

PATIENT INFORMATION FORM

TODAY'S Date: _____

PATIENT #: _____

PORT JEFFERSON STATION, NY 11776
631-331-7267

WADING RIVER, NY 11792
631-929-0325

PATIENT DEMOGRAPHIC WORKSHEET

PATIENT	PATIENT NAME		DATE OF BIRTH	SEX	AGE	ALERT NOTE <input type="checkbox"/> Y <input type="checkbox"/> N	
						AUTHORIZATION RESTRICTION <input type="checkbox"/> Y <input type="checkbox"/> N	
	PATIENT STREET ADDRESS		CITY AND STATE	ZIP	Patient Resides With: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Siblings <input type="checkbox"/> Others _____		
	RESP PARTY-NAME		PRIMARY CONTACT (CIRCLE ONE) HOME CELL WORK EMAIL		Resp Party HOME PHONE (631) _____		
	RESPONSIBLE PARTY STREET ADDRESS		RESPONSIBLE PARTY CITY AND STATE		Resp Party CELL PHONE () _____		
	APT/SUITE #		RESPONSIBLE PARTY ZIP CODE		Resp Party WORK PHONE () _____		
PATIENT TYPE		CHART Location		EMAIL ADDRESS			

INSURANCE INFORMATION

INSURANCE	(CIRCLE) VFC: NONE CHP: EMPIRE BCBS THE EMPIRE PLAN PPO EPO POS HMO COPAY _____						
	MEDICAID NYC CHP		EFFECTIVE DATE		ID / GROUP NUMBER		
	PRIMARY INSURANCE		RELATIONSHIP TO PATIENT		DATE OF BIRTH	SOCIAL SECURITY NUMBER	
	POLICY HOLDER NAME		EFFECTIVE DATE		ID / GROUP NUMBER		
SECONDARY INSURANCE		PATIENT / POLICY HOLDER RELATIONSHIP		DATE OF BIRTH	SOCIAL SECURITY NUMBER		
POLICY HOLDER NAME		EFFECTIVE DATE		ID / GROUP NUMBER			

FINANCIAL

DOES THIS PATIENT'S INSURANCE REQUIRE AN AUTHORIZATION OR REFERRAL NUMBER? (CIRCLE ONE) YES NO

IT IS MY RESPONSIBILITY TO PROVIDE KIDS FIRST PEDIATRICS WITH ACCURATE INSURANCE INFORMATION REGARDING MY CHILD'S COVERAGE AND TO INFORM THEM OF ANY CHANGES WITHIN THIRTY DAYS (30) OF THE CHANGE. I HEREBY AUTHORIZE ASSIGNMENT AND PAYMENT DIRECTLY TO KIDS FIRST PEDIATRICS, P.C., FOR MEDICAL SERVICES RENDERED. I AM AWARE, ALTHOUGH I MAY OR MAY NOT BE COVERED BY INS, I AM PERSONALLY RESPONSIBLE FOR THE PATIENT BALANCE ON MY ACCOUNT WHICH MAY INCLUDE DEDUCTIBLES, CO-PAYS, OR CO-INSURANCE FOR WHICH MY INSURANCE COMPANY DEEMS ME RESPONSIBLE. I AM AWARE KIDS FIRST PEDIATRICS, AS WELL AS MY INSURANCE CO, REQUIRE PAYMENT DUE AT THE TIME OF SERVICE. IF NOT PAID AT THE TIME OF SERVICE, I WILL BE CHARGED AN ADDITIONAL \$5 STATEMENT PROCESSING FEE.

SIGNED: _____ DATE: _____

AUTHORIZATION

I HEREBY AUTHORIZE KIDS FIRST PEDIATRICS, P.C. TO RELEASE INFORMATION TO MY INSURANCE COMPANY. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION, INCLUDING PRIVILEGED, SENSITIVE INFORMATION, TO MY CHILD'S SCHOOL IF REQUESTED, ANY HOSPITAL, PROVIDER IN THIS PRACTICE AND TO ANY SPECIALIST MY PROVIDER MAY REFER ME TO. I ALSO GIVE PERMISSION TO KIDS FIRST PEDIATRICS TO LEAVE ANY PERSONAL HEALTH INFORMATION RELATING TO MY CHILD ON ANSWERING MACHINES (HOME OR CELL) PERTAINING, BUT NOT LIMITED TO LABORATORY RESULTS, ACCOUNT INFO, OR QUESTIONS UNLESS RESTRICTED BELOW:

RESTRICTED: _____

I HEREBY AUTHORIZE _____ TO ACCOMPANY MY CHILD TO THE OFFICE OF KIDS FIRST PEDIATRICS IN MY ABSENCE. ANY PERSONAL HEALTH INFORMATION RELATING TO SAID CHILD PERTINENT TO THE VISIT MAY BE DISCLOSED.

