NORTH POINT PEDIATRICS

PATIENT INFORMATION FORM

Please Complete This Entire Form (list all children the information applies to)

PLEASE PROVIDE A COPY OF ANY DOCUMENTS RELATED TO CUSTODIAL RIGHTS FOR THE PATIENT'S RECORD

PATIENT LAST NAME: **GENDER:** □ ***M*** □ ***F*** □ ***Other***	**PATIENT FIRST NAME:**	**MIDDLE INITIAL:**	**PATIENT DATE OF BIRTH:**
PATIENT LAST NAME: **GENDER:** □ ***M*** □ ***F*** □ ***Other***	**PATIENT FIRST NAME:**	**MIDDLE INITIAL:**	**PATIENT DATE OF BIRTH:**
PATIENT LAST NAME: **GENDER:** □ ***M*** □ ***F*** □ ***Other***	**PATIENT FIRST NAME:**	**MIDDLE INITIAL:**	**PATIENT DATE OF BIRTH:**
PATIENT LAST NAME: **GENDER:** □ ***M*** □ ***F*** □ ***Other***	**PATIENT FIRST NAME:**	**MIDDLE INITIAL:**	**PATIENT DATE OF BIRTH:**
PATIENT LAST NAME: **GENDER:** □ ***M*** □ ***F*** □ ***Other***	**PATIENT FIRST NAME:**	**MIDDLE INITIAL:**	**PATIENT DATE OF BIRTH:**

MAILING ADDRESS:	**CITY:**	**STATE:**	**ZIP:**
PHYSICAL ADDRESS *(If different)*:	**CITY:**	**STATE:**	**ZIP:**

PRIMARY PHONE: ( )	**CELL PHONE:** □ ***Check if same as Primary*** ( )	**WORK PHONE:** ( )	**EXTENSION:**

PREFERRED PHARMACY: Name, Address and Phone Number	**ENABLE FOR PATIENT PORTAL:** □ **Yes** □ **No** □ **Not Applicable**

RACE: □ **American Indian/Alaskan Native** □ **Asian** □ **Black/African-American** □ **Hawaiian Native/ Pacific Islander** □ **White** □ **Declined to Specify** □ **Other (Details)** ________________________________

GUARANTOR INFORMATION

(Individual responsible for bills and payment – If you are an 18+ year old patient, this would be YOUR name)

GUARANTOR LAST NAME:	**GUARANTOR FIRST NAME:**	**MIDDLE INITIAL:**	**RELATIONSHIP TO PATIENT *(Check all that apply)*:** □ **Mother** □ **Father** □ **Stepmother** □ **Stepfather** □ **Legal Guardian** □ **Self** □ **Other *(Specify)*:**

STREET ADDRESS: □ ***Check if same as patient***	**CITY:**	**STATE:**	**ZIP**

PRIMARY PHONE: ( )	**CELL PHONE:** □ ***Check if same as Primary*** ( )	**WORK PHONE:** ( )	**EXTENSION:**

E-MAIL ADDRESS: □ **None**	**SOCIAL SECURITY #:**	**DATE OF BIRTH *(mm/dd/yyyy)*:**
GENDER: □ **Male** □ **Female** □ **Other**	**EMPLOYER NAME:**	**EMPLOYER PHONE #:** ( )
	Receive Statements via: □ **Mail** □ **Email**	**MAY WE RELEASE PROTECTED HEALTH INFORMATION TO THIS INDIVIDUAL:** □ **Yes** □ **No**

OTHER PARENT

PARENT LAST NAME:	**PARENT FIRST NAME:**	**MIDDLE INITIAL:**	**RELATIONSHIP TO PATIENT *(Check all that apply)*:** □ **Mother** □ **Father** □ **Stepmother** □ **Stepfather** □ **Legal Guardian** □ **Self** □ **Other *(Specify)*:**

