TENDERCARE PEDIATRICS, INC.
NEW PATIENT REGISTRATION

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

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

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

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

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

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

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

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

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

Child 4: *Last Name:* _____ *First Name:* _____ *MI:* _____

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

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

Mailing Address:

_____

(Street or PO Box) *(City)* *(State & Zip)*

Home Phone: (_____) _____ - _____

Who lives at this household? _____

Insurance:

Primary Policy: *Policy Holder's Name*: _____

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

Insurance Carrier: _____

ID# _____ *Group #* _____

Are there any other insurance policies? *Yes / No*

Parent 1: *Name:* _____ *Relation to Patient:* _____

Lives with patient? Yes / No *Date of Birth:* ____ / ____ / ____ *Social Security #:* ____ - ___ - ____

If no please provide address: _____

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

Home Email: _____ *Work Email:* _____

Employer: _____ *Occupation:* _____

How would you ideally prefer to be contacted regarding (circle one):

Medical Issues: Home Phone / Work Phone / Cell Phone / Home Email

Appointment Reminders: Home Phone / Cell Phone / Home Email / Work Email

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

Billing Statements: Home Address / Home e-mail / Work Email

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

Patient Portal Notifications: Cell Phone / Home Email / Work Email

Parent 2: *Name:* _____ *Relation to Patient:* _____

Lives with patient? Yes / No *Date of Birth:* ____ / ____ / ____ *Social Security #:* ____ - ___ - ____

If no please provide address: _____

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

Home Email: _____ *Work Email:* _____

Employer: _____ *Occupation:* _____

If this contact will need to be notified in addition to Contact 1 for Medical Issues, Appointment Reminders, Recall Notices, Billing Statements, General Practice Notices and Patient Portal Notifications list their preferences here:

_____

_____

Additional Contact Questions:

Who should receive billing statements? _____

May all contacts have access to the patient's records electronically? Yes / No / _____

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

Who has 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.

_____

Emergency Contacts, <u>other than parents</u>: Name & Relationship

1: _____ *Phone:* (_____) _____ - _____

2: _____ *Phone:* (_____) _____ - _____

TENDERCARE PEDIATRICS, INC.
NEW PATIENT REGISTRATION PACKET
INITIAL HISTORY QUESTIONNAIRE

PATIENT NAME: _____

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

PARENT COMPLETING FORM: _____

DATE: ____/____/____

SOCIAL HISTORY

WHO LIVES IN THE HOUSEHOLD?

NAME	RELATION TO PATIENT	BIRTHDATE	HEALTH PROBLEMS

1. ARE THERE ANY SIBLINGS NOT LISTED? IF SO THEIR NAMES, AGES AND WHERE THEY LIVE:
   _____
2. WHAT IS THE CHILDS LIVING SITUATION?
3. ___ ADOPTED ___ JOINT CUSTODY ___ SINGLE CUSTODY ___ FOSTER FAMILY ___ BOTH PARENTS
4. IF ANY PARENT IS NOT IN HOME HOW OFTEN DOES PATIENT SEE THIS PARENT: _____
5. ANY SMOKERS IN THE HOME? ____ YES ____ NO SPECIFY: _____
6. GUNS IN THE HOME? ____ YES ____ NO SPECIFY: _____
   ARE THEY PROPERLY LOCKED UP AND OUT OF REACH? ____ YES ____ NO SPECIFY: _____

