HEALTHY KIDS PEDIATRICS
PATIENT INFORMATION FORM

Staff Only:

File in _____ **Chart** **Acct. #:** _____ **Date:** _____
(Patient's Name)

HOME ADDRESS: _____ HOME PHONE #: _____

_____ CELL PHONE #: _____

School: _____ Phone #: _____ Parental status: Married Single Widowed Divorced

LEGAL GUARDIAN AND EMERGENCY CONTACT

PARENT/GUARDIAN: _____ PARENT/GUARDIAN: _____

HOME ADDRESS: _____ HOME ADDRESS: _____

_____ _____

PHONE #: _____ PHONE #: _____

BUSINESS PHONE #: _____ BUSINESS PHONE#: _____

CELL PHONE #: _____ CELL PHONE #: _____

E-MAIL: _____ E-MAIL: _____

OTHER EMERGENCY CONTACT: _____ RELATIONSHIP: _____

ADDRESS: _____

PHONE #: _____ CELL PHONE #: _____

I authorize my physician's office to contact me by using any of the above contact information _____
Please Initial

INSURANCE

PRIMARY INS: _____ POLICY #: _____ GROUP #: _____

POLICY HOLDER: _____ EFFECTIVE DATE: _____

RELATIONSHIP: _____ EMPLOYER: _____

SOCIAL SECURITY #: _____ ADDRESS: _____

DATE OF BIRTH: _____ BUSINESS PHONE: _____

SECONDARY INS: _____ POLICY #: _____ GROUP #: _____

POLICY HOLDER: _____ EFFECTIVE DATE: _____

RELATIONSHIP: _____ EMPLOYER: _____

SOCIAL SECURITY #: _____ ADDRESS: _____

DATE OF BIRTH: _____ BUSINESS PHONE: _____

PHARMACY INFORMATION

LOCAL PHARMACY _____ **MAIL AWAY PLAN:** _____

ADDRESS: _____ ADDRESS: _____

PHONE #: _____ PHONE #: _____ FAX: _____

CHILD'S NAME	DATE OF BIRTH	AGE	PRIMARY INS. ID #	SECONDARY INS. ID#
1				
2				
3				
4				
5				
6				

Initial History Questionnaire

Name

ID NUMBER

FORM COMPLETED BY

DATE COMPLETED

BIRTH DATE

AGE

M F

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, ages, and where they live. _____

What is the child's living situation if not with both biological parents?

☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody

☐ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

Birth History ■ Don't know birth history

Birth weight _____ Was the baby born at term? _____ OR _____ weeks

Were there any prenatal or neonatal complications?

☐ Yes ☐ No Explain _____

Was a NICU stay required? ☐ Yes ☐ No Explain _____

During pregnancy, did mother

Use tobacco ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No

Use drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins

What _____ When _____

Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, why?

Was initial feeding ☐ Formula ☐ Breast milk How long breastfed? _____

Did your baby go home with mother from the hospital?

☐ Yes ☐ No Explain _____

General DK = don't know

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

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ DK Explain _____

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

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

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ DK Explain _____

Do you feel your family has enough to eat? ☐ Yes ☐ No ☐ DK Explain _____

Biological Family History DK = don't know

Have any family members had the following?

Childhood hearing loss	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Asthma	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tuberculosis	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Heart disease (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
High cholesterol/takes cholesterol medication	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Anemia	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bleeding disorder	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Dental decay	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Cancer (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

(Biological Family History continued on back side.)

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

HE0328

Biological Family History *(Continued from front side.)* DK = don't know

Liver disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Kidney disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Diabetes (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bed-wetting (after 10 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Obesity	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Epilepsy or convulsions	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Alcohol abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Drug abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Mental illness/depression	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Developmental disability	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tobacco use	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

Additional family history _____

Past History DK = don't know

Does your child have, or has your child ever had,

Chickenpox	☐ Yes	☐ No	☐ DK	When _____
Frequent ear infections	☐ Yes	☐ No	☐ DK	Explain _____
Problems with ears or hearing	☐ Yes	☐ No	☐ DK	Explain _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Explain _____
Problems with eyes or vision	☐ Yes	☐ No	☐ DK	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	☐ DK	Explain _____
Any heart problem or heart murmur	☐ Yes	☐ No	☐ DK	Explain _____
Anemia or bleeding problem	☐ Yes	☐ No	☐ DK	Explain _____
Blood transfusion	☐ Yes	☐ No	☐ DK	Explain _____
HIV	☐ Yes	☐ No	☐ DK	Explain _____
Organ transplant	☐ Yes	☐ No	☐ DK	Explain _____
Malignancy/bone marrow transplant	☐ Yes	☐ No	☐ DK	Explain _____
Chemotherapy	☐ Yes	☐ No	☐ DK	Explain _____
Frequent abdominal pain	☐ Yes	☐ No	☐ DK	Explain _____
Constipation requiring doctor visits	☐ Yes	☐ No	☐ DK	Explain _____
Recurrent urinary tract infections and problems	☐ Yes	☐ No	☐ DK	Explain _____
Congenital cataracts/retinoblastoma	☐ Yes	☐ No	☐ DK	Explain _____
Metabolic/Genetic disorders	☐ Yes	☐ No	☐ DK	Explain _____
Cancer	☐ Yes	☐ No	☐ DK	Explain _____
Kidney disease or urologic malformations	☐ Yes	☐ No	☐ DK	Explain _____
Bed-wetting (after 5 years old)	☐ Yes	☐ No	☐ DK	Explain _____
Sleep problems; snoring	☐ Yes	☐ No	☐ DK	Explain _____
Chronic or recurrent skin problems (eg, acne, eczema)	☐ Yes	☐ No	☐ DK	Explain _____
Frequent headaches	☐ Yes	☐ No	☐ DK	Explain _____
Convulsions or other neurologic problems	☐ Yes	☐ No	☐ DK	Explain _____
Obesity	☐ Yes	☐ No	☐ DK	Explain _____
Diabetes	☐ Yes	☐ No	☐ DK	Explain _____
Thyroid or other endocrine problems	☐ Yes	☐ No	☐ DK	Explain _____
High blood pressure	☐ Yes	☐ No	☐ DK	Explain _____
History of serious injuries/fractures/concussions	☐ Yes	☐ No	☐ DK	Explain _____
Use of alcohol or drugs	☐ Yes	☐ No	☐ DK	Explain _____
Tobacco use	☐ Yes	☐ No	☐ DK	Explain _____
ADHD/anxiety/mood problems/depression	☐ Yes	☐ No	☐ DK	Explain _____
Developmental delay	☐ Yes	☐ No	☐ DK	Explain _____
Dental decay	☐ Yes	☐ No	☐ DK	Explain _____
History of family violence	☐ Yes	☐ No	☐ DK	Explain _____
Sexually transmitted infections	☐ Yes	☐ No	☐ DK	Explain _____
Pregnancy	☐ Yes	☐ No	☐ DK	Explain _____
(For girls) Problems with her periods	☐ Yes	☐ No	☐ DK	Explain _____

Has had first period ☐ Yes ☐ No Age of first period _____

Any other significant problem _____

This American Academy of Pediatrics Initial History Questionnaire is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 3rd Edition.

HE0328

9-223/0109

Does your child need a lead test?

Child's Name:
Child's Date of Birth:
Today's Date:
(FOR OFFICE ONLY) – MRN #:

