BAY AREA PEDIATRICS

Welcome!

NEW PATIENT REGISTRATION FORM

(PLEASE PRINT)

D. James Kalliongis, MD Samantha Hoffman, CPNP Jaime Schell, CPNP Courtney Freimuth, CPNP

PARENT INFORMATION (Primary Insurance Card Holder)

Parent Name: First:		Last:	
Relationship: Mother Father Stepmother Stepfather Guardian		Marital Status: Married / Single / Divorced / Widowed	
Street Address:		Email Address:	
City, State, Zip:			
Date of Birth:	Home Phone:	Cell Phone:	
Employer:	Occupation:	SS#	

PARENT INFORMATION

Parent Name: First:		Last:	
Relationship: Mother Father Stepmother Stepfather Guardian		Marital Status: Married / Single / Divorced / Widowed	
Street Address:		Email Address:	
City, State, Zip:			
Date of Birth:	Home Phone:	Cell Phone:	
Employer:	Occupation:	SS#	

CHILD(REN) INFORMATION

Full Name (First, Middle, Last)	Date of Birth	Gender
1.		M F
2.		M F
3.		M F
4.		M F
5.		M F
6.		M F

EMERGENCY CONTACT INFORMATION (Not living with you)

Full Name:	Relationship:
Home Phone:	Cell Phone:

INSURANCE INFORMATION

We will need to make a copy of your insurance card. It is your responsibility to provide us with timely updates to your insurance. Should claims be denied because you haven't provided us with updated information, you will be billed for the visit(s).

If you have a secondary insurance, you MUST make both insurance companies aware that you have double coverage. If the secondary insurance is not aware of your primary insurance, we will not file with the secondary. If you have a commercial policy and a Medicaid policy, the Medicaid policy is always your secondary coverage.

Parent Signature: _____ ***Date:*** _____

Please provide insurance card(s) and a copy of your child(ren)'s immunization record with this form.

BAY AREA PEDIATRICS
FINANCIAL POLICY

As a patient you have certain responsibilities for your care. Those responsibilities include, but are not limited to:

- Providing current, accurate billing information at all visits including a copy of insurance card
- Providing physician with complete medical history
- Being aware of your insurance coverage, including which benefits are and which are not covered

Copays must be paid at the time of the visit. Failure to do so may result in an additional fee.

Failure to cancel an appointment at least 24 hours in advance, as well as missed appointments, may result in a "No Show" fee as follows: sick/recheck appointments $25.00; well visits and medication appointments $50.00.

There will be a $35.00 fee for returned checks.

You hereby authorize treatment by Bay Area Pediatrics, LLC, and agree to pay all fees and charges for such treatment. You authorize the release of any pertinent information to your insurance company and any other doctors involved in your care.

You hereby authorize your insurance benefits to be paid directly to Bay Area Pediatrics, LLC. You agree to be financially responsible for any balance due.

You agree to reimburse Bay Area Pediatrics, LLC, the fees of any collection agency, which may be based on a percentage at a maximum of 35% of the debt, and all costs, and expenses, including reasonable attorney's fees, we incur in such collection efforts.

Your signature acknowledges understanding and consent to all the above information.

Signature _____

Patient or Parent/Guardian if signing for minor

Date _____

BAY AREA PEDIATRICS

Acknowledgment of HIPAA Privacy Practices

PLEASE READ CAREFULLY BEFORE SIGNING

I understand that the patient's health information is private and confidential. I understand that Bay Area Pediatrics works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Bay Area Pediatrics may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations.

Bay Area Pediatrics has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the "Notice" before signing this Acknowledgment.

Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but aren't limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communications or alternative location. This Notice of Privacy Practices may be updated periodically.

SIGNATURE: _____ DATE: _____
(Patient or Responsible Party, if patient is a minor)

Print Patient Name: _____ Patient DOB: _____

Print Patient Name: _____ Patient DOB: _____

Print Patient Name: _____ Patient DOB: _____

Print Patient Name: _____ Patient DOB: _____

Print Patient Name: _____ Patient DOB: _____

Print Patient Name: _____ Patient DOB: _____

BAY AREA PEDIATRICS

Parent/Guardian Consent for Medical Treatment

Child's Information

_____ _____
Child's Name Date of Birth

_____ _____
Child's Name Date of Birth

_____ _____
Child's Name Date of Birth

_____ _____
Child's Name Date of Birth

_____ _____
Child's Name Date of Birth

_____ _____
Child's Name Date of Birth

Caregiver's Information

_____ _____
Caregiver's Name Phone Number

_____ _____
Caregiver's Name Phone Number

_____ _____
Caregiver's Name Phone Number

The above name caregiver(s) shall be authorized to consent for all medical treatment, medical procedures and diagnostic testing, etc., for the above-named child(ren), which may be required during my absence.

