HUNTSVILLE PEDIATRIC AND ADULT MEDICINE ASSOCIATES

PATIENT INFORMATION

Patient's Name _____ Sex __ Male __ Female Date of Birth _____
Address _____City/State_____ Zip Code_____
Home Phone _____ Cell Phone _____ E-mail address _____

Driver License # _____ Marital Status __ Single __ Married __ Widowed
Occupation _____ Employer's Name _____ Work Phone _____
Spouse's Name _____ Employer's Name _____ Work Phone _____
In case of emergency, notify_____ Relation to Patient_____ Phone _____
Your Pharmacy _____ Phone _____ Referred by _____

Complete the Following if the Patient is a <u>Minor or a College Student</u>
Responsible Party's Name _____ Relationship to Patient _____
Father's Name _____ Home Phone_____ Cell Phone_____
Date of Birth _____ **Driver License #** _____
Employer _____ Work Phone _____ OK to call ____ Yes ____ No
Mother's Name _____ Home Phone_____ Cell Phone_____
Date of Birth _____ **Driver License #** _____
Employer _____ Work Phone _____ OK to call ____ Yes ____ No
Hospital where child was born _____
Other Children (Names and Ages) _____
Is there anyone other than a parent authorized to seek treatment for your child? If so, please list below:
Name _____ Relationship to patient _____
Name _____ Relationship to patient _____

INSURANCE INFORMATION: (Please provide copy of <u>current</u> insurance card)
Insurance Name _____ Policyholder's Name _____ **D.O.B**. _____
Policy Number _____ Group #_____ Group Name _____
Medicare # _____ Medicaid # _____

<u>RELEASE OF INFORMATION</u>:
I authorize Huntsville Pediatric and Adult Medicine Associates to release any medical or other information necessary to process claims for services provided to me.

<u>ASSIGNMENT OF BENEFITS</u>:
I authorize payment of government or other medical benefits to Huntsville Pediatric and Adult Medicine Associates for any services provided to me.

<u>FINANCIAL POLICY</u>:
I acknowledge that I have read and/or been offered a copy of this office's Financial Policy.

<u>PRIVACY POLICY ACKNOWLEDGEMENT</u>:
I acknowledge that I have read and/or been offered a copy of this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.
I have read and agree to the Release of Information, Assignment of Benefits, Financial Policy, and Privacy Policy Acknowledgement paragraphs as stated above.

_____ DATE _____
Patient or Responsible Party Signature

_____
Relationship to Patient If Not Parent or Legal Guardian

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PEDIATRIC PATIENT HISTORY FORM Today's Date: ____/____/_____

Patient Name: _____ Date of Birth: ___/___/_____ Age: ____ Gender: □Male □Female

*If Student: □Full-Time □Part-Time
Name of School/Location: _____
List name(s) of Parent/Guardian(s):
_____
Who lives at home with patient? _____

Pregnancy and Birth History
Is your child: □Birthed □Adopted □Stepchild
□Other: _____

Hospital born at: _____ Birth Weight: ___lbs. ___oz. Birth Length: ___ in. ___cm.
Blood Type: ___

Were there any medical problems during pregnancy? □Yes □No If yes, please describe: _____
_____

Type of Delivery: □Vaginal □Caesarean
If Caesarean, why? _____
Please indicate any medical problems during the baby's newborn period: □None □Premature weeks: _____
Circumcision: □Yes □No What pregnancy number was the patient? _____
Other Information: _____
Please list your past surgeries:

Surgery Type and Date	Hospital	Surgeon
_____	_____	_____
_____	_____	_____

Please list your past hospitalizations:

Hospitalization Type and Date	Hospital	Physician
_____	_____	_____
_____	_____	_____

Illness History
Which of the following conditions are currently being treated or have been treated for in the past (please check all that apply)

□ADD/ADHD
□Anxiety
□Asthma
□Autism/Asperger's
□Bronchitis
□Cerebral Palsy
□Chicken Pox
□Depression
□Diabetes
□Dizziness/Fainting
□Epilepsy/Seizures
□Frequent Ear Infections
□Headaches/Migraines
□Hearing Problems
□Heart Murmur
□Kidney/Bladder problems
□Liver problems / Hepatitis
□Lung problems/cough
□Mononucleosis
□Neurological problems
□Psychiatric care
□Rheumatic Fever
□Seasonal allergies
□Sinus Problems
□Shortness of breathe
□Tonsillitis
□Other: _____
□Other: _____

Medications
Please list all prescription and over the counter medications currently taking:

Drug Name	Dosage	Reason Prescribed	Drug Name	Dosage	Reason Prescribed
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Patient Name: _____ Date of Birth: ___/___/_____

Nutrition and Feeding

Was your child breastfed? □Yes □No If yes, how long? _____
If no, what type of formula? _____

Any unusual feeding/dietary concerns? □Yes □No
If yes, describe: _____

Current Milk intake: □Cow (non-fat, 1%, 2%, whole) □Soy □Rice □Other: _____
Average ounces per day: _____

Vitamin Supplement? □Yes □No
If yes, what type? _____

Other foods: _____

Sleep

Hours of sleep per night: _____ Naps (number and length):_____

Any sleep concerns? □Yes □No If yes, please describe: _____

Development

Please indicate what age your child first did the following: _____ Held up head _____ First teeth
_____ Smiled _____ Crept _____ Sat alone _____ Stood alone _____ Walked alone
_____ Said words _____ Reached for objects _____ Said sentences _____ Toilet trained