1. Does your child live in or regularly visit a building built before 1978 with potential lead exposures, such as peeling or chipping paint, recent or ongoing renovation or remodeling, or high levels of lead in the drinking water?	YES	NO	NOT SURE
2. Has your child spent any time outside the United States in the past year?	YES	NO	NOT SURE
3. Does your child live or play with a child who has an elevated blood lead level?	YES	NO	NOT SURE
4. Does your child have developmental disabilities, put nonfood items in their mouth, or peel or disturb painted surfaces?	YES	NO	NOT SURE
5. Does your child have frequent contact with an adult who may bring home traces of lead from a job or hobby such as: house painting, plumbing, renovation, construction, auto repair, welding, electronics repair, battery recycling, lead smelting, jewelry, stained glass or pottery making, fishing (weights, "sinkers"), firearms, or collecting lead or pewter figurines?	YES	NO	NOT SURE
6. Does your family use traditional medicines, health remedies, cosmetics, powders, spices, or food from other countries?	YES	NO	NOT SURE
7. Does your family cook, store, or serve food in crystal, pewter, or pottery from other countries?	YES	NO	NOT SURE
8. Did your child miss a lead test? New York State requires all children be tested for lead at age 1 and again at age 2.	YES	NO	NOT SURE

If you answered "YES" or "NOT SURE" to any of these questions, your child may need a blood lead test.

Lead is a concern, especially for children under age 6. It's important for you and your health care provider to know your child's blood lead level.

www.health.ny.gov/LeadTestKids

NEW YORK STATE | Department of Health

Healthy Kids
Pediatrics

Madeline Pugliese, D.O., F.A.A.P.
Naomi Jackman, M.D., F.A.A.P.

211 Main Street Port Washington, NY 11050 Tel. (516) 944-6015 Fax (516) 944-0387

FINANCIAL POLICY

Upon registration we will need the following information and items: insurance card (if you are a member of one of the plans that we participate with), the name, date of birth, address of the person who is the plan member, government-issued photo ID, address, patient's date of birth, contact phone numbers of both parents and/or all guardians.

Health Insurance: When scheduling each appointment, our team will verify your insurance information with you. Our office staff will verify your eligibility prior to or upon check-in at each appointment. Please make sure that you bring your card to every appointment. If your insurance changes, please notify us as soon as possible.
We participate with many different plans and simply cannot know the provisions of every patient's policy. We do, however, recommend that you make every effort to understand your insurance coverage and if necessary contact your carrier prior to receiving services in order to verify your coverage levels and copay, deductible and coinsurance responsibilities. If you are new to the practice and have an HMO plan, please make sure you have called your plan to select our practice/doctor as your PCP before the day of your visit. Otherwise your child cannot be seen.

Initial:_____

Non-covered Services: Please note that there are some services that your insurance may not cover. These may include important tests which are considered pediatric standards of care such as Vision screens, Hearing screens, Developmental screens and in office lab tests. They may be part of your annual well-child visit. If your insurance rejects the claim for these screens or other services, we will bill you a discounted fee to ensure that you can afford the highest standards of pediatric care. We pride ourselves on providing only the highest quality of care for your child and do this by following American Academy of Pediatrics clinical guidelines and recommendations from other trusted evidence-based resources.

Initial_____

Balances, Deductibles and Copayments: It is our responsibility, as detailed by the terms of our contracts with health insurance companies that we participate with, to collect copayments at the time of service, and to bill you for any portion of your treatment that your health insurance carrier assigns as your responsibility. It is your responsibility to pay this portion of your bill. We are happy to set up a payment plan with you if you are unable to pay the balance in full at any time. Just make sure to set that up as soon as you receive the bill.

Initial_____

Returned Checks: If your payment by check is returned by the bank for insufficient funds, you will be required to pay a fee of $50. If more than one check is returned in any given period, we reserve the right to require all future payment by credit card or cash to prevent this situation from recurring.
Missed Appointments: Life happens and we understand that sometimes you cannot make your appointment. Please call us at least 24 hours in advance to cancel or change your appointment. No call to our office equals a No Show" and if we can't fill your slot, we will need to charge you a $25 fee.

Initial_____

Self-pay-patients: If you do not have health insurance, payment is required at the time of the visit. If we are out-of-network for your particular insurer, payment is required at the time of the visit. Our office can provide a claim form for you to submit to your out-of-network insurer.

Initial_____

Pending Insurance: If your child has lapsed insurance, no well visit will be scheduled until coverage becomes active. You will be required to pay for each sick visit at our self-pay rate. If you are able to get coverage retroactively, we will submit claims retroactively and refund your self-pay charges after claims are processed minus any copays, deductibles, co-insurance and/or personal responsibility. If your child is a newborn, please see our Newborn Insurance Policy.

