Centerpoint
FAMILY PRACTICE
Convenient, Family-Centered Medical Care

Pediatric Patient Information:

Child's Full Name: _____ Preferred Name:_____

Sex: M / F Date of Birth: _____ Age: _____ Social Security Number: _____

Patient Lives With: Mother / Father / Both / Other _____ Primary Language: _____

Parent/Guardian Information:

Primary Parent/Guardian's Name: _____ Relationship to Patient: _____

Sex M / F Date of Birth: _____ Social Security Number: _____

Mailing Address: _____ City: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Employer: _____

Secondary Parent Name: _____ Relationship to Patient: _____

Sex M / F Date of Birth: _____ Social Security Number: _____

Mailing Address: _____ City: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Employer: _____

Emergency Contact:

Name:_____ Relationship to Patient: _____

Phone Number: _____

Centerpoint
FAMILY PRACTICE
Convenient, Family-Centered Medical Care

Insurance Information:

Primary Insurance: _____ Policy # _____

Policy Holder Name: _____ Date of Birth: _____

Other Children in the Family:

1. Name / Date of Birth: _____
2. Name / Date of Birth: _____
3. Name / Date of Birth: _____
4. Name / Date of Birth: _____

Pregnancy and Birth:

PLEASE ANSWER EACH QUESTION WITH A "YES" OR "NO" AND EXPLAIN IF NEEDED

Mother's Age at Pregnancy: _____ Any Illness during Pregnancy: **Y** / **N** _____

Medication during Pregnancy: **Y** / **N** _____

Smoking : **Y** / **N** Alcohol: **Y** / **N** Street Drugs: **Y** / **N** during pregnancy.

Weeks Gestation: _____ Type of Delivery: **VAGINAL** **C-SECTION** **VBAC**

Birth Weight: _____ Length: _____ APGARS: _____

Complications: **Y** / **N** _____

Problems with baby at birth: Breathing: **Y** / **N** Jaundice: **Y** / **N** Other: _____

Problems soon after: **Y** / **N**

Child's Medical History:

Medications: (Prescription and non-prescription medications, vitamins)

Medication:	**Dose**:	**Frequency**:

Centerpoint
FAMILY PRACTICE
Convenient, Family-Centered Medical Care

Allergic Reactions: (Food, Medications, Environmental): **Y / N**

_____

_____

_____

Immunizations UTD: **Y / N** Shot Record: **Y / N**

Hospitalizations: _____

_____

_____

_____

Serious Injuries (When/ Where) _____

_____

_____

_____

PLEASE ANSWER "YES" OR "NO" TO THE BELOW CONDITIONS:

MEASLES		MUMPS		SEIZURES	
CHICKENPOX		WHOOPING COUGH		PROBLEMS WITH HEARING	
SCARLET FEVER		RECURRENT EAR INFECTIONS		VISION	
ASTHMA/ WHEEZING		ECZEMA/ HIVES		OTHER	
ANEMIA		HEPATITIS		BLOOD TRANSFUSIONS	
BLEEDING TENDENCY		GERMAN MEASLES		THROAT	
NASAL ALLERGIES		RHEUMATIC FEVER		HEART PROBLEM/ MURMUR	
FREQUENT STOMACH PAIN		CONSTIPATION		BLADDER OR KIDNEY INFECTION	
BEDWETTING AFTER AGE 5		ACNE		FREQUENT HEADACHES	
THYROID/ ENDOCRINE PROBLEMS		DIABETES		DEVELOPMENTAL DELAY	
ADD/ADHD		ANXIETY/ DEPRESSION		GIRLS: FIRST MENSTRUAL PERIOD	

DEVELOPMENT AND BEHAVIOR: LIST THE AGE AT WHICH THE CHILD COMPLETED

Sat Alone: _____ Used a Sentence: _____

Centerpoint
FAMILY PRACTICE
Convenient, Family-Centered Medical Care

Walked: _____ Rode a Bicycle: _____

Toilet Trained: _____

Development compared to other children:

Grade in school: _____Problem in school: **Y / N** _____

Learning Problems: **Y / N** _____

Getting along with other children: **Y / N** _____

Behavior Problems: **Y / N** _____

Bad Habits: **Y / N** Bedwetting: **Y / N** Nail Biting: **Y / N**

Sleeping Habits: _____

Hobbies/ Sports/ Social Activities: _____

_____

Use of Illegal Drugs: **Y / N** _____ Cigarettes: **Y / N** Alcohol: **Y / N**

FAMILY MEDICAL HISTORY

LIST ALL BLOOD RELATIVES OFÄHE CHILD WHOHAVE THE FOLLOWING PROBLEMS: FATHER (F), MOTHEROIL BROTHER (B), SISTER (S), MOTHER'S MOTHER (MM); MOTHER'S FATHER (MF), FATHER'S MOTHER (FM), FATHER'S AUNT UNCLE U , COUSIN C