PATIENT'S BIRTH HISTORY

7. BIRTH WEIGHT _____LB _____OZ
8. PRETERM OR FULLTERM SPECIFY: _____
9. C SECTION OR VAGINAL SPECIFY: _____
10. TYPE OF DELIVERY SPECIFY: _____
11. BREASTFED OR BOTTLE FED SPECIFY: _____
12. BREASTMILK OR FORMULA SPECIFY: _____
13. PULSE OX SCREEN FOR CHD ____ YES ____ NO SPECIFY: _____
14. RESUSCITATION AT DELIVERY ____ YES ____ NO SPECIFY: _____
15. VITAMIN K ____ YES ____ NO SPECIFY: _____
16. HYPOGLYCEMIA ____ YES ____ NO SPECIFY: _____
17. HYPOTHERMIA ____ YES ____ NO SPECIFY: _____
18. SEPSIS ____ YES ____ NO SPECIFY: _____
19. JAUNDICE ____ YES ____ NO SPECIFY: _____
20. CIRCUMSIZED ____ YES ____ NO SPECIFY: _____
21. DELAYED MECONIUM PASSAGE ____ YES ____ NO SPECIFY: _____
22. HEART MURMUR ____ YES ____ NO SPECIFY: _____
23. OXYGEN GIVEN? ____ YES ____ NO SPECIFY: _____
24. ANTIBIOTICS DURING LABOR ____ YES ____ NO SPECIFY: _____
25. HEAD ULTRASOUND ____ YES ____ NO SPECIFY: _____
26. HIGH RISK PREGNANCY ____ YES ____ NO SPECIFY: _____
27. AMNIOCENTISIS ____ YES ____ NO SPECIFY: _____
28. ABSENCE OF PRENATAL CARE ____ YES ____ NO SPECIFY: _____
29. INDUCED LABOR ____ YES ____ NO SPECIFY: _____
30. USE OF ALCOHOL, DRUGS, OR TOBACCO DURING PREGNANCY ____ YES ____ NO SPECIFY: _____
31. PROBLEMS WITH FETUS ____ YES ____ NO SPECIFY: _____
32. ANY PRENATAL ABNORMALITIES ____ YES ____ NO SPECIFY: _____

PATIENT PAST MEDICAL HISTORY

33. SERIOUS INJURIES/ ACCIDENTS ____ YES ____ NO SPECIFY: _____
34. SURGERIES ____ YES ____ NO SPECIFY: _____
35. HOSPITALIZATIONS ____ YES ____ NO SPECIFY: _____
36. CHICKEN POX ____ YES ____ NO SPECIFY: _____

37. FREQUENT EAR/ SINUS INFECTIONS ____ YES ____ NO SPECIFY: _____
38. PHARYNGITIS/TONSILLITIS ____ YES ____ NO SPECIFY: _____
39. OTHER INFECTIOUS ILLNESSES ____ YES ____ NO SPECIFY: _____
40. ALLERGIC RHINITIS OR OTHER ALLERGIES ____ YES ____ NO SPECIFY: _____
41. ANIMALS IN HOME ____ YES ____ NO SPECIFY: _____
42. OUTDOOR ALLERGENS ____ YES ____ NO SPECIFY: _____
43. INDOOR ALLERGENS ____ YES ____ NO SPECIFY: _____
44. ASTHMA, BRONCHITIS, BRONCHIOLITIS, PNEUMONIA, OR CROUP ____ YES ____ NO SPECIFY: _____
45. HEART PROBLEMS/ HEART MURMURS ____ YES ____ NO SPECIFY: _____
46. ABDOMINAL PAIN / GERD ____ YES ____ NO SPECIFY: _____
47. CONSTIPATION REQUIRING DOCTOR VISITS ____ YES ____ NO SPECIFY: _____
48. BLADDER/KIDNEY INFECTIONS, UROLOGIC PROBLEMS ____ YES ____ NO SPECIFY: _____
49. BEDWETTING AFTER 5 YEARS OLD ____ YES ____ NO SPECIFY: _____
50. EYE CONDITIONS/ CORRECTIVE LENSES ____ YES ____ NO SPECIFY: _____
51. PROBLEMS WITH EARS OR HEARING ____ YES ____ NO SPECIFY: _____
52. CHRONIC OR RECURRENT SKIN ISSUES (ECZEMA, ACNE, ETC.) ____ YES ____ NO SPECIFY: _____
53. ANEMIA OR BLEEDING PROBLEMS ____ YES ____ NO SPECIFY: _____
54. BLOOD TRANSFUSIONS ____ YES ____ NO SPECIFY: _____
55. FREQUENT HEADACHES ____ YES ____ NO SPECIFY: _____
56. SEIZURES, DEVELOPMENTAL DELAYS, - ADD/ADHD, OR OTHER NEURO DISORDERS ____ YES ____ NO SPECIFY: _____
57. MENTAL HEALTH CONCERNS ____ YES ____ NO SPECIFY: _____
58. ORTHOPEDIC PROBLEMS ____ YES ____ NO SPECIFY: _____
59. DIABETES ____ YES ____ NO SPECIFY: _____
60. THYROID OR ENDOCRINE PROBLEMS ____ YES ____ NO SPECIFY: _____
61. IF FEMALE, HAVE THEY STARTED MENSTRUAL ____ YES ____ NO SPECIFY: _____
62. USE OF ALCOHOL OR DRUGS ____ YES ____ NO SPECIFY: _____
63. EMOTIONAL PROBLEMS ____ YES ____ NO SPECIFY: _____
64. TAKING ANY MEDICATIONS, VITAMINS, SUPPLEMENTS ____ YES ____ NO SPECIFY: _____
65. FOLLOWED BY ANY SPECIALIST ____ YES ____ NO SPECIFY: _____
66. ALLERGIES OR REACTIONS TO MEDICINES OR DRUGS ____ YES ____ NO SPECIFY: _____
67. DELAYED VACCINES SCHEDULE OR ANTIVACCINES ____ YES ____ NO SPECIFY: _____

