TODAY'S DATE _____

☐ NEW PATIENT

☐ UPDATED INFORMATION

ACCT#_____

VFC CODE: ☐ Yes ☐ No

COMPREHENSIVE PEDIATRICS, PC

NEWBORN • INFANT • PEDIATRIC • ADOLESCENT MEDICINE

WWW.COMPREHENSIVEPEDIATRICSNY.

Please Print

PATIENT MEDICAL HISTORY

Patient's Name _____
As It Appears on Insurance Card — Last — First — Mi

Male ☐ Female ☐ Date of Birth _____ (MM DD YYYY) Age _____ TODAY

GENERAL MEDICAL INFORMATION

PRESENT HEALTH CONCERNS: _____

MEDICINES VITAMINS: _____

ALLERGIES TO MEDICATIONS/VACCINES: _____

PREVIOUS PEDIATRICIAN, OTHER PHYSICIAN(S) TREATING YOUR CHILD: _____

PREGNANCY & BIRTH

IS THIS CHILD YOURS BY: ☐ BIRTH ☐ STEPCHILD ADOPTION

OTHER: _____

ANY PROBLEMS DURING PREGNANCY: ☐ NO ☐ YES

PLEASE EXPLAIN: _____

DELIVERY TYPE: ☐ VAGINAL BIRTH ☐ CAESARIAN

PLEASE EXPLAIN: _____

MEDICAL PROBLEMS DURING BABY'S NEWBORN PERIOD. ☐ NONE
IF PREMATURE, HOW EARLY?

BIRTH WEIGHT: _____ BIRTH HEIGHT: _____

HOSPITAL: _____ OBGYN: _____

NUTRITION & FEEDING

WAS YOUR CHILD BREASTFED? ☐ NO ☐ YES, HOW LONG? _____

DOES YOUR CHILD HAVE ANY UNUSUAL FEEDING/DIETARY PROBLEMS? ☐ NO ☐ YES

IF YES, EXPLAIN: _____

SLEEP

HOURS PER NIGHT: _____ NAPS (NUMBER & LENGHT): _____

ANY SLEEP PROBLEMS: _____

DEVELOPMENT

AT WHAT AGE DID CHILD: SIT ALONE: _____ WALK ALONE: _____

SAY WORDS: _____ TOILET TRAIN: _____

GIRLS ONLY: AGE AT FIRST MENSTRUAL PERIOD: _____

IMMUNIZATIONS

ARE YOUR CHILD'S IMMUNIZATIONS UP TO DATE? ☐ NO ☐ YES

HAS YOUR CHILD HAD ANY OF THE FOLLOWING DISEASE:

☐ CHICKEN POX ☐ MEASLES ☐ MUMPS
☐ RUBELLA ☐ MENINGITIS ☐ TUBERCULOSIS (TB)

PLEASE BRING CHILD'S VACCINE RECORDS

EXPOSURE & HABITS

ANY CONCERNS ABOUT LEAD EXPOSURE? (OLD HOME/PLUMBING/PEELING PAINT) ☐ NO ☐ YES

DO ANY HOUSEHOLD MEMBERS SMOKE? ☐ NO ☐ YES

TV - HOURS PER DAY _____ COMPUTER - HOURS PER DAY: _____

VIDEO GAMES - HOURS PER DAY _____

SPORTS/EXCERCISE: TYPE: _____

HOW OFTEN? _____ HOW LONG? _____

PAST MEDICAL HISTORY

☐ ASTHMA / HAY FEVER / ECZEMA
☐ FREQUENT EAR INFECITONS
☐ ATTENTION PROBLEMS
☐ PROBLEMS GOING POTTY
☐ URINARY TRACK INFECTION
☐ RSV
☐ BROKEN BONES
☐ CHICKEN POX
☐ ANEMIA
☐ PNEUMONIA
☐ CROUP
☐ OBESITY

OTHER: _____

HOSPITALIZATION/OPERATIONS (WITH DATES): _____

BROKEN BONE/SEVERE SPRAINS _____

DENTAL HISTORY

HAS CHILD BEEN SEEN BY A DENTIST ? ☐ NO YES, HOW OFTEN? _____

LAST VISIT _____

FAMILY HISTORY

PLEASE INDICATE DEATHS OF IMMIDIATE FAMILY MEMBERS: _____

PLEASE INDICATE FAMILY MEMBERS WITH ANY OF THE FOLLOWING CONDITIONS:
(FATHER, MOTHER, BROTHER, SISTER, GRANDMOTHER, GRANDFATHER, AUNT, UNCLE)