STREET ADDRESS: □ ***Check if same as patient***	**CITY:**	**STATE:**	**ZIP:**

PRIMARY PHONE: ( )	**CELL PHONE:** □ ***Check if same as Primary*** ( )	**DATE OF BIRTH *(mm/dd/yyyy)*:**
	E-MAIL ADDRESS:	**MAY WE RELEASE PROTECTED HEALTH INFORMATION TO THIS INDIVIDUAL:** □ **Yes** □ **No**

PLEASE CONTINUE ON THE NEXT PAGE

*********PLEASE LIST BELOW PEOPLE GIVEN PERMISSION TO BRING IN YOUR MINOR CHILD FOR MEDICAL CARE**********

CONTACT NAME:	RELATIONSHIP TO CHILD*:*	CONTACT PHONE:
CONTACT NAME:	**RELATIONSHIP TO CHILD:**	**CONTACT PHONE:**

□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No
May pick up prescriptions	**May pick up forms**	**May pick up medical records**	**May speak to nurse or doctor for medical advice**

INSURANCE INFORMATION ONLY IF CURRENT INSURANCE CARD NOT PRESENT

(*Please present all current insurance cards to the Front Desk)*

I HAVE INSURANCE: ☐ **Yes** ☐ **Yes, but pending, not active, or you're not contracted** ☐ **No *(Self Pay)***			
PRIMARY INSURANCE:		**SECONDARY INSURANCE:**	
SUBSCRIBER:	**RELATION TO PT:**	**SUBSCRIBER:**	**RELATION TO PT:**
Policy ID:	**Group ID:**	**Policy ID:**	**Group ID:**
GENDER: □ **Male** □ **Female** □ **Other**		**GENDER:** □ **Male** □ **Female** □ **Other**	
DATE OF BIRTH:	**SOCIAL SECURITY #:**	**DATE OF BIRTH:**	**SOCIAL SECURITY #:**

CONFIDENTIAL COMMUNICATION

(*I hereby request to receive confidential communications from North Point Pediatrics in the following manner)*

PHONE MESSAGES – Please leave messages as follows
(Check All That Apply)

Primary Phone: ☐ Mom ☐ Dad ☐ Both

☐ Self (for 18+ year old patients)

☐ **BRIEF MESSAGE** ☐ **DETAILED MESSAGE**

Cell Phone: ☐ Mom ☐ Dad ☐ Both

☐ Self (for 18+ year old patients)

☐ **BRIEF MESSAGE** ☐ **DETAILED MESSAGE**

APPOINTMENT CONFIRMATIONS/RECALLS

CONTACT: (Check one)

☐ Mom ☐ Dad ☐ **Self (for 18+ year old patients)**

VIA THE FOLLOWING METHOD: (Check one)

☐ Text message

☐ Home/Cell Phone – automated call

☐ Email address

If needed, I agree to participate in Telehealth visits through a HIPAA Compliant platform. _____YES _____NO

Telephone. Email Contacts

I hereby consent and agree that: (1) anyone acting on behalf of North Point Pediatrics (herein known as "NPP") may contact me as necessary regarding my account (including for collections purposes or related to insurance coverage); (2) any and all of NPP's contacts with me may be made via text message or with an automated dialing and announcing or similar device, and via email; (3) NPP may contact me at any telephone number I provide to them, whether a residential, business number, or cellular number; (4) I have an established business relationship with NPP and that NPP may contact me at the telephone number or email address I provide to them, in any of the ways described above. I understand that, if I accept now, I may change at any time by notifying NPP staff. □ **Accept** □ **Decline**

Initials: _____

Release of Protected Health Information in Emergency Situation

I understand that my protected health information may be released as my physician determines appropriate in an emergency situation.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:

I hereby authorize North Point Pediatrics to examine and treat my child when necessary. I also authorize the release of my protected health information, acquired in the course of examination to carry out treatment, payment and heath care operations of my child. I hereby authorize payment directly from my insurance company to the physicians of NPP for medical treatment(s) provided to my child. I understand that payment in full of my responsible portion is required at the time of visit. If North Point Pediatrics is not a provider on my insurance, full payment is due on the date of service. If North Point Pediatrics is a provider on my insurance, then any deductibles, copays, or percentages are due at the time of service. Additionally, if I miss a schedule appointment, I understand I may be charged $35. If I miss two scheduled appointments I may be charged $75. ***By signing below, I am acknowledging that I have read and understand the above statements.***

_____	_____	_____
Parent, Legal Guardian, or Patient (18 or older) Printed Name	**Parent, Legal Guardian, or Patient (18 or older) Signature**	**Date Signed**

Name:_____ Birth Date:_____

PATIENT HISTORY

Is child adopted?_____ At what age?_____ Race_____ Is child aware?_____

Where was the child born?_____ Obstetrician:_____

Full term pregnancy?____ If no, how early?_____ Type of delivery?_____

Problems at birth or in first few weeks? (i.e., Ventilator, Oxygen Therapy, etc.)_____

Does the mother or father have any history of STD or other infections (herpes, HIV, Group B Strep)? _____

Any developmental issues or delays?_____

List any medications your child is currently taking_____

PATIENT'S PAST MEDICAL/SOCIAL HISTORY AND ALLERGIES

Allergic to any medication?_____

Allergic to any food or insects?_____

Any smokers at home?_____ Any pets?_____

CHICKEN POX Disease_____ Vaccine_____ PNEUMONIA_____
CONVULSIONS/SEIZURES_____ URINARY INFECTIONS_____
MENINGITIS_____ ASTHMA_____
HEART DISEASE_____ HEART MURMUR_____
Has child received blood transfusion or blood products?_____

Previous Pediatrician_____

Has your child seen a Specialist? (If yes, name and reason for visit):
_____

OPERATIONS (Enter Dates)
_____
_____

SCHOOL PROBLEMS/PERFORMANCE:
Scholastic:_____
Conduct:_____

FAMILY HISTORY
(Any history in mother, father or close relative (grandparent, sibling, aunt, uncle) of:

(please check appropriate items and indicate which family member it belongs to)

_____**Birth Defects**	_____**Kidney Disease**
_____**Bleeding Tendencies**	_____**Liver Disease**
_____**Cancer**	_____**Mental or Emotional Problems**
_____**Diabetes**	_____**Other Heart Disease**
_____**Early Heart Attacks**	_____**Seasonal Allergies**
_____**Genetic Disorders**	_____**Seizures or Epilepsy**
_____**High Blood Pressure**	_____**Substance Abuse**
_____**High Cholesterol**	_____**Sudden Unexpected Death**
_____**HIV/AIDS**	**or Fatality from Illness**
_____**Interrupted Pregnancies**	_____**Thyroid Disease**
_____**Other**	_____ **Tuberculosis**

Has there been a separation, divorce or death?_____ When?_____

Who is legal guardian?_____ Whom does the child live with?_____

_____

OFFICE USE ONLY: **Today's Date:_____**

Nurse:_____ Physician:_____

Information from the American Academy of Pediatrics

Patient Education on Billing

As you may know, there are very specific regulations about billing for health care services. As your health care provider, we are obligated to follow those regulations in how we report services provided to you. Additionally, every insurance plan may have different rules that vary from insurer to insurer and may even vary between plans of the same insurer.

- All physicians/providers must report services using a variety of codes to tell the insurance company what was done and why.
- It is not uncommon for patients in the course of a visit to receive management and treatment services for a separate and specific problem, as well as routine or preventive services at the same visit. This results in billing a sick visit with a well visit.
- Both services must be reported to the insurance company and may result in an additional co-payment or charge as per the insurer's plan rules which we are obligated to follow.
- There are many different insurance companies and plans; addressing a problem may trigger a co-payment or additional charges to your account.
- Your financial responsibility is determined by the rules of your insurance company, which we are obligated to follow.
- If you have questions, please check with your insurance plan.

We are dedicated to providing the best possible care for you and your family and to being respectful of your time. If our business office can help, please call them at (678) 336-1409.

YOUR COPY TO KEEP