SIGNED: _____ DATE: _____

Kids First Pediatrics, PC

Port Jefferson Station
Wading River

Phone: (631) 331-7267
Phone: (631) 929-0325

Fax: (631) 331-7289
Fax: (631) 929-0360

Notice of Privacy Policies

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Effective Date: April 14, 2003

The privacy of your medical information is important to us. You may be aware that U.S. government regulators established a privacy rule ("HIPPA") governing protected health information. This notice tells you about how it may be used, and about certain rights that you have.

Kathleen Johnson, HIPPA Compliance Officer and Cathryn Mackie, Office Manager, are in charge of privacy matters at our office. They may be contacted at 631-331-7267 if you desire further information or have any questions or concerns.

Use and disclosure of protected information

Federal law provides that we may use your medical information (protected health information) for treatment of you, without further specific notice to you, or written authorization by you.

e.g. if we refer you to a specialist, we may provide laboratory or test data to that specialist (subject to more stringent New York laws, such as restriction on disclosure of information concerning HIV/AIDS)

Federal law provides that we may use your medical information to obtain payment for our services without further specific notice to you, or written authorization by you.

e.g. our accountants may see you name, dates of treatment and procedure codes during audits of our books. Or we may use your information for financial services, quality assurance, risk reduction and claim management purposes with our medical professional liability insurer.

We may use or disclose your medical information, without further notice to you, or specific authorization by you, where:

1. required by law;
2. required for public health purposes;
3. required by law to report child abuse;
4. where required by a health oversight agency for oversight activities authorized by law, such as the Department of Health, Office of Professional Discipline or Office of Professional Medical Conduct;
5. Required by law in judicial or administrative proceedings;
6. required for law enforcement purposes by a law enforcement official;
7. required by a coroner or medical examiner;
8. permitted by law to a funeral director;
9. permitted by law for organ donation purposes;
10. permitted by law to avert a serious threat to health or safety;
11. permitted by law and required by military authorities if you are a member of the armed forces of the United States;
12. Research purposes

New York state law provides additional protection for information regarding HIV/AIDS. We will continue to follow New York State law with respect to such information.

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We may contact you by mail or phone, at your residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may leave a message for you on any answering device or with any person who answers the phone at your residence.

You can make reasonable request, in writing, for us to use alternative methods of communicating with you in a confidential manner.

Rights that you have

You have the right to request restrictions on certain of the uses of disclosures described above. Except as stated below, we are not required to agree to such restrictions.

You have the right to inspect and obtain copies of your medical information (a reasonable fee will be charged).

You have the right to request amendments to your medical information. Such requests must be in writing, and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosures we make of your medical information, except for: disclosures we make to you, or to carry out treatment, payment or health care operations, or as requested by your written authorization, or as permitted or required under 45 CFR § 164.502, or for emergency or notification purposes, or for national security or intelligence purposes as permitted by law, or to correctional facilities of law enforcement officials as permitted by law or for research or public health purposes after being de-identified or limited to remove personally identifiable information or disclosures made before April 14, 2003.

If you have received this notice electronically, you have the right to obtain a paper copy from our office.

Obligations that we have

We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices.

We are required to abide by the terms of this notice as long as it is currently in effect.

We reserve the right to revise this notice, and to make a new notice effective for all protected health information we maintain. Any revised notice will be posted in our office, and copies will be available there.

If you have any concerns regarding violations of your privacy rights, you have the right to file a complaint with the Secretary of the Department of Health and Human Services of the United States.

You may also file a complaint with us. Complaints should be directed to:

Kathleen Johnson, HIPPA Compliance Officer; or

Cathryn Mackie, Office Manager

No retaliatory action will be taken against you for any complaint you may make.

