

Patient Information

_____ Age: _____ Birth Date: _____
Last Name First Name
Gender: Male Female Patient's Social Security #: _____
Address: _____ Phone: (____) _____
Street
City State Zip Code

Parent(s) or Guardian(s) Information

_____ Phone: (____) _____
Last Name First Name
CHECK ONE: RELATIONSHIP TO PATIENT Mother Father Grandparent Foster Parent Other _____
Address: _____
Occupation: _____ Social Security # _____
Work Address: _____ Phone: (____) _____
_____ Phone: (____) _____
Last Name First Name
CHECK ONE: RELATIONSHIP TO PATIENT Mother Father Grandparent Foster Parent Other _____

Address: _____
Occupation: _____ Social Security # _____
Work Address: _____ Phone: (____) _____
IN CASE OF EMERGENCY, PLEASE PROVIDE THE NAME OF A **FRIEND** OR **RELATIVE** AT A **DIFFERENT ADDRESS**:
_____ Phone: (____) _____
Name Address

Pharmacy: _____
Referred By: _____

Health Insurance

1) Company Name: _____
CHECK ONE: Primary Insurance Secondary Insurance
Address: _____
Agreement or Subscriber #: _____
Group # _____ Date Coverage Began: _____
Subscriber's Name: _____
Subscriber's Date of Birth: _____
CHECK ONE: RELATIONSHIP OF SUBSCRIBER TO PATIENT
 Mother Father Grandparent Other _____

2) Company Name: _____
CHECK ONE: Primary Insurance Secondary Insurance
Address: _____
Agreement or Subscriber #: _____
Group # _____ Date Coverage Began: _____
Subscriber's Name: _____
Subscriber's Date of Birth: _____
CHECK ONE: RELATIONSHIP OF SUBSCRIBER TO PATIENT
 Mother Father Grandparent Other _____

Medical Assistance

Recipient #: _____ Social Security #: _____ Issue #: _____

Copy of Card Goes Here

Copy of Card Goes Here

FINANCIAL POLICY:

I understand, accept, and acknowledge the following terms: (please initial each line)

- _____ Payment for all services is my responsibility and is due and payable at the time services are rendered.
- _____ If my health insurance carrier has accepted Pediatric Practices of Northeastern PA (PPNP) as a participating provider at the time of service, PPNP will submit a claim to my insurance carrier.
- _____ Claims not paid within a timely manner (60 days) by my insurance company, become fully my responsibility.
- _____ If my health insurance carrier HAS NOT accepted PPNP as a participating provider at the time of service, I am responsible for full payment at time of service unless prior arrangements have been made with PPNP's billing department.
- _____ Upon my request to PPNP's billing department, documentation will be provided so that I may submit a claim for reimbursement of out-of-pocket expenses from my insurance carrier.
- _____ Any contract for insurance coverage is made between my employer, the insurance company and myself. PPNP has no influence over available benefits or the approval of claims.
- _____ If I wish to use my insurance benefits to cover the cost of any ordered tests, procedures or visits to third party providers it is my responsibility to contact my insurance carrier to verify available benefits as well as participating facilities, providers and specialists. Payment for such services is my responsibility under the terms provided by said individuals.
- _____ I am responsible for requesting any necessary referrals prior to seeing any specialists, and prior to having any tests or procedures performed. When possible these requests should be made 5 days prior to the appointment date with the specialist. It is up to the discretion of a PPNP provider whether or not to issue a referral requested after the appointment or procedure date.
- _____ Referrals are not a guarantee of insurance benefits or payment. Concerns regarding denial of payment for ordered tests, procedures or visits to third party providers are to be directed to my insurance carrier.
- _____ I am responsible for all co-payments and non-covered services at the time of service unless prior arrangements have been made with PPNP's billing department.
- _____ Any co-insurance, deductibles or rejected claims are to be paid in full to PPNP within 30 days of receipt of a bill.
- _____ I will pay these charges by Cash Check MasterCard Visa.
(Any checks returned unpaid by your financial institution will be subject to a fee of \$20.)

Signature of Parent or Guardian: _____ Date: _____

I hereby grant authorization to PPNP the use of my credit card for unpaid balances.

