Lockport Pediatrics
Providing Quality Care for Children & Adolescents
139 Professional Parkway, Lockport, NY 14094
P. 716-433-6711 F. 716-433-0546

Patient Demographics:

Patient Name_____ Sex ◯ M ◯ F DOB: _____/_____/_____

Address_____ **City**_____ **Zip** _____

Preferred Language: ◯ English ◯ Spanish ◯ Other_____

Race: ◯ Caucasian ◯African American ◯ American Indian ◯ Asian
◯ Hawaiian or Other Pacific Islander ◯ Other Race _____

Ethnicity: ◯ Not Hispanic or Latino ◯ Hispanic or Latino ◯ Other

Preferred Appointment Reminder Method: (Choose only one)

◯ Text to: _____-_____ ◯ Email (as below) ◯ Phone Call to: _____-_____

Parent Email Address: _____ _____@_____

Mother's Current Name_____ **DOB** _____/_____/_____

Mother's *Maiden* Name _____ SSN_____-_____-_____

Occupation_____ **Employer**_____ **Phone**_____-_____

Father's Name_____ **DOB** _____/____/____ **SSN**_____-_____-_____

Occupation_____ **Employer**_____ **Phone**_____-_____

Emergency Contacts

Name	Phone Number	Relation	Authorized to Seek Treatment?
1).			
2).			
3).			

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). ****Mother's maiden name is used as a secondary identifier by NYSIIS to confirm the appropriate immunization information for a patient is linked to the correct patient.* This authorization is active until the patient transfers their records to another office, unless Lockport Pediatrics is notified in writing to the contrary.

Parent/Guardian (please print) _____

Signature_____

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 _____#_____oz 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? _____
Vaccines up to date? _____ Current Medications_____
Allergies: (Specify if known)
Medications_____ Food_____
Animals_____ Insects_____ Nature Related _____
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_____

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: _____

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**
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____

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):_____ **Date:** _____/_____/_____

Signature: _____

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 an appt 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:** _____/_____/_____