If circumstances permit, please attempt to contact me at the following number: _____

This consent serves as permission for treatment by Bay Area Pediatrics. NOTE: Consents are NOT required in emergency situations. This authorization shall be effective until: (circle one of the following)

a) _____ b) unless earlier revoked by me
month, day, year

Signature

_____ _____
Parent/Guardian (circle one) Date

_____ _____
Parent/Guardian (circle one) Date

BAY AREA PEDIATRICS

New Patient Questionnaire

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

HOUSEHOLD- Please list all those living in the child's home

Name	*Relationship to Child*	*Birth Date*	*Health Problems*

Are there siblings not listed? If so, please list their name and age and where they live. _____

_____

If mother & father are not living together, or if child does not live with parents, what is the child custody status. _____

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home? _____

Mother's Occupation _____ *Mother's Employer* _____

Father's Occupation _____ *Father's Employer* _____

Does anyone in the house use tobacco? Yes □ No□ *Are there any pets in the home? Yes □ No□*

Activity Level? Sedentary Active Competitive Sports

Amt of TV/Video Games daily? _____*min/day*

Uses seatbelts Car seat Booster Seat

DEVELOPMENT

Are you concerned about your child's physical development? Yes □ No□ Explain _____

*Are you concerned about your child's emotional development? Yes □ No □ Explain*_____

*Are you concerned about your child's attention span? Yes □ No □ Explain*_____

Is your child in school? Yes□ No □

How is his/her behavior in school? _____

Has he/she failed or repeated a grade in school? _____

How is he/she doing in academic subjects? _____

Is he/she in special resource classes? _____

BAY AREA PEDIATRICS

New Patient Questionnaire

Birth History

Any problems during the pregnancy? Yes □ *No*□ _____

Was mom on any medications? Yes □ *No*□ *If yes* _____

Birth Hospital? _____ *Birth Weight* _____ *lbs* _____*oz*

Was your child born: On Time *Early (weeks _____)* *Late (weeks _____)*

How was your baby born? Vaginally Delivery C-Section Vacuum Forceps

Any Problems with baby at birth? Yes □ *No*□ *If Yes* _____

Did child/children go home with mom from the hospital? Yes □ *No*□ _____

Past Medical History

*When was your child's Last well- check?*_____

Previous Doctor? _____ *Dentist?* _____

Does your child take any medications? Yes □ *No*□ _____

Any Medication Allergies? *No* □ *Yes*□ _____

Prior Hospitalization? *No* □ *Yes*□ _____

Is your son circumcised? *No* □ *Yes*□ _____

Other Prior Surgeries? *No* □ *Yes*□ _____

Has your child had a history of:

Please circle all that apply:

ADHD/ADD *Anemia* *Asthma* *Wheezing* *Bedwetting*

Cerebral Palsy *Constipation* *Diabetes requiring insulin/Type 1 DM*

Developmental Delay *Ear infections* *Eczema* *Food Allergies*

Headache *Hearing Loss* *Heart Murmur* *Broken Bones*

Chicken Pox *Insulin Resistance/ Type II DM* *Obesity* *Pneumonia*

Seasonal Allergies *Seizures* *Sports Injury* *Urinary Tract Infection*

Urticaria/ Hives *Vaccine Reaction* *Vision Problems* *Vitamin D deficiency*

*Other*_____

BAY AREA PEDIATRICS

New Patient Questionnaire

Family History

Considering the child's parents, grandparents, aunts, uncles, and siblings, is there a family history of:

Asthma? *Whom:* _____

Alcohol or Drug Abuse? *Whom:* _____

Anemia? *Whom:* _____

Bleeding Disorder? *Whom:* _____

Cancer? *Whom:* _____

Skin Cancer? *Whom:* _____

Breast Cancer? *Whom:* _____

Childhood or Sudden Infant Death? Whom: _____

Deafness? *Whom:* _____

Developmental Delay? *Whom:* _____

Diabetes? *Whom:* _____

Hearing problems? *Whom:* _____

Heart disease (before 50 years old)? Whom: _____

High Blood Pressure (before 50 years old)? Whom: _____

High Cholesterol? *Whom:* _____

Intellectual Disability? *Whom:* _____

Kidney Disease? *Whom:* _____

Liver Disease? *Whom:* _____

Mental Illness/ Depression? *Whom:* _____

Nasal Allergies? *Whom:* _____

Retinoblastoma? *Whom:* _____

Stroke/ Blood Clots? *Whom:* _____

Tuberculosis? *Whom:* _____

Vision Problems? *Whom:* _____

Patient Portal Registration

BAY AREA PEDIATRICS

Parent

Name (first): _____
Name (last): _____
Email: _____
Phone: _____

Children

Name	Date of Birth
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

What is My Kid's Chart?

Our patients can securely access their personal medical record online, from the privacy of their home or any other location with an internet connection utilizing the My Kid's Chart patient portal. Bay Area Pediatrics remains an independent private pediatric practice, but we have partnered with My Kid's Chart to utilize the patient portal system.

My Kid's Chart members can:
Go online to view their current health issues
View details of past appointments
Request renewals of prescriptions
Check results of lab and imaging tests
Send questions or requests to our Bay Area Pediatrics team