PEDIATRIC NEW PATIENT APPLICATION

AMERICAN FAMILY MEDICAL

Current date: _____

PATIENT INFORMATION

By what name do you like to be called: _____

Patient's Last Name: First Name: MI

_____

Patient's Date of Birth: _____ Sex: Male Female

Parent/Guardian Last Name: First Name: MI Relation to patient:

_____

Phone # of Parent/Guardian: _____ Email: _____

Parent/Guardian Last Name: First Name: MI Relation to patient:

_____

Phone # for Parent/Guardian: _____ Email: _____

Patient's Primary address:
Street City State Zip Code

_____

Patient's Secondary address:
Street City State Zip Code

_____

Parent/Guardian Employer: Work Status: Full-time Part-time

_____ Occupation: _____

Parent/Guardian Employer: Work Status: Full-time Part-time

_____ Occupation: _____

IN CASE OF EMERGENCY:

Name of a friend or relative (not living at the same address): _____

Phone #: _____ Relation to patient: _____

INSURANCE INFORMATION

Primary Insurance Name: _____ Subscriber's Name: _____

Social Security #: _____

Relationship to Patient: _____ Date of birth: _____

Policy #: _____

Group#: _____

Secondary Insurance Name: _____ Subscriber's Name: _____

Social Security #: _____

Relationship to Patient: _____ Date of birth: _____

Policy #: _____

Group#: _____

Person responsible for the bill: _____

Address: _____

Phone #: _____

Whom may we thank for referring you? Advertisement Friend Internet Family Other: _____

If I cannot bring my child, the persons listed below will have the authority to bring in and authorize treatment:

	Name:	Relationship to patient:
1	_____	_____
2	_____	_____
3	_____	_____
4	_____	_____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize American Family Medical, LLC or my insurance company to release any information required to process claims.

_____ _____

Parent/Guardian Signature Date

FAMILY HISTORY (Please check all that apply to your family members)

Allergy___ Asthma___ Cystic Fibrosis___
Ear Infection___ Hearing Loss/Deaf___ Bleeding Disorders___
Thyroid Disease___ Problem with Anesthesia___ Cancer___ Type_____
Auto Immune Condition___ Type_____

SOCIAL HISTORY

- Are your child's immunizations up to date? __YES __NO
- Is your child currently in daycare? __YES __NO
- Is your child exposed to tobacco smoke? __YES __NO
- Is there concern for suspected abuse, physical assault, sexual molestation/rape, domestic violence, unsafe living conditions, substance abuse or caregiver with psychiatric diagnosis in the home? __YES __NO
- Does your child live in or regularly visit a home built before 1978(lead risk purposes) __YES __NO
- In the past year, has your child been exposed to repairs, repainting, or renovations of a home built before 1978? __YES __NO

BIRTH HISTORY

- Was your child born prematurely? __YES __NO
  - If yes, how many weeks?_____
- What was your child's birth weight? _____lbs. _____ounces
- Has your child ever needed a breathing tube or ventilator? __YES __NO
- Did your child pass their newborn screening tests? __YES __NO
- Did your child have any problems at the time of delivery? __YES __NO
- Did your child require a NICU stay? __YES __NO

OTHER IMPORTANT MEDICAL INFORMATION NOT LISTED ON THE QUESTIONAIRE:

Questionnaire completed by:

Name Relationship to patient Date

Signature Date

FOR OFFICE USE ONLY

Physician Acknowledgement Date

Preventative Care Appointments

Your child's health and wellbeing are our top priority at American Family Medical! To ensure our providers deliver the highest level of medical care to all our patients, our office follows the American Board of Pediatrics guidelines for pediatric standards. These guidelines require all patients to receive preventative care visits annually (and at specific age intervals), as well as any requires immunizations. In these visits, the physician does a complete health examination which is essential to maintaining good health. If wellness visits and required immunizations are reluctant to be scheduled or kept, this will result in the child, and all siblings, to be discharged from our practice.

AMERICAN FAMILY MEDICAL

Check-Up Schedule	Vaccinations/ Test Due
3 to 5 days	Newborn Visit
2 weeks	
1 month	
2 month visit	Pediarix, Prevnar 13, Hib, Rotarix
4 month visit	Dtap, IPV, Prevnar 13, Hib, Rotarix
6 month visit	Pediarix, Prevnar 13
9 month visit	Developmental Screening
12 month visit(MUST be after 1st birthday	Hib, MMR, Varicella, Prevnar 13 Hemoglobin & Lead Screening
15 month visit	Hep A, DTaP
18 month visit	
2 year visit	Hep A, Development/Growth
30 month visit	This visit is recommended by the American Academy of Pediatrics for speech and developmental screenings
3 year visit	
4 year visit(Must be after 4th birthday)	Kinrix(Dtap, Polio) & Proquad(MMR & Varicella) Hearing and Vision
5 year visit	Hearing, Vision, & Urine
Annually from 6-18 years old	Annual Hearing & Vision Screening, Urine Test TDaP at 11 years old, HPV series, Meningitis Vaccine

FLU VACCINE AVAILABLE AT 6 MONTHS AND OLDER

Dear Patient:

In an effort to make our office as efficient as possible, and to reduce waiting time for you the patient, please review the following suggestions. We have found that when patients' follow these simple steps we are able to provide better care in a more timely and efficient manner.