FAMILY MEDICAL HISTORY

68. NASAL ALLERGIES / OTHER ALLERGIES ____ YES ____ NO SPECIFY: _____
69. ASTHMA/ LUNG DISEASE ____ YES ____ NO SPECIFY: _____
70. HEART DISEASE OR HEART CONDITIONS ____ YES ____ NO SPECIFY: _____
71. HIGH BLOOD PRESSURE ____ YES ____ NO SPECIFY: _____
72. HIGH CHOLESTEROL ____ YES ____ NO SPECIFY: _____
73. DIABETES/ ENDOCRINE ISSUES ____ YES ____ NO SPECIFY: _____
74. CANCER ____ YES ____ NO SPECIFY: _____
75. ANEMIA ____ YES ____ NO SPECIFY: _____
76. BLEEDING DISORDER ____ YES ____ NO SPECIFY: _____
77. EPILEPSY OR CONVULSIONS ____ YES ____ NO SPECIFY: _____
78. MENTAL RETARDATION/DEVELOPMENTAL DELAYS ____ YES ____ NO SPECIFY: _____
79. NEUROLOGIC ISSUES INCLUDING ADD/ADHD ____ YES ____ NO SPECIFY: _____
80. LIVER DISEASE ____ YES ____ NO SPECIFY: _____
81. OTHER GI DISEASES ____ YES ____ NO SPECIFY: _____
82. KIDNEY DISEASE ____ YES ____ NO SPECIFY: _____
83. BEDWETTING AFTER 10 YO ____ YES ____ NO SPECIFY: _____
84. HEARING IMPAIRMENT ____ YES ____ NO SPECIFY: _____
85. VISION IMPAIRMENT ____ YES ____ NO SPECIFY: _____
86. IMMUNE ISSUES INCLUDING HIV/AIDS ____ YES ____ NO SPECIFY: _____
87. ALCOHOL ABUSE ____ YES ____ NO SPECIFY: _____
88. DRUG ABUSE ____ YES ____ NO SPECIFY: _____
89. MENTAL ILLNESS ____ YES ____ NO SPECIFY: _____
90. TUBERCULOSIS ____ YES ____ NO SPECIFY: _____
91. ANY ADDITIONAL MEDICAL CONDITIONS ____ YES ____ NO SPECIFY: _____

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT, AND TREATMENT CONSENT

Health and accident policies are a contractual arrangement between an insurance carrier and the insured. It is the responsibility of the insured to verify eligibility for health care benefits. Possession of a medical insurance member ID card is NOT a guarantee of coverage. As a courtesy to you, we will gladly submit your medical bills to your insurance carrier.

