SCHOOLHOUSE ROAD
PEDIATRIC ASSOCIATES, P.C.
81 Schoolhouse Road
Albany, New York 12203
(518) 456-1211
Fax: (518) 452-2535

11835 Rte 9W, Suite 3
West Coxsackie, NY 12192
(518)731-3800
Fax: (518) 731-3838

PEDIATRIC INTAKE HISTORY

PATIENT NAME: _____ NICKNAME: _____
DATE OF BIRTH: _____/_____/_____ AGE: _____ SEX: MALE: _____ FEMALE: _____
ETHNICITY:_____ PRIMARY LANGUAGE:_____
PARENTS: MOTHER: FATHER:

Please ANSWER ALL QUESTIONS
AS THEY ALL HAVE A BEARING ON YOUR CHILD'S WELL BEING

PRENATAL HISTORY:

Hospital of Delivery: _____
Length of Pregnancy: _____ Obstetrician: _____
Birth Weight: _____ Type of Delivery: _____ Length of Labor: _____

Mother's age at the time of delivery:_____ Medications taken during pregnancy:_____
List any illness(es) that mother had during pregnancy:_____
Were there any problems at time of delivery? Yes:_____ No:_____ If yes, what?_____

_____

Baby's Apgar scores at delivery:_____
Did the baby have any of the following problems after delivery?_____
Jaundice_____ Treatment_____
Infections _____ Treatment _____
Other _____ Treatment _____
What,if any, street drugs did mother use druing or before pregnancy?_____
Amount_____ Last time used_____
How much alcohol did mother consume during pregnancy?_____

CHILD'S PAST MEDICAL HISTORY:

Name of previous Physician:_____ Date of last Well-Child Exam_____
Please circle any illnesses your child had in the past:

Anemia				
Chicken Pox	Asthma	Bronchitis	Bladder Infections	Broken Bones
Eye Problems	Concussion	Croup	Diabetes	Eczema
Heart Problems/	Frequent Ear Infections	Frequent Nose Bleeds	German Measles	Hay Fever
murmurs/defects	Hepatitis	High Cholesterol	High Lead Level	Influenza
Pneumonia	Loss of Hearing	Measles	Meningitis	Mumps
Whooping Cough	Rheumatic Fever	Scarlet Fever	Sickle Cell Anemia	Tonsillitis

ALLERGIC REACTIONS:

Food_____ Medications_____
Environmental_____ Other_____
Type of Reaction_____
Has your child ever been hospitalized? Yes____ No____ If yes, for what and when?_____

_____

Does your child take any medications regularly? Yes___ No___ If yes, for what and when?_____

_____

Is your child up to date on all his/her immunizations? Yes____ No____
Please give your doctor a copy of these records

FAMILY HISTORY: (Please check any areas that apply)

ILLNESS	MOTHER	FATHER	SIBLING	GRANDPARENT	OTHER
Alcohol Problems					
Allergies					
Anemia					
Asthma					
Bleeding Problems					
Convulsions					
Diabetes					
Ear/Hearing Problems					
Eczema					
Glaucoma					
Heart Problems					
High Blood Pressure					
HIV Infection					
Immune Problems					
Kidney Problems					
Lead Poisoning					
Mental Illness					
Stroke					
Tuberculosis					
Weight Problems					
Other (Please List)					

SOCIAL HISTORY: Please list everyone that lives in your home, their ages, and relationship to child.

NAME	AGE	RELATIONSHIP

Does anyone in your home smoke? ……	Yes	No
Are there any pets in your home?.....	Yes	No
Does your child always use a seat restraint in the car? ……	Yes	No
Does your child wear a helmet when riding his/her bicycle? ……	Yes	No
Do you live in an older home (old pipes)? ……	Yes	No
Does your child attend a child care center or babysitter? ……	Yes	No
Are there any problems such as peeling paint, mice, insects in your home? ……	Yes	No

PREFERRED PHARMACY LOCATION:

NAME:_____

ADDRESS: _____

TELEPHONE:_____

FAX: _____

Parent/Guarantor Information for **SCHOOLHOUSE ROAD PEDIATRICS**, Please complete the following:

Father's Name:	Home Phone:
Address:	Cell Phone:
City, State, Zip	DOB:
Email Address:	
Employer: Work Phone:	Marital Status:

I hereby consent to any treatment necessary, diagnostic tests and/or treatment for my child for whom I am legally responsible. The release of medical information to any insurance carrier for treatment and/or examination rendered is authorized. I hereby accept responsibility for payment of charges for medical services rendered. ***** A SERVICE CHARGE OF $10.00 WILL BE ADDED TO ACCOUNTS SENT TO COLLECTIONS.*****