KNOW YOUR MEDICATIONS:

The name of the medication, what the medication is being taken for, and also the strength and dose. Keep an updated list of your medications with you for quick reference. This includes any supplements that you may be taking. Please bring all of your prescription medications to every visit.

REFILLS:

Advise the medical assistant of any refills you need and whether your insurance prefers 30 or 90 day refills. Also, provide a name and phone number of your pharmacy, as we send all prescriptions electronically. When calling in for a prescription refills, please check your prescription bottle first to avoid any confusion or delay in refill. Allow 3 business day for all refill request to be completed. If your prescription requires prior authorization for refill, it is your responsibility to notify the practice. Authorization of a medication can take up to two weeks for approval or denial by insurance company.

INSUANCE FORMULARY:

Become familiar with your insurance formulary plan for prescriptions. If we prescribe a medication for you that is not on your formulary and you don't inform us, there will be need for you to schedule an appointment with the provider to select another medication that is best suited for your medical condition.

OFFICE VISITS: Our office tries, if possible, to evaluate only one-two medical problems per patient, per visit. This allows our appointment schedule to run at a manageable rate and has proven to be the fairest to all concerned. Emergencies and exceptions do arise some problems take longer to evaluate than others. We make every effort to minimize our patients waiting time.

SCHEDULING APPOINTMENTS:

Allow yourself sufficient time when scheduling office appointments; realizing that due to the nature of our office we do handle medical emergencies when they arise, this may cause our schedule to run behind.

Thank you so much for your attention to these important matters. If you have any further questions or

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

YOUR INSURANCE:

We have made prior arrangements with many insurers and health plans. We will bill those plans whom we have an agreement, and will collect any required copayment, coinsurance, or deductible AT THE TIME OF SERVICE. Copayment, coinsurance, and/or deductible will collected upon sign in for your appointment time without exceptions. Payment may be made via cash, check, or debit. In the event your health plan determines a service "not covered", you will be responsible for the complete charge. PLEASE INFORM US WHEN YOUR INSURANCE PLAN CHANGES.

MINOR PATIENTS:

For all services rendered to minor patients, the adult accompanying the patient is responsible for payment in full at the time of service, regardless of who is legally responsible. All minors mist be accompanied by a parent or legal guardian unless prior arrangement for another party to be present of children under 12 years old to be seen alone has been made in writing by a parent or legal guardian.

MISSED APPOINTMENTS:

In order to provide the best possible service and availability to all our patients, it is our policy to charge a $20.00 fee for missed lab appointments, $60.00 fee for any missed "brief" appointments **NOT** cancelled 24 hours in advance, and $150.00 for missed physicals. Please call us as early as possible if you know you will need to reschedule your appointment.

MEDICAL RECORDS:

Medical records maybe released with a signed consent from the patient only, and maybe charged $1.00 per copy. There is also a $40.00 charge for completion of medical forms(i.e. FMLA, Medication Authorization, Supply Forms)

COMPLIANCE:

In an effort to maintain optimal health, each patient is expected to comply with the physicians advice regarding their health care needs. Failure to do so may result in our inability to continue providing your health care. In order to maintain continuity of care, we request that you scheduled an annual physical exam.

FINANCIAL AGREEMENT:

We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. You mut realize, however that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not party to that contract.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services that will not be covered(e.g. yearly physicals, pap smears, mammograms, urinalysis, hemoccult, blood work). It is YOUR responsibility to be familiar with your health insurance plan.

We must emphasize that as your medical care providers, our relationship and concern with you and your health, not your insurance company. ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE OF SERVICE RENDERED. For your convenience we accept VISA, MASTERCARD, PERSONAL CHECKS, and DEBIT CARDS. There will be a $45.00 charge on all returned checks. All past due accounts over 60 days will be charged a late fee of 5% of the unpaid monthly balance. On any balance on your account over 90 days, including those that insurance has not paid, collection action will be taken. If it becomes necessary to collect any sum due through an attorney, then the patient/guarantor agrees to pay all reasonable costs of collection, including attorney's fees, whether suit is filed or not. If you have any questions about the above information or uncertainty regarding insurance coverage, please do not hesitate to ask us, as we are here to assist you.

I have read and understand the policies of American Family Medical, LLC. I understand and agree that such terms may be amended from time-to-time by the practice.

Signature of Patient/Parent _____ Date _____