1. **Primary/Secondary Insurance**: I request that payment of authorized benefits be made on my behalf to TenderCare Pediatrics, Inc. for services rendered to me. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or the release of medical information necessary to pay the claim. TenderCare Pediatrics accepts the charge determination of the carrier as the full charge. I am responsible only for the deductible, coinsurance, copay, and non-covered services. Coinsurance and deductibles are based upon the charge determination on the carrier and are due at the time of service. Any benefits of any type under any policy of insurance insuring the patient of any other party liable to the patient is hereby assigned to TenderCare Pediatrics. As a courtesy, TenderCare Pediatrics will file with your insurance; however, by signing below you are stating that you understand that you as the patient are ultimately responsible for payment for services rendered. In addition, I request that payment of authorized secondary insurance benefits be made on my behalf to TenderCare Pediatrics if possible if otherwise to me, at which time I would forward all payments to TenderCare Pediatrics.
2. **Release of Information:** TenderCare Pediatrics may disclose all or any part of my medical record and/or financial ledger to an person or corporation (1) which is or may be liable or under contract with TenderCare Pediatrics for reimbursement for services rendered and (2) any health care provider for continued patient care. TenderCare Pediatrics may also disclose, on an anonymous basis, any information concerning my case, which is necessary ir appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statutes, or regulation.
3. **Non-Covered Services:** I understand that TenderCare Pediatrics contracts with health insurance plans. Accordingly, the undersigned accepts full financial responsibility for all items and services which are determined by the health care insurance plan as non-covered services.
4. **Financial Agreement:** I agree that in return for the services provided to me or my child by TenderCare Pediatrics, I will pay m account at the time service is rendered or will make financial arrangements satisfactory to TenderCare Pediatrics for payment. **If an account is sent to collections, I agree to pay the collections expense.** I understand and agree that if my account is found to be delinquent and sent to collections, I will be charged a service fee that is **35% of the total account balance**. It is understood that the undersigned and/or the patient are primarily responsible for the payment of the bill. Furthermore, by signing below I acknowledge that I have been made aware that there is a **$35.00 fee for all returned checks and/or NSF card transactions including any payment plan agreements** In addition to **a $25.00 fee for any missed appointment where proper notice is not given.** The parent/legal guardian bringing the child to our facility will be responsible for required copays, deductibles, or coinsurance, etc. at the time of service.
5. **Privacy Plan:** I agree that I have been given the opportunity to read and have received a copy of TenderCare Pediatrics' Notice of Privacy Practices.
6. **UNDER 18 POLICY:** Anyone under the age of 18 will not be seen without a parent or guardian present unless you are an emancipated minor.
7. **Treatment Consent**: By signing below I hereby consent and give my permission to the doctor (including but not limited to doctor assistants or designated replacements) to administer and perform such procedures upon me, or my child, as the doctor deems necessary in the diagnosis and treatment of myself or my child/
8. I hereby authorize TenderCare Pediatrics to release 3231 and 3300 forms to myself, my child's daycare/school when needed.
9. **I authorize the following people to consent to treatment for my child during my absence:**

   Name: _____ Relationship to Patient: _____ DOB: _____

   Name: _____ Relationship to Patient: _____ DOB: _____

   Name: _____ Relationship to Patient: _____ DOB. _____

10. **Additional Disclosure Authority**: Additional parties we can speak with regarding your account. (including account balances, labs, and other pertinent information)

    Name: _____ Relationship to Patient: _____ DOB: _____

    Name: _____ Relationship to Patient: _____ DOB: _____

    Name: _____ Relationship to Patient: _____ DOB. _____

11. **Medical Records Fee**: I understand that Federal and State law allows a fee to be charged for the copying and printing of patient records and I understand and agree that I will be responsible for the payment of fees listed below if requesting patient records.

    a. (Admin Fee: $25.88) (Pages 1-20: $0.97ea) (Pages 21-100: $0.83ea) (Pages 101+: $0.66ea)

    *b. If certification or postage is required additional fees may apply**

THIS ASSIGNMENT WILL REMAIN INTO EFFECT UNTIL REVOKED BY ME IN WRITING, A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS THE ORIGINAL.