ALOHOLISM: _____

HIGH CHOLESTEROL: _____

CANCER, SPECIFY: _____

HIGH BLOOD PRESSURE: _____

HEART DISEASE: _____

STROKE: _____

DEPRESSION/SUICIDE" _____

BLEEDING OR CLOTTING DISORDER: _____

GENETIC DISORDERS: _____

ASTHMA/COPD: _____

DIABETES: _____

OTHER: _____

SOCIAL HISTORY

WHO LIVES AT HOME?

NAME	AGE	RELATIONSHIP	HIGHEST EDUCATION LEVEL

ARE CHILD'S PARENTS: ☐ MARRIED ☐ UNMARRIED ☐ SEPARATED ☐ DIVORCED

IF DIVORCED OR SEPARATED, WHEN? _____

CHILD CARE SITUATION: ☐ PARENTS OTHER, WHO? _____

CONCERNS ABOUT CHILD: ☐ ALCOHOL USE ☐ TOBACCO ☐ SEXUAL ACTIVITY ☐ AGGRESIVE BEHAVIOR

IS VIOLENCE AT HOME A CONCERN? ☐ NO ☐ YES

ARE THERE GUNS AT HOME? ☐ NO ☐ YES

SCHOOL HISTORY

DID/DOES YOUR CHILD ATTEND SCHOOL OR PRESCHOOL? ☐ NO YES, GRADE? _____

NAME OF SCHOOL: _____

ANY CONCERNS ABOUT RELATIONSHIP WITH: TEACHERS ☐ NO ☐ YES
PEERS ☐ NO ☐ YES

COMPREHENSIVE PEDIATRICS, PC

Today's Date: _____ Office Use Only New Patient Account#: _____

PATIENT INFORMATION – PRINT PLEASE – COMPLETE ALL SECTIONS – COMPLETE 2 SIDES PLEASE

Patient's Name: _____ ( ) Male ( ) Female: Date of Birth: ____/____/_____

Address: _____APT#: _____City: _____State: _____ Zip: _____

E Mails… Share with us. We frequently send information about special programs at Comprehensive Pediatrics via e mail.

Does your child have an email? If yes, please share with us: _____@_____.com
Do you have an email? If yes, please share with us: _____@_____.com

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GUARANTOR - Who pays the bills?

Name: _____ SS#: _____-_____-_____

Guarantor's Phone # _____, Cell # _____

DOB: _____/_____/_____ Address: _____APT#: _____
MM DD YYYY
Email:_____@_____.com City: _____State: _____ Zip: _____

PRIMARY CONTACT (Who do we call about your child(ren)'s Healthcare)

Name: _____ Relationship: ( ) Mom ( ) Dad Other: _____

Primary Phone:_____ Cell Phone: _____Work Phone:_____

PRIMARY INSURANCE	SECONDARY INSURANCE
NEW BORN? HAVE YOU NOTIFIED THE INSURANCE CARRIER THAT THE CHILD IS BORN? Y or N	
Name of Insurance: _____	Name of Insurance: _____
Policy Holder's Name: _____	Policy Holder's Name: _____
Relationship to Child: Father Mother Self (Child) Other	Relationship to Child: Father Mother Self (Child) Other
Gender: Male: ☐ Female: ☐ DOB: ____/_____/_____ (MM DD YYYY)	Gender: Male: ☐ Female: ☐ DOB: ____/_____/_____ (MM DD YYYY)
Certificate/Policy#: _____	Certificate/Policy#: _____
SS# of Policy Holder:_____	SS# of Policy Holder:_____
Group#: _____	Group#: _____
Effective Date: _____ Copayment: _____	Effective Date: _____ Copayment: _____
FOR INSURANCE SUBMISSION OF YOUR BILLS, PLEASE PROVIDE:	FOR INSURANCE SUBMISSION OF YOUR BILLS, PLEASE PROVIDE:
Employer Name: _____	Employer Name:_____
Address: _____	Address: _____
Floor/Suite/Room # _____	Floor/Suite/Room # _____
City _____, State _____, Zip _____	City _____, State _____, Zip _____
WORK PHONE # _____	WORK PHONE# _____

