Dr. T's Pediatrics PLLC

New Patient Information Record

PATIENT INFORMATION Date:

Patient's Name (First, Mid. Init., Last) Date of Birth: Sex: Race:

Street Address: City: State: Zip Code:

Social Security Number: Home Number: Cell Phone Number:

Referred By: In case of an Emergency, Contact: Phone Number:

PARENT INFORMATION

Mother's Name: Mother's Maiden Name: Mother's Date of Birth:

Street Address: City: State: Zip Code:

Mother's Social Security Number: Home Phone Number:

Mother's Employer: Work Phone Number:

Father's Name: Father's Date of Birth:

Street Address: City: State: Zip Code:

Father's Social Security Number: Home Phone Number:

Father's Employer: Work Phone Number:

INSURANCE INFORMATION

Person Responsible for Payment: Primary Insurance Name:

Primary Policy Holder: Primary Policy Number: Primary Group Number:

Secondary Insurance Name: Secondary Policy Holder: Secondary Policy Number:

Secondary Group Number:

******If co-pay is not paid at time of service, a $10.00 service charge will be charged to your account.******

Authorization: I hereby authorize the physician indicated above to furnish information to insurance carriers concerning this illness/accident, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether covered or not by insurance.

Responsible Party Signature:

Child's Name _____ **Date of Birth**

CHILD'S SOCIAL DEVELOPMENT

1. Mother's age? _____ Father's age?
2. Child has how many sisters? _____ Brothers?
3. Child is _____ in family?
   Oldest, Youngest, Middle
4. Other children's ages ____/____/____/____/____
5. Who spends more time caring for child?
6. Does child go to day care, baby-sitter,or preschool on regular basis? ___YES___NO
7. Are there any pets in the home? ___YES____ NO Number_____ Type_____
8. Child sat up at: _____ Age
9. Child crawled at:_____Age
10. Child walked at: _____ Age
11. Child started talking at:_____ Age
12. Any Smokers in the home? ____ YES _____ NO

CHILD'S BIRTH HISTORY

Place of Child's Birth: _____

During your pregnancy with this child did you:

1. Have high blood pressure? __Yes __No
2. Have diabetes or sugar in your urine?
3. Have German (3day) Measels? __Yes __ No
4. Take any Medicines? __ Yes __ No
5. Smoke cigarettes? __Yes __ No
6. Get treatment for gonorrhea or syphillis? ___Yes ___No
7. Test positive for vaginal Group B strep? ___ Yes ___ No
8. Drink Alcohol? ___ Yes ____ No
9. Use other drugs? ___ Yes ____No
10. Have this child early (premature)? ___Yes___No
11. Have more than one baby delivered?___Yes__No
12. Have a difficult labor and/or delivery?___Yes___No
13. Was it breech (bottom first) delivery? ___Yes___No
14. Was it a Cesarian delivery? ___Yes___No
15. What was your due date?_____
16. How early did you start seeing the doctor?_____
17. What is the mother's blood type?_____
18. What is baby's blood type?___Yes___No

CHILD'S PAST/PRESENT MEDICAL/ NUTRITIONAL HISTORY

1. Baby's birth weight?_____lbs_____oz
2. Did your baby breathe/cry immediately at birth?__Yes__No
3. Was the baby juandiced at birth ___Yes___No
4. Did the baby have RH problem?___Yes___No
5. At birth, did the baby appear normal?___Yes___No
6. Was PKU testing done at birth?___ Yes ___No
7. During baby's FIRST year, did you breast feed?___Yes__No
8. During baby's FIRST year, did you formula feed?__Yes__No
   How long_____
9. If feeding problem, explain:_____
   _____
10. Weaning from breast completed at_____Age
11. Solid food started at:_____Age

IMPORTANT MEDICAL HISTORY

Illness/Hospitalization Accident/Surgery	Complication/ Severity	Allergic Reactions To: Drugs,Food,Ect?	Age of Child
1.			
2.			
3.			
4.			

Child's Name _____ **Date of Birth**

FAMILY HISTORY

Check box that applies for any relative who has been treated for the following conditions:

Condition	Mother	Father	Mother's Mother	Mother's Father	Father's Mother	Father's Father	Sibling
Allergies							
Cancer							
Diabetes (sugar in urine)							
Gastrointestinal Disease							
Heart Disese (including High Blood Pressure, High Cholesterol)							
Kidney Disease							
Lung Disease (including Asthma)							
Mental Illness (including alcohol/substance abuse)							
Tuberculosis (TB)							
Vision or Hearing Impaired							

CONCERN/PROBLEMS

Does your baby/child have any on-going problem (s) that concern you?

___ Eats too little
___ Eats too much
___ Speaks unclearly
___ Cries a lot
___ Has frequent temper tantrums
___ Wet bed
___ Difficulty sleeping
___ Frequently constipated
___ Seem small for age
___ School problems
___ Behavior problems
___ Sees poorly
___ Doesn't always respond to nosie or spoken words
___ Always has a runny nose/cough

Are there any other problems? Please list.

Dr. T's Pediatrics PLLC

Tel # 718-520-8585

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Dear Paren/Guardian:

As your physicians, we believe that wellness exams are a reasonable and necessary part of your child's healthcare. These exams include a Well-Child-Check, Sports Physical, and Complete Physical Exam. The diagnosis and procedure codes submitted to your insurance company for these types of visits will be wellness codes.

Please be aware that some insurance plans DO NOT COVER Wellness Visits. In addition, those plans that do cover Wellness Visits will often cover only one Wellness Visit during a specific interval of time. For example, one Complete Physical every12 months or a 6 month Well-Child Check on or after the child is actually 6 months old.

In addition, some insurance plans do not cover any immunizations or cover them only when administered according to a pre-defined schedule. Be advised that the burden of researching which immunizations are covered, if any, lies with the policyholder and not with this office.

Should your insurance company deny payment for any portion of a Wellness Visit you will be responsible for entire balance. **If copayment is not paid at time of service, a $10.00 service charge will be charged to your account.**

Thank you for your cooperation in this matter.

Child's Name:

Printed Parent/Guardian Name:

Parent/Guardian Signature:

Today's Date: