

Young Pediatrics

4804 South State Route 159 Glen Carbon, IL 62034

Ph: 618-288-9305 Fx: 618-288-9308

Child 1: Last Name: _____ First Name: _____ MI: _____

D.O.B.: ____/____/____ Sex: _____ Primary Language: _____

Ethnicity: Hispanic / Non-Hispanic / Unknown **Race:** Asian / Black / Hawaiian / White /Unknown/ Other _____

Insurance Information

Primary Policy: Policy Holder's Name: _____

Policy Holder's Birth Date: _____ **Policy Holder's Sex: Male / Female**

Insurance Carrier: _____ Policy ID#: _____

Group #: _____ SSN _____

Secondary Policy: Policy Holder's Name: _____

Policy Holder's Birth Date: _____ Policy Holder's SSN: _____ - _____ - _____

Insurance Carrier: _____ Policy ID#: _____

Group #: _____ SSN _____

Child 2: Last Name: _____ First Name: _____ MI: _____

D.O.B.: ____/____/____ Sex: _____ Primary Language: _____

Ethnicity: Hispanic / Non-Hispanic / Unknown **Race:** Asian / Black / Hawaiian / White /Unknown / Other _____

Insurance if Information is different than 1st child (if child has distinctive suffix please specify)

Primary Policy: Policy Holder's Name: _____

Policy Holder's Birth Date: _____ Policy Holder's Sex: Male / Female

Insurance Carrier: _____ Policy ID#: _____

Group #: _____ SSN _____

*We DO NOT bill Medicaid (including the Managed Care Plans) secondary

Secondary Policy: Policy Holder's Name: _____

Policy Holder's Birth Date: _____ Policy Holder's SSN: _____ - _____ - _____

Insurance Carrier: _____ Policy ID#: _____

Group #: _____ SSN _____

Child 3: Last Name: _____ First Name: _____ MI: _____

D.O.B.: ____/____/____ Sex: _____ Primary Language: _____

Ethnicity: Hispanic / Non-Hispanic / Unknown **Race:** Asian / Black / Hawaiian / White/ Unknown

Insurance if Information is different than 1st child (if child has distinctive suffix please specify)

Primary Policy: Policy Holder's Name: _____

Policy Holder's Birth Date: _____ Policy Holder's Sex: Male / Female

Insurance Carrier: _____ Policy ID#: _____

Group #: _____ SSN _____

*We DO NOT bill Medicaid (including the Managed Care Plans) secondary

Secondary Policy: Policy Holder's Name: _____

Policy Holder's Birth Date: _____ Policy Holder's SSN: _____ - _____ - _____

Insurance Carrier: _____ Policy ID#: _____

Group #: _____ SSN _____

Mailing Address: _____
(Street or PO Box) (City) (State & Zip)

Primary Phone: (_____) _____ - _____

Who lives at this household? _____
(Please note, this information is being requested to improve intake of your child's Social History.)

Contact Information

1. Contact Name: _____ Date of Birth: ____ / ____ / ____

Lives with patient? Yes / No If no, please list Contact's address: _____

Main Phone: _____ Is this a cell phone? Yes / No

Relation to Patient: _____ Biological Relation to Patient: _____

(Please note, this information is being requested to improve intake of your child's Family Medical History.)

Work Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Preferred Email: _____ (please circle) Home email / Work email

Employer _____ Profession _____

How would this contact ideally prefer to be contacted regarding (circle **only one**):

Recall Notices: Home Address / Home Phone / Work Phone / Cell Call / Cell Text / Email

General Practice Notices: Home Address / Home Phone / Cell Call / Cell Text / Email

Patient Portal Notifications: Cell Text / Email

Appointment Reminders: Cell Text / Email

2. Contact Name: _____ Date of Birth: ____ / ____ / ____
Lives with patient? Yes / No If no, please list Contact's primary phone number: _____
Is this a cell phone? Yes / No and their Address: _____
Relation to Patient: _____ Biological Relation to Patient: _____
(Please note, this information is being requested to improve intake of your child's Family Medical History.)
Work Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____
Preferred Email: _____ Home email Work email (please circle)
Employer _____ Profession _____

How would this contact ideally prefer to be contacted regarding (circle only one):

Recall Notices: Home Address / Home Phone / Work Phone / Cell Call / Cell Text / Email

General Practice Notices: Home Address / Home Phone / Cell Call / Cell Text / Email

Patient Portal Notifications: Cell Text / Email

Appointment Reminders: Cell Text / Email

Emergency Contacts, other than parents: Name & Relationship

1: _____ Relationship _____ Phone: (____) _____ - _____

2: _____ Relationship _____ Phone: (____) _____ - _____

Additional Contact Questions:

Who should receive billing statements? _____ S.S. # _____

If parents are divorced or separated please fill out this section:

Who has primary custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

The following individuals are able to authorize medical treatment for my child(ren) in my absence:
(If child is 16 and will may drive self and come alone please add his/her name and self as relationship):

Name _____ Phone _____ Relationship to patient(s) _____

Name _____ Phone _____ Relationship to patient(s) _____

Name _____ Phone _____ Relationship to patient(s) _____

Name _____ Phone _____ Relationship to patient(s) _____

Name _____ Phone _____ Relationship to patient(s) _____

Name _____ Phone _____ Relationship to patient(s) _____

Collection Clause

In the event the undersigned customer fails to pay pursuant to the terms of this contract Young Pediatrics reserves the right to pursue all available legal remedies pursuant to the laws of the State of Illinois. Should your claim be referred to a collection agency and/or attorney for collections, the customer agrees to pay all necessary fees of collection, along with all legal fees with interest to be accrued at the annual rate of 10 % per annum.

Printed Name

Date

Signature

Relation to Patient

Young Pediatrics History Questionnaire

Form Completed By _____

Date Completed _____

Patient Name _____	
Date of Birth _____	Male or Female _____

Household Please list all those living in the child's home

Name	Relationship	Birth date	Health Problems

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

If mother and father are not living together or if child does not live with parents, what is the child's custody status? _____

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

Birth History

Birth Weight _____ Birth Height _____

Mom's Gestation _____ weeks

Did mom have any illness or problem with her pregnancy? _____

If yes, explain _____

During pregnancy did mom

Smoke _____ Drink alcohol _____

Use drugs or medications _____ If yes please list what and when _____

Was the delivery Vaginal? Or Cesarean?

If cesarean, why? _____

Did baby have any problems right after birth? _____

If yes, explain _____

Was initial feeding Breast? Or Bottle?

Did baby go home with mother form hospital? _____

If no, explain _____

General

Do you consider your child to be in good health? Yes No Explain _____

Does your child have any serious illness or medical condition? Yes No Explain _____

Has your child had serious injuries or accidents? Yes No Explain _____

Has your child had surgery? Yes No Explain _____

Has your child ever been hospitalized? Yes No Explain _____

Is your child allergic to any medications or drugs? Yes No Explain _____

Development

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

Are you concerned about your child's mental or emotional development? Yes No Explain _____

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

If your child is in school:

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 or resource classes? _____

Family History

Have any family members had the following:

Deafness	Yes	No	Who _____	Comments _____
Nasal Allergies	Yes	No	Who _____	Comments _____
Asthma	Yes	No	Who _____	Comments _____
Tuberculosis	Yes	No	Who _____	Comments _____
Heart disease (before age of 50 years)	Yes	No	Who _____	Comments _____
High Blood Pressure (before 50 years)	Yes	No	Who _____	Comments _____
High Cholesterol	Yes	No	Who _____	Comments _____
Anemia	Yes	No	Who _____	Comments _____
Bleeding Disorder	Yes	No	Who _____	Comments _____
Liver Disease	Yes	No	Who _____	Comments _____
Kidney Disease	Yes	No	Who _____	Comments _____
Diabetes (before 50 years)	Yes	No	Who _____	Comments _____
Bed-Wetting (after 10 years of age)	Yes	No	Who _____	Comments _____
Epilepsy or Convulsions	Yes	No	Who _____	Comments _____
Alcohol Abuse	Yes	No	Who _____	Comments _____
Drug Abuse	Yes	No	Who _____	Comments _____
Mental Illness	Yes	No	Who _____	Comments _____
Mental Retardation	Yes	No	Who _____	Comments _____
Immune Problems, HIV, or AIDS	Yes	No	Who _____	Comments _____
Additional family history	_____			