Initial_____

Continued

over

Guarantor: The parent or guardian who signs the patient's paperwork is the party responsible for all charges and payments. Due to confidentiality rules we can only bill the person who signs the practice paperwork. Therefore, if the person responsible for the medical bill changes, the new guarantor must complete a new set of paperwork. Please inform us as soon as circumstances change.

Initial _____

I have read, fully understand, accept and agree to comply with all of the above policies. I agree to comply with any future amendments to the policies. I consent to the assignment of authorized health insurance benefits by my health insurer to Healthy Kids Pediatrics for any service furnished to my dependent or ward, and understand that failure to make payments timely may result in collection fees.

Patient Name_____

Parent/Guardian's Signature_____Date_____

Parent/Guardian's Name (print)_____

Relationship to Patient:_____

HEALTHY KIDS PEDIATRICS
211 MAIN STREET
PORT WASHINGTON, NY 11050

PATIENT CONSENT FORM

With my consent, Healthy Kids Pediatrics may use and disclose protected health information (PHI) about me/my child to carry out treatment, payment, and healthcare operations (TPO). Please refer to Healthy Kids Pediatrics' Notice of Privacy Practices for a more complete description of such uses and disclosures.

I understand that, under the Health Insurance Portability Accountability of 1996, I have certain rights to privacy in regards to my/my child's PHI. I have received, read, and understand the Notice of Privacy Practice.

Healthy Kids Pediatrics reserves the right to revise its Notice of Privacy Practices at any time. Should I wish to review the revised Notice of Privacy Practice, it may be obtained by forwarding a written request to Healthy Kids Pediatrics at the address above.

With my consent, Healthy Kids Pediatrics may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my/my child's clinical care, including laboratory results among others.

With my consent, Healthy Kids Pediatrics may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that Healthy Kids Pediatrics restrict how it uses my/my child's PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Healthy Kids Pediatrics' use and disclosure of my/my child's PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Healthy Kids Pediatrics has the right to decline to provide treatment to me/my child, other than emergent care, if they choose to.

Patient Name:_____ Date of Birth:_____

Signature:_____ Date:_____/_____/_____

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Newborn Financial Policy

Patient Name:_____

At your baby's first visit, you will be required to make a $100 Newborn Deposit.

We will check your baby's insurance eligibility before each visit to our office. If your baby is still not covered by insurance beyond 30 days following birth, you will be required to pay $75 per office visit and $125 per well visit that takes place in our office 30 days beyond birth. You will be required to pay these deposits at time of service. Check-ups will not be permitted without payment at time of service.

Once your baby's insurance eligibility is established for all past visits and paid for by the insurance company, you will be refunded any deposits, minus any personal responsibility due (i.e. deductible, co-insurance, copay).

It is essential that you enroll your newborn on your insurance policy within a few days of birth. This involves contacting your health insurance provider and/or employer as soon as possible and making sure that all the correct information is given.

Please call our office as soon as your newborn becomes active on your insurance policy so that we can submit charges to the insurance company. Until claims are processed and paid, you are still required to pay the above-mentioned deposits.

I understand that I am required to pay a $100 deposit at the first visit, and if insurance eligibility is not established 30 days after birth, an additional deposit will be due at each time of service.

Signature_____

Date_____

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AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH RECORDS PURSUANT TO HIPPA

PATIENT NAME:_____

DATEOF BIRTH:_____

To Whom it may concern:

I request that a copy of my child's medical records (immunization record, growth chart, recent lab work, specialist reports, and the most recent physical exam) be released and mailed to:

Healthy Kids Pediatrics
211 Main Street
Port Washington, New York 11050
Phone: 516 944-8555
Fax: 516 944-0387

As the person signing this authorization, I understand that I am giving my permission to the above-named health care entity for disclosure of confidential health records. I understand that information disclosed under this authorization might be redisclosed by the recipient and this redisclosure may no longer be protected by federal or state law. I also understand that I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to the person who is in possession of my health records and is not effective as to health records already disclosed under this authorization.