I understand verbal authorization is required for each transaction and that under no circumstances will the card be used without such verbal authorization. My credit card information is as follows:

Credit Card #: _____ Expiration Date: _____ MasterCard Visa
(mm/yyyy)

Cardholders Name as it appears on Card: _____

Authorized Signature:* _____ **Witness:*** _____

Verbal authorization received: Date: _____ By: _____

Time: _____ Witness: _____ Patient Name: _____

* Authorized Signature to be given in the presence of and witnessed by a PPNP staff member.

Patient History

Patient Name: _____ Birth Date: _____ Date: _____

Name all persons living in the patient's home at the present time.

Name	Age	Relationship	Medical Concerns

Family History

Check if any of the patient's parents, brothers, sisters, aunts, uncles or grandparents have had any of the following:

- | | |
|---|--|
| <input type="checkbox"/> Anemia, Hemophilia | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart Attack (less than 60 years of age) | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Psychiatric Illness |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Mental Retardation |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Drug or Alcohol Dependence |
| <input type="checkbox"/> Rheumatoid Arthritis / Lupus | <input type="checkbox"/> Children with Birth Defects |
| <input type="checkbox"/> Thyroid or Endocrine Disease | <input type="checkbox"/> Congenital Heart Disease |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Stillbirth, Miscarriage or Infant Death |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Has anyone died prior to age 60? |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Is anyone living in the patient's home seriously ill? |
| <input type="checkbox"/> Seizures (Epilepsy) | <input type="checkbox"/> Does anyone living in the patient's home have an immune deficiency? |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Does anyone smoke in the patient's home? |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Other |
| <input type="checkbox"/> Hay Fever / Allergy | |
| <input type="checkbox"/> Atopic Dermatitis (Eczema) | |

Birth History

Where was the patient born? _____ Birth Weight _____

Was the patient born: At full term Premature

How many weeks Premature? _____

How many days did the patient stay in the hospital after birth? _____

Did the patient have any medical problems following birth? No Yes

Describe: _____

Were there any problems with labor or delivery? No Yes

Describe: _____

Type of delivery: Vaginal Cesarean Section

During the pregnancy with this child, did the mother: (check all that apply)

Smoke? Describe: _____

Drink alcohol or take drugs? Describe: _____

Have any illness? Describe: _____

Take medications or hormones? Describe: _____

Maternal Statistics

How many
 _____ Pregnancies
 _____ Children born full term
 _____ Children born premature
 _____ Abortions or Miscarriages
 has this patient's mother experienced?
 _____ How many living children does this patient's mother have?

!!! If your child is less than 1 month old, stop here !!!

Patient's Health History

Is the patient transferring care from another primary healthcare provider? No Yes

Provider's Name: _____ Group/Practice Name: _____

Type of Provider: Doctor Physician's Assistant Nurse Practitioner Location: _____

Other than at birth, has the patient been hospitalized? No Yes

Reason: _____

Location: _____ Age: _____

Has the patient had any surgery? No Yes Describe: _____

Has the patient ever had x-rays? No Yes Describe: _____

Is the patient allergic to any of the following: (Please list type of reaction)

Medications No Yes _____

Injections No Yes _____

Foods No Yes _____

Other No Yes _____

Does the patient take: Vitamins Iron Fluoride Other Medications _____

Has the patient ever had any of the following: (check as many as apply)

Anemia

Asthma

Allergic rhinitis

Atopic Dermatitis (Eczema)

Urinary Tract Infections

Pneumonia

Croup

Seizures

Heart Murmur

High Blood Pressure

Hepatitis or Jaundice

Arthritis

Diabetes

Strep Throat or Scarlet Fever

Ear Infections (more than 3 in 1 year)

Broken Bones

Head Injuries

Cuts Requiring Sutures

Loss of Consciousness

Accidentally Taken Medications or Poison

Vision Problems ➔ Wears Glasses

Hearing Problems

Frequent Headaches

Frequent Nose Bleeds

Chronic Cough

Frequent Stomach Ache

Frequent Vomiting

Frequent Diarrhea

Constipation

Bed Wetting

Dental Problems

Chicken Pox

Other _____

Was there any delay in the patient's learning to: Sit Walk Talk

Does the patient have difficulty in school with: Not in School Learning Behavior Other _____

How many days of school has the patient missed in the past 6 months? _____

Describe the patient's behavior by marking the appropriate category:

	No Problem	Minor Problem	Major Problem
Short Attention Span	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cannot Sit Still	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aggressive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unusually Quiet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overly Active	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Extremely Poor Looser	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Getting Along With Others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I would like to discuss the following concerns: _____