Lockport Pediatrics New Patient History/Consents/Authorizations

139 Professional Parkway
Lockport, NY 14094
P. 716-433-6711 f. 716-433-0546

Patient Demographics:

Patient Name_____ Sex: M or F Date of Birth _____
Address_____ City_____ Zip _____
Preferred Language_____

Please circle the appropriate option:
Race: (WH) White (AA) African American (AI) American Indian (AS) Asian
(HP) Hawaiian or other Pacific Islander (OR) Other Race _____
Ethnicity: (01) Not Hispanic or Latino (02) Hispanic or Latino (03) Other

Father's Name_____ Date of Birth_____ SSN_____
Occupation_____ Employer_____ Phone_____
Mother's Name_____ Date of Birth_____ SSN_____
Occupation_____ Employer_____ Phone_____
Phone Numbers:
Home_____ Cell_____
Emergency Contact_____ Relationship_____
Emergency Contact Phone_____

Authorization To Release Information

In accordance with Health Insurance Portability and Accountability Act (HIPAA), I hereby authorize Lockport Pediatrics to release any pertinent medical or incidental information that may be necessary for either medical care or in regards to payment or treatment purposes including sending vaccine information to the New York State Immunization Information System (NYSIIS). This authorization is active until the patient transfers their records to another office, unless Lockport Pediatrics is notified the office in writing to the contrary.

Patient (please print) _____ Date_____

Parent/Guardian (please print)_____ Signature_____

Patient Name: _____

Pregnancy & Birth

Mother's age at pregnancy_____ Illnesses while pregnant_____
Medications while pregnant_____ (exclude vitamins & iron)
Smoking/Alcohol/Street Drugs while pregnant? _____
Pregnancy full term or pre-term? _____ Delivery Type_____
Birth weight_____ Length_____
Were there any birth complications? _____
Breathing_____ Jaundice_____Other_____
Problems in nursery or at home soon after birth? _____

Patient Past Medical History

Previous Medical Care_____ Were records transferred? _____
Vaccinations up to date? _____
Allergies: (Specify if known)
Medications_____ Food_____
Animals_____ Insects_____ Nature Related _____
Current medications_____
Hospitalizations (when, where, why) _____
Serious Injuries (when, where) _____
Please write **Y (YES)** or **N (NO)** if the patient has had any issues with the following:
Chicken Pox___ Whooping Cough ___Scarlet Fever___ Rheumatic Fever___
Seizures___ Eczema___ Asthma/Wheezing___ Anemia___ Hives____ Vision____
Hearing___ Recurrent ear infections (3 or more)___ Other(specify)_____
Has the patient ever had a blood transfusion?_____ If yes then when?_____

Feeding & Nutrition

Breast fed? _____ Number of months? _____ Formula_____
Current formula brand_____ Vitamins_____ Fluoride_____
Did or does the patient have any feeding problems? _____
Is the patient on a special diet? _____

Development & Behavior

Please indicate the age at which the patient (answer N/A if not applicable):
Sat Alone_____ Walked_____ Used Sentences_____ Toilet Trained_____
Behavioral Problems_____ Learning Problems_____ Bedwetting_____ Habits_____
Nail biting_____ Thumb-sucking_____ Alcohol Use_____ Tobacco Use_____
Illegal Drug Use_____ Current Grade in School_____

Patient Name:_____

Family Profile

Patient's Father: Highest Schooling Completed_____ Health_____
Patient's Mother: Highest Schooling Completed_____Health_____
Please list siblings and their dates of birth below:

Sibling	Date of Birth
_____	_____
_____	_____
_____	_____

Family Medical History

For the list below please indicate which blood relatives have had complications with the following problems. Blood relatives include the child's mother, father, grandparents, siblings, aunts, uncles and first cousins. The information you offer will enable us to maintain your child's health.