Past History

Does your child have or has he/she ever had:

Chickenpox	Yes	No	When _____
Frequent ear infections	Yes	No	Explain _____
Problems with ears or hearing	Yes	No	Explain _____
Nasal Allergies	Yes	No	Explain _____
Problems with eyes or visions	Yes	No	Explain _____
Asthma, Bronchitis, Bronchiolitis, or Pneumonia	Yes	No	Explain _____
Any heart problem or heart murmur	Yes	No	Explain _____
Anemia or bleeding problem	Yes	No	Explain _____
Blood transfusion	Yes	No	Explain _____
Frequent Abdominal pain	Yes	No	Explain _____
Constipation requiring doctor visits	Yes	No	Explain _____
Bladder or kidney infection	Yes	No	Explain _____
Bed-Wetting (after 5 years of age)	Yes	No	Explain _____
(for girls) Has she started her menstrual periods?	Yes	No	When _____
(for girls) Are there any problems with her periods?	Yes	No	Explain _____
Any chronic or recurrent skin problems	Yes	No	Explain _____
Frequent headaches	Yes	No	Explain _____
Convulsions or other neurologic problems	Yes	No	Explain _____
Diabetes	Yes	No	Explain _____
Thyroid or other endocrine problems	Yes	No	Explain _____
Any other significant problem	Yes	No	Explain _____
Use of alcohol or drugs	Yes	No	Explain _____
List any medications child is currently taking	_____		

Child Name _____

DOB _____

Young Pediatrics

Missed Appointment Policy

Office Policy Addressing Missed Appointments

- After the first missed appointment, a \$25.00 fee will be charged. The appointment may be rescheduled.
- If a second scheduled appointment is missed, a \$25.00 fee will be charged. Statement is sent, again reiterating our policy. The appointment may be rescheduled.
- If a third scheduled appointment is missed per family, it will be necessary to terminate our professional relationship with the patient and family. Termination letter is sent.

As a parent/guardian of a patient of Young Pediatrics I agree to pay any charges that may accumulate from missed appointments.

Parent's/Guardian's Signature

Date

I have received a packet of Young Pediatrics Appointment, After Hour/Exchange, Health Forms, Disclosure of Health Records, and Office Financial Policies.

Parent's/Guardian's Signature

Date

Child Name _____ DOB _____

CONSENT TO USE & DISCLOSE HEALTH INFORMATION

Young Pediatrics

This office is required by Federal Regulations to inform our Patients in regards to the use of your child's health information in accordance to Health Insurance Portability & Accountability Act of 1996 or HIPAA.

PLEASE READ THE FOLLOWING CAREFULLY!

I understand that as part of my child's health care, Young Pediatrics originates and maintains paper and/or electronic records describing my child's health history, symptoms, examination and test results, diagnoses, treatments, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning care and treatment
- A means of communication among health professionals who contribute to my child's care.
- A source of information for applying diagnosis and treatment information to my bill.
- A means by which a third-party can verify the services billed to me actually took place.

I understand and have been provided access to a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. This notice is located in the waiting area in plain view. I understand that I have the following rights and privileges:

- The right to review the *Notice of Privacy Practices* prior to signing this consent, allowing treatment, or making payment for services rendered.
- The right to object to the use of my child's health information for directory purposes.

I understand that Young Pediatrics is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization may refuse to treat my child as permitted by Federal Regulations. I understand that Young Pediatrics reserve the right to change their *Notice of Privacy Practices*. I further understand that Young Pediatrics may use a computerized state vaccine registry to track immunization requirements and maintain immunization records. Young Pediatrics may enroll patients unless you inform us in writing that you do not wish to participate.

Please note that I consent to the following uses of my child's medical information (Initial Below)

_____ I allow my child's immunization records and/or State Certificate of Examination form to be faxed or mailed to their school/daycare.