_____ _____

SIGNATURE OF PATIENT, PARENT, GUARDIAN, OR REPRESENTATIVE DATE

_____ _____

PRINTED NAME OF ABOVE SIGNED RELATIONSHIP TO PATIENT

_____ _____

PATIENT NAME PATIENTS DATE OF BIRTH

TENDERCARE PEDIATRICS, INC.
NEW PATIENT REGISTRATION PACKET
COMPLETION OF FORMS CONSENT

Due to the large number of requests for letters to be written and other documents to be completed that require a physician's attention: **there will be a charge for letters and/or completion of documents that require the physician's attention.** The types of letters that require a physician's attention include but are not limited to the following:

1. Medical leave papers (FMLA)	$30.00	(1-2 Weeks to Complete)
2. Letters to utility companies	$20.00	(24 Hours)
3. Letters to Daycare/Schools	$15.00	(3-5 Days)
4. Physical therapy Occupational therapy Speech therapy forms		(7-10 Days)
5. All Demi wavier forms	$45.00	(1-2 Weeks to Complete)
6. Medical letters for landlords, etc.	$15.00	(3-5 Days)
7. Physical, camp forms, college forms	$15.00	(3-5 Days)
8. 504 Plans	$25.00	(1-2 Weeks to Complete)
9. Medical Records (Transfer of Records)	**	(Up to 30 Days)

** (Admin Fee: $25.00) (Pages 1-20: $0.97ea) (Pages 21-100: $0.83ea) (Pages 101+ $0.66ea)

If requiring certification or postage, additional fees may apply

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Tendercare Pediatrics, Inc. **will not** charge for a physical, camp, or college form if it is brought in **within 24 hours** of patient's physical. We will allow 2 free PE/camp form per year.

As usual, there are no charges for immunization forms and hearing and vision forms (3231 and 3300 forms). We do ask you to allow us 72 hours to complete forms.

WE WILL NOT HONOR ANY REQUESTS TO WAIVE FEES.

I have read the above and have been allowed to ask questions. I authorize TenderCare Pediatrics, Inc. to fax my forms to the school, daycare, job, or any other company (ies) I designate. I understand that it may take up to 72 hours to process the request.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Printed Name: _____

Patient Name: _____ Date Of Birth: _____

TENDERCARE PEDIATRICS, INC.
NEW PATIENT REGISTRATION PACKET
NCNS & DIAGNOSTIC TEST DISCLOSURE

1. **No Call No Show**

I understand that it is my responsibility to cancel any appointments I am unable to attend at least 24 hours prior to scheduled date in order to avoid any fees or penalties associated. I also acknowledge that my child(ren) may be dismissed from TenderCare Pediatrics once a total of three appointments are missed without notification during a two-year period.

2. Diagnostic Test, X-rays, and/or Bloodwork

I understand that at times the doctor may order bloodwork, X-ray, and/or other diagnostic procedures that are my responsibility to complete. I am aware that if these are not obtained on the date they are ordered, scheduled or within the given timeframe I am to notify the office upon completion. Furthermore, I understand that failure to obtain studies may not only place my child at risk for unforeseen medical issues, but may lead to dismissal of practice.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Printed Name: _____

Patient Name: _____ Date Of Birth: _____

TENDERCARE PEDIATRICS, INC.
NEW PATIENT REGISTRATION PACKET
NOTICE OF PRIVACY AND OFFICE POLICIES

I certify that I have received a copy of TenderCare Pediatrics, Inc. Notice of Privacy Policy as well as a copy of the office policies for my records.

I understand that a signed copy of my signature will remain on file in my child's chart as acknowledgement and will be considered as valid as an original.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Printed Name: _____

Patient Name: _____ Date Of Birth: _____