Anemia: _____
Other Blood Disease (Specify which):_____
Asthma: _____
Mental Retardation: _____
Drug Problem: _____
Alcoholism: _____
Cancer: _____
AIDS (HIV): _____
Cystic Fibrosis: _____
Muscular Dystrophy: _____
Tuberculosis: _____
Arthritis: _____
Epilepsy/Seizures: _____
Heart Disease: _____
High Blood Pressure: _____
Kidney or Urine Problems: _____
Cholesterol Problems: _____
Smokers: _____
Diabetes: _____
Migraines: _____
SIDS (Sudden Infant Death Syndrome): _____
Birth Defects: _____
Deafness at Birth: _____
Mental Health Problems: _____
Other Chronic Illnesses: _____

Patient Name:_____

Insurance and Billing Information

Insured: Father_____ Mother_____ Relationship to patient_____
Insurance Company: _____ Address_____
Subscriber's Name_____ ID#:_____
Subscriber's Date of Birth:_____ Effective Date: _____
Group #: _____ Child's ID Number: _____

I hereby authorized direct payment of surgical/medical benefits to Lockport Pediatrics for services rendered at this office. I understand that I am financially responsible for any balance not covered by my insurance or deductible that my insurance has allowed.

Guarantor (print):_____Signature: _____ Date: _____

Financial Policies

We are committed to providing you and your family with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our policies is important to our professional relationship. Please ask if you have any questions about our fees, policies or your responsibility.

- All patients must have this patient information form completed before being seen by the doctors.
- Co-Payments are due at the time of service.
- We accept cash, checks, and credit cards (Visa/MasterCard/Discover) as payment.
- Payment options are available if needed through are business office.

****In regards to insurance, we will do our best to help you receive maximum benefits. However, insurance is a contract between you and your insurance company. If we accept your insurance we file the insurance claims as a courtesy to our patients. In the event of a dispute with the insurance company regarding deductibles, copays, or covered charges, we will only supply the factual and relevant information. It is ultimately the guarantor's responsibility to deal with their insurance company to assure payment and keep the account current. ****

Missed Appointments

We would appreciate 24 hours' notice in the event a scheduled appointment needs to be changed or cancelled. In order to control health care costs it is important for the patient to notify our office if they are unable to keep a scheduled appointment so that we can book another patient. In the event our office is not notified and an appointment is missed we will place a **$50.00** no show fee on the account. A simple phone call can save future problems for everyone involved.

If you have any questions regarding our financial polices please speak to the business office and we will be happy to explain them in more detail.

By signing below I understand my financial obligation that pertains to my insurance and missed appointments.

Responsible Party(please print): _____
Signature: _____ Date: _____

Lockport Pediatrics Associates is your Patient-Centered Medical Home and is currently working toward NCQA (National Committee for Quality Assurance) Recognition

What is a Patient-Centered Medical Home?

- A team approach to providing total health care at our office for your child

Who is part of your child's Patient-Centered Medical Home team?

- Your health care provider
- All other staff at your health care provider's office
- Most-importantly-**YOUR CHILD and YOUR FAMILY!** You are all the most important people on your health care team. Patient-centered is a way of saying that your child and you are the focus of the health care

What do you need to do as part of your child's Patient-Centered Medical Home team?

1. Keep your child's medical home providers informed!
   - Let your child's health care provider know about care they receive from other health care professionals
   - **Call your child's medical home first with questions, appointment requests, before you go to an Urgent Care or Emergency Room**
     - **During regular business hours: 716-433-6711**
     - **After hours and on weekends: 716-827-3523**
   - Let your medical home know if your child has been in the hospital
   - Let your medical home know of any change in your child's medications after a hospital stay or from another health care provider
   - Bring all your child's medications with you to each visit at your child's medical home
2. Take an active role in your child's health
   - Follow the health care plan that you and your team agreed on for your child
   - Set goals that your child can reach. Once these goals have been reached discuss new goals
   - Tell your team if your child is having trouble staying with their care plan or if it is not working for them

What can your child's Patient-Centered Medical Home do for them?

- Help them manage their health care
- Help answer all your health questions regarding your child's care
- Listen to your concerns
- Coordinate your child's care if additional services are needed
- Encourage you to play an active part in your child's health care