providers will not call the non-attending parent following visits.
6. Additionally, we will not call the other parent for consent regarding appointments scheduled, restrict either parent's involvement in the patient's care unless authorized by law or tolerate appointment scheduling/cancelling patterns of behavior between parents.
7. Furthermore, payments including copays, deductibles, coinsurance or any additional fees charged by your insurance are due at the time of service regardless of which parent is responsible for medical expenses. We are **not** a party to your divorce agreement. We will collect payment from the parent who brings the child to their visit. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent. Any disputes about payment that end up in the collection process, will be due at the next time of service or the patient will not be seen.
8. If we feel any of the above points are becoming an issue at the office and/or compromising patient care, we have the right to discharge the family from the practice.

By signing this form, you agree to honor the above policy and understand that breaking this agreement may result in the discharge of your family from the practice.

Print- Parent/Legal Guardian	Sign- Parent/Legal Guardian	Date
Print – Parent/Legal Guardian	Sign – Parent/Legal Guardian	Date

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PATIENT CONTACT RECORD

Patient Name: _____

The HIPAA Privacy Rule gives individuals the right to restrict release of their Private Health Information (PHI). A copy of Anderson Family Care, LLC's Notice of Privacy Practices is included in this packet.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

WRITTEN ACKNOWLEDGEMENT OF FORM

I, _____, have received a copy of Anderson Family Care, LLC's Notice of Privacy Practices.

Signature _____ Date _____

AUTHORIZATION TO RELEASE MEDICAL HISTORY TO ANOTHER INDIVIDUAL

Please list the individual(s) you will allow Anderson Family Care, LLC to release or discuss your child's PHI with. Do not list other physicians.

Name	Relationship	Phone Number

AUTHORIZATION TO OBTAIN MEDICATION HISTORY

I, _____, hereby authorize Anderson Family Care, LLC to obtain/download my child's medication history from Pharmacies and/or Pharmacy Benefit Managers. This authorization will allow my child's physician to check drug-to-drug interactions for any new prescriptions he/she may prescribe and to facilitate electronic pharmacy prescriptions. I understand this authorization will remain in effect until revoked by me in writing.

AUTHORIZATION TO LEAVE RECORDED MESSAGES

I give Anderson Family Care permission to leave protected health information on an answering machine or voicemail.

(Circle Yes or No) YES NO

AUTHORIZATION OF ELECTRONIC CORRESPONDENCE

I give Anderson Family Care permission to communicate protected health information with me via email, text message and other electronic mechanisms. I understand the potential risks associated with electronic correspondence.

(Circle Yes or No) YES NO

Signature _____ Date _____

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ASSIGNMENT OF BENEFITS

Your signature is necessary for us to process any insurance claims and to ensure payment of services rendered.

I request that payment of authorized insurance benefits be made on my/my child's behalf to Anderson Family Care, LLC for any equipment or services provided to me by its physicians or clinical staff.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to Anderson Family Care, LLC, my insurance carrier, or other medical entity. A copy of this authorization will be sent to my insurance company or other entity if requested. The original authorization will be kept on file by Anderson Family Care, LLC.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my child's health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for services rendered.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I have read and I understand the information above. I agree to be financially responsible for all charges as discussed above.

Patient/Insured's Signature _____

Date_____