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

enrollment form 8/2017

I, _____, acknowledge that I am responsible and liable for all charges accessed for professional services rendered. I acknowledge that I am responsible for all charges regardless of my existing medical coverage. In the event my insurance company forwards payments directly to me, I will deliver such payment to Comprehensive Pediatrics. I understand that I am responsible for meeting my insurance copayment, deductibles, coinsurances, and any non-covered services. Should my account become past due, the balance shall become immediately due and payable. I further authorize the release to my insurance company of any medical information necessary to process a claim, and hereby assign payment of all medical benefits to Comprehensive Pediatrics.

Signature: _____ Date: _____/_____/_____

Comprehensive Pediatrics is permitted to contact us via Cell Phone: Yes No Initial: _____
Comprehensive Pediatrics is permitted to contact us via Email: Yes No Initial: _____
Comprehensive Pediatrics is permitted to contact us via Text: Yes No Initial: _____

How did you hear about us? Physician/Ob-Gyn? Name/Address/Tele#: _____

HIPAA NOTICE OF PRIVACY PRACTICES/PATIENT PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Comprehensive Pediatrics PC ***is required by law to maintain the privacy and confidentiality of your protected health information and to advise you with notice of our legal duties and privacy practices with respect to your protected health information.***

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:

Your protected health information may be used and disclosed by your physician, our office staff, and external sources that may are involved in your care and ***treatment for the purpose of providing health care services to you***, ***to pay your health care bills, to support the operation of the physician's practice*****,** and any other ***uses required by law.***

Treatment: We will use and disclose your protected health information to provide, coordinate, and manage your health care.

Payment: We may disclose your protected health information to your insurance company for the purpose of payment for healthcare.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of our physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, and conducting or arranging business practices.

Required by Law: We may use or disclose you protected health information without your authorization, when required by law. This include emergencies, public health issues, communicable diseases, health oversight, abuse or neglect, FDA requirements, legal proceedings, coroner/medical examiner reporting, criminal activity, workers' compensation, military activity, national security, law enforcement, research.

Under the law, we must make disclosures to you and required to the Secretary of the Department of Health and Human Services to investigate and determine our compliance with the requirements of *section 164.500.* Other Permitted and Required Uses and Disclosures will Be Made Only with Your Consent, Authorization, or Opportunity to Object unless required by law.

YOUR PATIENT RIGHTS:

You have the right to inspect and receive a copy of your protected health information
You have the right to request a restriction to your protected health information.
You have the right to request to receive confidential communication from us by alternative means or at an alternative location.
You have a right to obtain a paper copy of this notice from us.
You may have a right to have your physician amend your protected health information.
You may have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

COMPLAINTS:

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. **We will not retaliate against you for filing a complaint.** This notice was published and becomes effective on/or before April 14, 2003. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have and objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone via 718-256-1057.

PARENT/GUARDIAN: Your signature below acknowledges that I have received this Notice of Comprehensive Pediatrics P.C.'s Privacy Practices.

Print Name: _____Signature:_____ Date: _____/_____/_____

PLEASE INDICATE YOUR RACE, ETHNICITY, AND LANGUAGE (*REQUIRED BY THE STATE OF NEW YORK)*

RACE
- ☐ African
- ☐ Asian
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ European
- ☐ Filipino
- ☐ Israeli
- ☐ Italian
- ☐ Korean
- ☐ West Indian
- ☐ White
- ☐ Other: _____
- ☐ Decline to Specify

ETHNICITY
- ☐Central American
- ☐Cuban
- ☐Dominican
- ☐Hispanic or Latino
- ☐Puerto Rican
- ☐South American
- ☐Not Hispanic or Latino
- ☐Decline to Specify
- ☐Unknown

LANGUAGE
- ☐Albanian
- ☐Arabic
- ☐Chinese
- ☐Greek
- ☐English
- ☐French
- ☐Hebrew
- ☐Hindi
- ☐Italian
- ☐Korean
- ☐Russian
- ☐Spanish
- ☐Decline to Specify
- ☐Other: _____