_____ I allow my Child's immunization records to be faxed or mailed to me.

_____ Other: _____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my child's protected health information to another entity. I hereby consent to such disclosure for these permitted uses. I also hereby consent to such disclosures via fax.

I fully understand and accept the terms of this consent.

Parent/Guardian Printed Name & Relation

Signature

Date

Young Pediatrics

The Importance of Immunizing Children: Our Practice Policy

We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives.

We firmly believe in the safety of our vaccines.

We firmly believe that all children and young adults should receive all of the recommended vaccines according to the schedule published by the Centers for Disease Control and the American Academy of Pediatrics.

We firmly believe, based on all available literature, evidence and current studies, that vaccines **do not** cause autism or other developmental disabilities. We firmly believe that thimerosal, a preservative that has been in vaccines for decades and remains in some vaccines, does not cause autism or other developmental disabilities.

We firmly believe that vaccinating children and young adults may be the single **most important** health-promoting intervention we perform as health care providers, and that you can perform as parents/caregivers. The recommended vaccines and their schedule given are the results of years and years of scientific study and data gathering on millions of children by thousands of our brightest scientists and physicians.

These things being said, we recognize that there has always been and will likely always be controversy surrounding vaccination. Indeed, Benjamin Franklin, persuaded by his brother, was opposed to smallpox vaccine until scientific data convinced him otherwise. Tragically, he had delayed inoculating his favorite son, Franky, who contracted smallpox and died at the age of 4, leaving Ben with a lifetime of guilt and remorse. Quoting Mr. Franklin's autobiography:

In 1736, I lost one of my sons, a fine boy of four years old, by the smallpox...I long regret bitterly, and still regret that I had not given it to him by inoculation. This I mention for the sake of parents who omit that operation, on the supposition that they should never forgive themselves if a child died under it, my example showing that the regret may be the same either way, and that, therefore, the safer should be chosen.

The vaccine campaign is truly a victim of its own success. It is precisely because vaccines are so effective at preventing illness that we are even discussing whether or not they should be given. Because of vaccines many of you have never seen a child with polio, tetanus, whopping cough, bacterial meningitis or even chickenpox, or known a friend or family member whose child died for one of these diseases. Such success can make us complacent or even lazy about vaccinating. But such an attitude, if it becomes widespread, can only lead to tragic results.

Over the past several years, many people in Europe have chosen not to vaccinate their children with the MMR vaccine after publication of an unfounded suspicion (later retracted) that the vaccine caused autism. As a result of under immunization, there have been small outbreaks of

measles and several deaths from complications of measles in Europe over the past several years.

We are making you aware of these facts not to scare you or coerce you, but to emphasize the importance of vaccinating your child. We recognize that the choice may be a very emotional one for some parents. We will do everything we can to convince you that vaccinating according to the schedule is the right thing to do. However, **should you have doubts, please discuss these with your health care provider in advance of your visit.** In some cases, we may alter the schedule to accommodate parental concerns or reservations. **Please be advised, however, that delaying or "breaking up the vaccines" to give one or two at a time over two or more visits goes against expert recommendations, and can put your child at risk for serious illness (or even death) and goes against our medical advice as providers at Young Pediatrics.** Such additional visits will require additional co-pays on your part. Furthermore, please realize that you will be required to sign a "Refusal to Vaccinate: acknowledgement in the event of lengthy delays.

Finally, if you should absolutely refuse to vaccinate your child despite all our efforts, we will ask you to find another health care provider who shares your views. We do not keep a list of such providers nor would we recommend any such physician. Please recognize that by not vaccinating you are putting your child at unnecessary risk for life-threatening illness and disability, and even death.

As medical professionals, we feel very strongly that vaccinating children on schedule with currently available vaccines is absolutely the right thing to do for all children and young adults. Thank you for your time in reading this policy, and please feel free to discuss any questions or concerns you may have about vaccines with any one of us.

I have read and understand the Vaccine Policy Statement.

Patient name

Signature, patient or Representative

Date

Relationship to Patient