ANEMIA/ BLOOD D/O		ARTHRITIS	
ASTHMA		EPILEPSY/SEIZURES	
MENTAL RETARDATION		HEART DISEASE	
DRUG PROBLEM		HIGH BLOOD PRESSURE	
ALCOHOLISM		CHOLESTEROL PROBLEM	
CANCER		MIGRAINE	
AIDS		SDS	
CYSTIC FIBROSIS		BIRTH DEFECTS	
MUSC.DYSTROPHY		EARLY DEAFNESS	
TUBERCULOSIS		DIABETES	

Centerpoint
FAMILY PRACTICE
Convenient, Family-Centered Medical Care

GENERAL CONSENT FOR MEDICAL TREATMENT:

As a patient of Centerpoint Family Practice, the Clinic, I understand that the clinic has an obligation to provide screening and emergency medical treatment when appropriate and to provide appropriate care and treatment of all patients. I hereby authorize the clinic, and its affiliated physicians and other licensed providers to order and/or provide direct and indirect services in efforts to diagnose and treat diseases, disorders, injuries, or other conditions. I understand that the providers will act in good faith to provide quality care and treatment. However, a specific cure or resolution cannot be promised. My patient rights include my participation in my care plans and treatment options. I may revoke this consent for general treatment. Additional informed consent shall be given for medical procedures or treatments for which I need to specifically consent.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT:

By signing this form, I acknowledge receipt of the notice of privacy practices of the clinic. Our notice of privacy provides information about how we may use and disclose your protected health information. We are required by federal law to obtain your acknowledgement that you have received this Notice. If you have any questions about our notice of privacy practices, please contact us at the above telephone number.

REASSIGNMENT OF BENEFITS AND PAYMENT GUARANTEE:

I authorize the clinic to bill my insurance company or other designated third-party payer for the services provided as related to my care. I acknowledge that the clinic will file claims on my behalf as a courtesy and that I, as guarantor of the account, remain responsible for payment of services. I acknowledge that I am also responsible for deductibles, co-insurance amounts, co-payment amounts, and non-covered services. I/we agree to pay the established rates of the clinic for all services rendered for the patient named below. I also acknowledge that I am aware that the clinic may have policies

_____ _____ _____

Name Printed Signature Date

Relationship to Patient: MOTHER / FATHER / OTHER _____

MISC CONSENTS: (PLEASE CIRCLE Y or N)

PHOTOGRAPHIC CONSENT:

In certain instances, the physician or her assistants may take photographs for use in your personal medical record only (ie, for the purposes of establishing a baseline prior to therapy, to document response to therapy, or to document a biopsy site). Do you consent to this? **Y / N**

PERMISSION TO CONTACT YOU:

May we send postcards to your address above with promotional information? **Y / N**
May we leave a message on your answering machine? **Y / N**

Patient Name:_____ Date of Birth_____

Signature: _____ Date: _____

Relationship to Patient: MOTHER / FATHER / OTHER _____

Centerpoint
FAMILY PRACTICE
Convenient, Family-Centered Medical Care

INSURANCE AND FINANCIAL AUTHORIZATION

We appreciate your confidence in choosing us for your medical care. Please take a moment to review your responsibilities and financial obligations.

Please note that you will be responsible for the amount not covered by your primary insurance unless a secondary policy is in place at time of service and there will be a $25 fee for appointment "no shows".

CO-PAYMENTS
If you are an enrollee of a managed care plan (HMO or PPO) that we are contracted with, you are required to pay the co-payment each time you are seen for medical reasons.

PROCEDURE DEDUCTIBLES
Please be advised that biopsies, intralesional injections of steroids, removal of benign or malignant lesions, incision and drainage, acne surgery, and the destruction of warts, molluscum, precancers, inflamed seborrheic keratoses, and other lesions by methods such as freezing, scraping, burning, or the application of chemicals, are considered procedures and are applied toward any procedure deductible even when performed in the setting of an office visit.

ANNUAL DEDUCTIBLES
In addition to the co-payment, some insurance plans also have an annual deductible. If your deductible has not been met, you are required to pay this deductible amount at the time of service. If there is a balance due from you after your insurance carrier has paid its portion, we will bill you for the patient portion due. If you have any questions regarding a billing statement you received from our office, please do not hesitate to contact our billing staff.

BIOPSY AND LABORATORY STUDIES
Skin biopsies, cultures, and blood work are sent to outside facilities. You and /or your insurance company will receive a separate bill for these services.

YOUR RESPONSIBILITIES
It is your responsibility to understand your insurance carrier's requirements for coverage. Some insurance plans do not cover services performed by physicians outside their network and others reimburse those services at a lesser rate, often with a deductible preceding coverage for benefits. For maximal coverage, it is your responsibility to insure the physician you choose is a provider for your insurance plan.

AUTHORIZATIONS
I request that payment for medical benefits be made to the physician for services rendered. I authorize and consent to the release of my medical and other information to my insurance carrier to process my insurance claim.

I understand and agree that I will be responsible for any fees incurred by Centerpoint Family Practice to collect fees for services rendered, including collection agency fees, attorney's fees, bank fees and court costs. Please sign below acknowledging that you have reviewed the above information and understand your financial obligations.

_____ _____ _____
Name Printed Signature Date

Relationship to Patient: MOTHER / FATHER / OTHER _____