Signature of Individual or Individual's Legal Representative if individual is a minor or unable to sign:

_____

Print Name_____

Relationship to individual _____ Date_____

Previous doctor's name_____
Phone number_____
Fax number_____

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OFFICE POLICIES

Our goal is to provide and maintain a good provider-patient relationship. Letting you know about our office policies in advance allows for a good flow of communication and enables us to achieve our goal. Please read each section carefully and initial. Do not hesitate to ask any questions you may have.

Appointments

Schedule an appointment by calling 516 944-8555

Please arrive a few minutes early so that we can verify insurance information, collect paperwork and collect copays.
Before making an annual physical appointment, please check with your insurance company as to whether the visit will be covered as a well child visit.

Initial:_____

Patients who arrive on time are seen at their appointment time. Patients who have arrived on time will be seen ahead of those who arrive late. If you arrive late, you may need to wait or have to reschedule your child's appointment.

Initial:_____

Missed Appointments: Life happens and we understand that sometimes you cannot make your appointment. Please call us at least 24 hours in advance to cancel or change your appointment. No call to our office equals a "No Show" and if we can't fill your slot, we will need to charge you a $25 fee.

Initial:_____

Late Arrivals: (>15 minutes after scheduled appointment) will be offered the next available appointment. We will do all that is possible to accommodate you on the same day.
We strive to minimize any wait time but emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.

Initial:_____

Appointments for additional children should be made by phone prior to coming to the office. An additional $25 charge will be applied to add-on appointments. If you would like another child to be seen, please schedule appointments for both children by phone prior to coming to the office.
Please note that our schedule does not allow us to schedule three back-to-back well visits for one family in the same day. If all three need to be seen in one day, there needs to be a gap of at least one hour in between the first two visits and the third.

Initial:_____

After-Hours Calls:

Please limit after-hours calls to urgent issues and emergencies. Please call the office during regular office hours for prescription refills, appointment requests and other routine matters.

When calling in after-hours and leaving a message, please:

Speak slowly and clearly and indicate the reason for the call
Leave a call-back number and disable your call block feature
Follow the doctor's instructions

We are here to provide the best care that we can to your children should the need arise. As always we welcome the opportunity to care for your children and appreciate your trust in the services that we provide.

Initial:_____

Our Vaccine Policy

Healthy Kids Pediatrics does not accept new patients whose parents or caregivers choose not to vaccinate. Parents or caregivers of established patients who choose not to vaccinate will be given a one month grace period to find another pediatrics practice. We will not be able to provide families with names of practices accepting unvaccinated or vaccine delayed patients. Healthy Kids Pediatrics strongly recommends vaccination according to the schedule published by the American Academy of Pediatrics (AAP). Please recognize that an unvaccinated or vaccine-delayed child is at higher risk of life-threatening illness, disability, and death than vaccinated children. Furthermore, an unvaccinated or vaccine-delayed child puts other children at risk, especially those who are too young for vaccination.

Initial:_____

Referrals

Three to five day advance notice is needed for all non-emergent referrals. It is your responsibility to know if a selected specialist participates in your plan. Please call the office with the name of the provider and his NPI or ID number, date of the appointment, reason for appointment and phone and fax number.

Initial:_____

Forms

There is a $20 annual form fee per child. This includes school forms, camp forms, sports forms, etc. Payment is due when the forms are dropped off. We require a minimum 5 day turnaround time.

Initial:_____

Prescription Refills

We require 72 hours' notice for monthly medication refills. You may be required to come in for follow-up visits for certain medication refills. Please plan accordingly.

Initial:_____

I have read, fully understand, accept and agree to comply with all of the above policies and accept the responsibility for any payment that becomes due. I agree to comply with any future amendments to office policy.

Patient Name_____DOB_____

Parent/Guardian Signature_____Date_____

Parent/Guardian's name (print)_____Relationship to patient_____

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