Immunizations – please provide our office with a copy of your immunization record

Allergies
Are you Allergic to or have you ever had any reaction to the following? (check all that apply)
□No Known Allergies □Lactose Intolerance □Sulfa Drugs □Penicillin
□Other: _____

Family History

Has any member of the family (including children and parents) had any of the following illnesses:

Illness	Which family member?	Illness	Which family member?
Allergies	_____	High Cholesterol	_____
Asthma	_____	HIV disease / AIDS	_____
Alcoholism	_____	Lung Problems	_____
Anemia or Blood disease	_____	Mental Illness / Depression	_____
Cancer	_____	Seizures	_____
Depression	_____	Stroke	_____
Diabetes	_____	Suicide	_____
Glaucoma	_____	Tuberculosis	_____
Heart disease	_____	Other serious illness	_____
High blood pressure	_____	Other serious illness	_____

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient/Legal Guardian Signature _____ Date _____

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Acknowledgement of Financial Policy

- I understand Huntsville Pediatric and Adult Medicine Associates (HPAM) will copy my insurance card and driver's license. I further understand it is my responsibility to notify HPAM in the event of insurance coverage change.
- I understand HPAM will obtain demographic information including mailing address, contact phone numbers, and email address. In addition, I understand HPAM may use and disclose demographic and medical information in order to provide a written, telephone, text message, or email reminder of an upcoming appointment. I further understand it is my responsibility to notify HPAM if any demographic information changes.
- I understand HPAM does not accept Worker's Comp.
- I understand payment for co-payments, deductibles, and percentages not covered by insurance are due from me at the time services are rendered. In addition, I understand the amount collected is only an estimate and the amount due may increase due to accounting error, insurance company payments and/or correspondence and additional services provided during and/or after visits including additional lab.
- I understand if I do not have insurance coverage I will be responsible for services rendered at the time of service and any additional services provided after my visit including additional lab services.
- If I am a Medicare recipient, I understand I will be responsible for annual deductibles, 20% co-insurance, non-covered services, and any charges Medicare states I am responsible for.
- I understand a $30.00 service charge will be applied to all returned checks.
- I understand a $25.00 fee will be charged for missed appointments and for appointments cancelled less than 4 business hours prior to my appointment time.
- I understand I will receive a separate statement from the Radiologist that interprets all x-rays done at HPAM.
- I understand that a fee is charged for copies of medical records and is due prior to the release of records.

For Insurance Billing:
I hereby authorize Huntsville Pediatric and Adult Medicine Associates (HPAM) to furnish my insurance company with all the information which the insurance company may request concerning me and/or my present illness or injury. I hereby assign to Huntsville Pediatric and Adult Medicine Associates all money to which I am entitled for medical expenses related to the service reported. I understand I am financially responsible to Huntsville Pediatric and Adult Medicine Associates for charges not covered by this assignment.

Patient Name: _____ **Patient DOB:** _____

Responsible Party: _____ **Responsibly Party:** _____
Printed Name **Signature**

Date: _____

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Patient Authorization to Release Protected Health Information

I, _____, give my authorization to release my protected information including results of my laboratory tests, x-ray, and/ or other test results to the following designated representative(s).

_____ (Initial) Spouse Name _____

_____ (Initial)Child(ren) Name(s) _____

_____ (Initial) Other Name(s) _____

_____ (Initial)Parent Name(s) _____

_____ (Initial) Authorize Huntsville Pediatric and Adult Medicine to call the following numbers and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items, and any calls pertaining to my clinical care such as test results.

_____(Initial) Home Number (as on file)

_____(Initial) Cell Number (as on file)

_____(Initial) Work Number (as on file)

_____(Initial) Other Number(s): _____

_____ (Initial) Authorize Huntsville Pediatric and Adult Medicine to mail to the following address any items that assist the practice in carrying out treatment, payment. And healthcare operations, such as appointment reminder cards, unable to reach patient by phone letters, and statements as they are marked Personal and Confidential.

_____(Initial) My home address (as on file).

_____(Initial) Other address: _____

_____

I understand that this release of information is considered valid until a new release of information is submitted or my child turns 18. The office will not disclose any information to any items above that do not have an initial beside it.

Patient or Legal Guardian Signature: _____

Patient Name: _____ Patient DOB: _____ Age:_____

Date:_____

Office Use Only:

_____This patient is a child and will be 18 as of ___/____/_____ and will need a new release of information form.

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Patient Name_____ DOB: _____

Billing Address_____City_____

Zip Code_____Primary Contact Number_____

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COORDINATION OF BENEFITS

My primary insurance coverage: _____

Subscriber Name: _____

ID #: _____ Group #: _____

Do you have other health coverage? Please check one:

__No, the above insurance is the only active insurance, go to signature section.

__No Insurance/Private Pay

__Yes, please give name of Other Insurance Carrier below, sign, and date.

OTHER INSURANCE CARRIER:

Name of the Other Insurance Carrier: _____

Name of the Subscriber for the Other Insurance policy:_____

Name of the Employer: _____

Insurance Carrier Claim address: _____

Insurance Carrier phone number: _____

Policy Number: _____Group Number: _____

Beginning date of Coverage: _____End date of Coverage (if applicable): _____

Other insurance covers? ____Self ____Spouse ____Child ____Other _____

_____

Signature (Parent/Guardian, if minor)/Relationship to Patient

_____

_____