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Acknowledgement of Notice of Privacy

Patient Information:

Patient Name: _____ Birth Date: _____
Gender: _____

I understand that the healthcare providers (physicians, physician assistants, and nurse practitioners), nursing, and administrative staff at Kids First Pediatrics, PC (KFP), may share my (or your child's) health information for treatment, payment, and health care operations, such as:

1. Sharing my (my child's) health information among providers (both inside and outside KFP), on a need-to-know basis, to give me (my child) treatment;
2. Using my (my child's) health information for billing purposes, including giving referrals to specialists, when necessary and appropriate;
3. Sharing my (my child's) health information with health insurance companies, government agencies, or other payers that request information related to benefits determinations, claims filed for visits or admissions, and other billing matters;
4. Using my (my child's) health information for monitoring the quality of care, audits and surveys, and carrying out other business and administrative activities.

I understand that all reasonable efforts will be made to protect the privacy of my (my child's) health information, whether maintained on paper or electronically, and regardless of how it is communicated (paper, e-mail, and fax).

I have been given the opportunity to read the NOTICE OF PRIVACY PRACTICES that outlines in more detail how my (my child's) health care information is used and shared with others. The NOTICE OF PRIVACY PRACTICES explains (1) when I need to give further approval, and (2) when my permission is NOT needed for the providers to use my (my child's) health information or share it outside KFP.

I understand that KFP has reserved the right to change the NOTICE OF PRIVACY PRACTICES at any time. I may obtain a current copy of the NOTICE OF PRIVACY PRACTICES by contacting the Privacy Officer or from the KFP website.

My signature below constitutes my acknowledgment that I have been provided a copy of the NOTICE OF PRIVACY PRACTICES.

Name of Parent/Guardian:

Printed Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____

Date Form Completed: _____

KIDS FIRST PEDIATRICS, PC

Port Jefferson Station (631) 331-7267 Fax (631) 331-7289

Wading River (631) 929-0325 Fax (631) 929-0360

Past Medical & Surgical / Family / Social Histories and Review of Systems

Date of Encounter _____ **HISTORIAN:** ___ mother ___ father ___ other _____

PATIENT DATA:

Patient Name		Date of Birth	
Address		Phone	H / W
		Phone	H / W

FAMILY HISTORY: (M - mother, F - father, S - sibling, O -other)

Name	Age	Relation	Health
M / O			
F / O			
S / O			
S / O			
S / O			
S / O			

FAMILY HEALTH / PSYCHOSOCIAL PROBLEMS: Check all that apply. Specify affected family / household member (M / F / S / O).

<input type="checkbox"/> THERE ARE NO PROBLEMS IN OUR FAMILY			
<input type="checkbox"/> Allergies to Medicine	<input type="checkbox"/> Severe Allergies to Foods	<input type="checkbox"/> Any One at Home Smoke?	<input type="checkbox"/> Any Involvement With Social Agency
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Emotional disorder
<input type="checkbox"/> Heart Attack < 55y old + male	<input type="checkbox"/> Heart Attack < 65 yrs + female	<input type="checkbox"/> Died Suddenly at Early Age	<input type="checkbox"/> Mental disorder
<input type="checkbox"/> Anemia / bleeding	<input type="checkbox"/> Tuberculosis		<input type="checkbox"/> Suicide
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> SIDS		<input type="checkbox"/> Drug / alcohol abuse

PRE BIRTH HISTORY (while mom was pregnant): Check all that apply.

<input type="checkbox"/> MOM HAD NO PROBLEMS THROUGH PREGNANCY			
<input type="checkbox"/> Mom Involved in Accident(s)	<input type="checkbox"/> Mom Drank Alcohol	<input type="checkbox"/> Mom Used Street Drugs	<input type="checkbox"/> Mom Used Tobacco Products
<input type="checkbox"/> Mom Used Prescription Meds	<input type="checkbox"/> Mom Used OTC Meds	<input type="checkbox"/> Mom Used Homeopathic Meds:	
<input type="checkbox"/> Mom Had Significant Illness			

BIRTH HISTORY:

How Many Weeks:		How Was Child Born:		Apgar Score:	
Birth Weight		Discharge weight		Hearing Screen	Pass / Fail

POST BIRTH HISTORY: Check all that apply.

<input type="checkbox"/> MY BABY HAD NO PROBLEMS IN THE NURSERY
<input type="checkbox"/> My baby stayed in hospital longer than expected
<input type="checkbox"/> My baby was in NICU
<input type="checkbox"/> My baby was Jaundice (yellow) in the nursery

PAST MEDICAL / SURGICAL HISTORY:

<input type="checkbox"/> MY CHILD HAS HAD NO PROBLEMS IN THE PAST
<input type="checkbox"/> Illnesses (ear infections, asthma, etc.)
<input type="checkbox"/> Operations (tonsils, adenoids, ear tubes, appendicitis, etc.)
<input type="checkbox"/> Injuries (requiring a visit to the Emergency Room)

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Past Medical & Surgical / Family / Social Histories and Review of Systems

PATIENT DATA:

Patient Name		Date of Birth	
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Date of Encounter _____

DEVELOPMENT – INFANT / Toddler:

- My child is over 5y old and developmentally normal - I don't have any concerns about my child's development.
- My child is over 5y old and I have concerns about my child's development.
- My child was evaluated through Early Intervention (EI) and did not qualify for services.
- My child was evaluated through EI and is receiving the following services: OT PT SPEECH SPECIAL ED

DEVELOPMENT – CHILD / ADOLESCENT:

School grade & performance	<input type="checkbox"/> normal	<input type="checkbox"/> abnormal
Sexual Development	<input type="checkbox"/> normal	<input type="checkbox"/> abnormal
Does Your Child::	<input type="checkbox"/> smoke	<input type="checkbox"/> drink

BEHAVIOR PROBLEMS: Check all that apply.

<input type="checkbox"/> MY CHILD HAS NO BEHAVIORAL PROBLEMS	
<input type="checkbox"/> Sleep	<input type="checkbox"/> Hyperactive
<input type="checkbox"/> Eating	<input type="checkbox"/> Antisocial
<input type="checkbox"/> Toileting	<input type="checkbox"/> Other

IMMUNIZATIONS: Check all that apply. If there were shots that were a problem, write in the name of shot if you can recall the name.

<input type="checkbox"/> No Problems With Shots	<input type="checkbox"/> All recommended shots were given	<input type="checkbox"/> Shots were deferred
<input type="checkbox"/> Problem(s) With Shots: _____		

ALLERGIES:

<input type="checkbox"/> MY CHILD HAS NO ALLERGIES		
Category	Name	Reaction
Med / Food / Insect		
Med / Food / Insect		
Med / Food / Insect		

REVIEW OF SYSTEMS:

<input type="checkbox"/> MY CHILD HAS NO PROBLEMS				
Any Problems With Your Child's:	Brain	Y / N	Eyes	Y / N
	Throat	Y / N	Lungs	Y / N
	Blood	Y / N	White Cells	Y / N
	Bones	Y / N	Urinary System	Y / N
			Ears	Y / N
			Heart	Y / N
			Stomach	Y / N
			Skin	Y / N
			Muscles	Y / N

Explanation: _____

CURRENT MEDICATIONS: Check all that apply.

<input type="checkbox"/> MY CHILD DOES NOT TAKE ANY MEDICATIONS		
<input type="checkbox"/> Vitamins	<input type="checkbox"/> Fluoride	<input type="checkbox"/> Inhalers
<input type="checkbox"/> Anti-Inflammatory	<input type="checkbox"/> ADD medications	

Write in the names of any medications, vitamins, or herbal supplements. _____

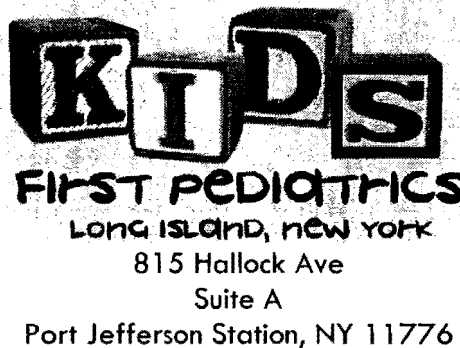
Authorization for Release of Medical Records

Attention: _____

Address: _____

Phone: _____ Fax: _____

Please release a complete copy of my child's medical records to:



Patient's Complete Name: _____

Date of Birth: _____

Please mail/fax these records for an appointment on: _____

Parent/Guardian

Name: _____ Signature: _____

Date: _____