Signature:	Date

Mother's Name:	Home Phone:
Address:	Cell Phone:
clty, State, Zip	DOB:
Email Address:	
Employer: Work Phone:	Marital Status:

I hereby consent to any treatment necessary, diagnostic tests and/or treatment for my child for whom I am legally responsible. The release of medical information to any insurance carrier for treatment and/or examination rendered is authorized. I hereby accept responsibility for payment of charges for medical services rendered. ***** A SERVICE CHARGE OF $10.00 WILL BE ADDED TO ACCOUNTS SENT TO COLLECTIONS.*****

Signature:	Date:

INSURANCE INFORMATION

**** Co-Payments <u>MUST</u> be made at the time of the visit or a $10.00 surcharge will be added****

Primary Insurance	ID#
Secondary Insurance	ID#

Children's Names	DOB

SCHOOLHOUSE ROAD PEDIATRIC ASSOCIATES, P.C.

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION AND FINANCIAL AGREEMENT

81 Schoolhouse Road
Albany, NY 12203
PH: 518-456-1211
Fax: 518-452-2535

11835 Rt. 9W, Suite 3
West Coxsackie, NY 12192
PH: 518-731-3800
Fax: 518-731-3838

Patient Name:_____ DOB: _____
Patient Personal Cell Number: (if over the age of 18) _____
Ethnicity (Latino, Non-Latino, Other):_____Primary Language_____
Race (Asian, Black, Hispanic, White, Other):_____

People/Organizations who may share information: (Please List)

_____ **School/College**: _____

_____ **Camps**: _____

_____ **Other:** _____

_____ **Relative (please list names)** _____

Please circle YES or NO to the information that you would or would NOT want released:

Yes / No	My Yearly Physicals (including for college)	**Yes / No**	Any Hospital Visits That I Have Had
Yes / No	My Immunizations	**Yes / No**	Gynecology Appointments (for females only)
Yes / No	My Med Consults	**Yes / No**	My Lab Work
Yes / No	My Sick Visits	**Yes / No**	Specialists (Urology, Psychiatrist, Dermatology…)
Yes / No	My Medication(s) I am Taking	**Other:**	_____

OR you may choose:

_____I do not wish to have ***any*** of my medical information to be given to anyone.

This authorization is valid for: (check one)

_____ This request only.

_____ One year from the date of this authorization **OR** _____ (insert date)

I hereby authorize the use and disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary and is revocable by me in writing, except to the extent that Schoolhouse Road Pediatrics has acted in reliance upon this authorization. My written revocation must be submitted to the Schoolhouse Road Privacy Officer at address listed above. Any health information disclosed by Schoolhouse Road Pediatrics pursuant to this authorization may be subject to re-disclosure by the recipients and may no longer be protected by the Federal HIPPA privacy regulations. Schoolhouse Road Pediatrics may not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this authorization. If you have Medicaid Fee for Service, not through a Managed Care Program, and you decide to receive care in our office, you agree that you are a private pay patient and we will render the service under this agreement. This means you will be responsible for the medical bill as we do not participate with the Medicaid Fee for Service Program.

_____ _____
Signature of Patient or Patient Representative — Today's Date

_____ _____
Printed name of Patient or Patient Representative — Relationship to Patient

SCHOOLHOUSE ROAD PEDIATRIC ASSOCIATES, P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ acknowledge that I have been notified of,
(Name of Patient)
and had the opportunity to receive a copy of Schoolhouse Road Pediatric Associates, P.C.'s *Notice of Privacy Practices.* This Notice describes how Schoolhouse Road Pediatric Associates, P.C may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____

(Signature of Patient, or Personal Representative) (Date)

_____

(Relationship to Patient)

SCHOOLHOUSE ROAD PEDIATRIC ASSOCIATES, P.C.

Financial Payment Policy

Schoolhouse Road Pediatrics requires payment at the time of your child's visit. We accept cash, checks or credit cards. For patients with insurance we ask that you pay the portion not covered by your insurance, such as co-payments and your deductibles, at the time of treatment.

It is your responsibility to notify us of any changes to your insurance. It is also your responsibility to notify your insurance company of any changes to your PCP.

If you have Medicaid Fee for Service, not through a Managed Care Program, and you decide to receive care in our office, you agree that you are a private pay patient and we will render the service under this agreement. This means you will be responsible for the medical bill as we do not participate with the Medicaid Fee for Service Program.

If you cannot pay the doctor's services at the time of treatment, then you must discuss this with our office prior to your appointment.

By signing below you are acknowledging your financial responsibility for any and all services rendered in our office.

Accepted and agreed:_____

(Signed by Parent or Legal Guardian)

Print Name of Patient(s):_____
(INCLUDE ALL SIBLINGS THAT COME TO OUR PRACTICE)

Patient(s)DOB:_____

Today's Date: _____