New Patient Medical Information

Patient's Name: _____

Parent's Name: _____ Parent's Name: _____

Parent's Cell Phone: _____ Parent's Cell Phone: _____

Parents's Business Phone: _____ Parent's Business Phone: _____

Patient's Address: _____

Home Phone: _____ E-Mail Address: _____

Referred by: _____

Family History

Please check only if the patient has an affected parent, sibling or grandparent.

□ Diabetes	□ High Blood Pressure	□ Epilepsy/Seizures
□ Allergies	□ Asthma	□ Cancer
□ Bleeding Disorders	□ Developmental Delay e.g. Down Syndrome	□ Tay-Sachs / metabolic diseases
□ Anemia	□ Heart Disease before age 50 yrs.	□ Muscular Dystrophy
□ Migraines	□ Thyroid Disease	□ Tuberculosis

_____

_____

_____

Past Medical History

Was patient conceived using in vitro fertilization, egg donation, etc.? If so, please explain. _____

_____

Were there any complications during pregnancy? If so, please describe.

_____

Was the patient born vaginally or by Caesarian Section? _____

Were there any complications at or shortly after delivery? _____

_____

What was the patient's birth weight? _____ Birth length? _____

Has the patient ever been seriously ill or hospitalized? _____

_____

Does the patient have any chronic or recurrent illnesses? _____

_____

Does the patient currently take any medications? _____

_____

Does the patient have allergies to any medications? _____

Has the patient ever undergone surgery? _____

_____

Please use this space to add any information which you think we should be informed of:

_____

_____

_____

Notice of Privacy Acknowledgement

Shores Pediatrics, LLC

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health insurance, I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices, I also understand that this practice has the right to change its Notice of Privacy Practices, I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian (print) **Date**

_____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of Notice of Privacy Practices:

Date: _____ **Attempt:** _____

Staff Name: _____

PRIMARY LANGUAGE _____ DATE _____

PATIENTS' INFORMATION

PATIENT'S NAME _____
LAST FIRST MIDDLE

BIRTHDATE _____ SEX _____ ALLERGIES _____

SOCIAL SECURITY # _____ PHONE ( ) _____

PERMANENT ADDRESS _____
CITY STATE ZIP

TO SEE DOCTOR _____ REFERRED BY _____

BROTHERS _____ SISTERS _____

PARENT'S INFORMATION

MARITAL STATUS _____

PARENT'S NAME _____ D.O.B _____ S.S # _____

ADDRESS _____ ZIP _____ CELL # _____
CITY, STATE

EMPLOYED BY _____ BUSINESS PHONE ( ) _____

E-Mail _____

PARENT'S NAME _____ D.O.B _____ S.S # _____

ADDRESS _____ ZIP _____ CELL # _____
CITY, STATE

EMPLOYED BY _____ BUSINESS PHONE ( ) _____

E-Mail _____

NEAREST RELATIVE(S) _____ PHONE ( ) _____

❑ HIPPA Notice Received & Reviewed

INSURANCE INFORMATION

(For Office Use Only)

❑ Please check here if any of the above information has changed in the last 12 months.

AUTHORIZATION

Patient's Name:_____ Date of Birth:_____

May we leave the following types of messages at your home, work, cell or emergency contact numbers?

(1) Appointment changes _____Yes _____ No

(2) Test Results _____Yes _____ No

(3) Prescription Info _____Yes _____ No

(4) Billing Answers _____Yes _____ No

(5) Telephone Nurse Advise _____Yes _____ No

Yes	No	I hereby authorize the physician(s) of **Shores** Pediatrics, to provide medical treatment to the patient on this form.
Yes	No	In the event that my child's legal guardian(s) is/are not able to be present during an office visit, I allow the person who accompanies my child (i.e., family member/friend, nanny, etc.) to make medical decisions on my behalf. (Note: Responding "no" to this statement would require a notarized statement indicating the names of the persons authorized to make such decisions.)
Yes	No	I hereby authorize third parties to pay directly to the physician(s) any insurance benefits due for services rendered on behalf of the named patient.
Yes	No	I authorize the physician(s) to furnish my insurance company and / or third party payers (or their representatives), any medical information necessary to process our insurance claims.
Yes	No	I understand that I am responsible for payment and all charges for medical services rendered to the named patient
Yes	No	As required by the Privacy Regulations, I hereby acknowledge that I have reviewed a current copy of "Notice of Privacy Policy". I have read the Privacy Policy and understand my rights contained in the notice.
Yes	No	By way of my signature, I provide **Shores** Pediatrics, my authorization and consent to use and disclose my child's protected healthcare information for the purposes of treatment, payment and healthcare operations described in the Privacy Policy.

Signature:_____ Date:_____

Printed Name:_____

Relationship to Patient: _____

Insurance Information

Insurance: _____

Subscriber Name: _____

Subscriber Date of Birth: _____

Last 4 Digits of Subscriber's SSN: _____