SHOREVIEW PEDIATRICS, S.C.

PATIENT REGISTRATION

DATE_____

Children's Full Names/Nickname if any Sex Date of Birth

_____

_____

_____

_____

_____

Live with: Both parents_____ Parent#1_____ Parent#2_____ Other_____

Parent #1 name: _____SS#_____ D.O.B_____ **SEX M or F**
Parent #1 address_____
City_____Zip_____Home phone_____ Cell phone_____
Work phone_____
Employer_____ Occupation_____

Parent #2 name: _____SS#_____D.O.B_____ **SEX M or F**
Parent #2_____
City_____Zip_____Home phone_____ Cell phone_____
Work phone_____
Employer_____ Occupation_____

Nearest friend/relative/ emergency contact_____
Phone number_____

Primary insurance _____Group#_____
ID#_____ Subscriber_____
Secondary insurance_____Group#_____
ID#_____ Subscriber_____

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I (Name of the insured/guardian)_____ hereby authorize my insurance company to pay and hereby assign directly to Shoreview Pediatrics, S.C. all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Shoreview Pediatrics, S.C. will be credited to my account, in accordance with the above said assignment.

X_____ _____/_____/_____
Authorized Signature of Subscriber Date

FINANCIAL/CREDIT POLICY

In compliance with the Federal Consumer Protection Act, Shoreview Pediatrics wishes to notify you of its policies regarding the financial responsibilities associated with services rendered to a member of your household/family.

1. Subscriber consents to covering all costs associated with out-of-network services including, but not limited to laboratory, imaging, specialists, emergency room/urgent care and therapy. Shoreview Pediatrics is not financially responsible.
2. All co-payments must be made at the time of service.
3. All accounts sent to collections will be charged a one-time 29% fee.
4. Notification of changes to your account including insurance company, phone numbers, and addresses must be given at the time of service.
5. We will furnish you with a monthly statement of your account.
6. If you are unable to pay your balance within 30 days of receipt of your statement call our office to arrange a payment program.
7. If we do not receive a request for a payment program within 30 days of the statement due date, and no payment has been made, a $25.00 late fee will be assessed.
8. We deem the financially responsible party as the parent or guardian bringing the child to our office and requesting service. This party is responsible forinsurance filing and insurance payment problems.
9. We do file all visits electronically to your current insurance plan.
10. We reserve the right to bill for extended telephone calls and electronic communication between patient and Shoreview staff.
11. We reserve the right to bill for an additional sick visit concurrent to the wellness visit if issues outside wellness care is discussed.

Payment of Services rendered:

1. You will be responsible for unpaid balances on your family account.
2. Cash, checks, MasterCard/Visa are options for payment. Extended payment programs are available to you if arranged and approved by our business office.

The undersigned hereby acknowledges to have read and agrees to the above FINANCIAL CREDIT POLICY of Shoreview Pediatrics, S.C.

Date:_____ Signed:_____
(Patient/Responsible Party)

Family name:_____

Patient Name (s):_____

_____

Shoreview Pediatrics, S.C.
Phone: 414-272-7009 Fax: 414-272-6261

Notice of Privacy Practices Acknowledgement of Receipt

I, _____, acknowledge that I have reviewed/received the
(Patient Name)
written Notice of Privacy Practices from Shoreview Pediatrics, S.C.

Signed_____Date_____
(Patient or legal representative or parent if under age 18)

Please indicate below how you would like Shoreview Pediatrics, S.C. to leave messages disclosing your protected health information.

_____ Home answering machine #_____

_____ Work phone #_____

_____ Cell phone #_____

_____ No messages should be left, speak with me directly.

The following is a family member, legal representative, or close friend I give permission to Shoreview Pediatrics, S.C. to disclose my protected health information with.

_____ _____
(Individual's Name) (Relationship)

_____ _____
(Individual's Name) (Relationship)

For Office Use Only:
Acknowledgment was unable to be obtained. Reason: _____
_____

_____ _____
(Employee Signature) (Date)

Wisconsin Immunization Registry
Organization: Shoreview Pediatrics, S.C. *Site:* SVP
Vaccine Administration Record

Information collected on this form will be used to document authorization for receipt of vaccines(s). Information may be shared through the Wisconsin Immunization Registry (WIR) with other health care providers directly involved with the patient to assure completion of the vaccine schedule. Information collected on this form is voluntary and the Social Security Number will be used by parent or guardian to access the Wisconsin Immunization Registry.

Patient's Name (Last, First, Middle Initial)	**CHART NUMBER**

Date of Birth (mm/dd/yyyy)	**Gender:** ❑ Male ❑ Female	**Ethnicity:** ❑ Hispanic ❑ Non-Hispanic
Race: (check one) ❑ African American ❑ Asian/ Pacific Islander ❑ Caucasian ❑ Hispanic ❑ American Indian/Alaska Native ❑ Other	**Mother's Maiden Name** (Last, First, Middle Initial)	

Check all that apply: ❑ Medicaid Eligible ❑ Native American ❑ Insured, Vaccines Not Covered ❑ Badger Care ❑ No Health Insurance ❑ Insured, Vaccines Covered

Name of Physician	**Insurance Provider**	**School or Day Care (if applicable)**	
Name of Parent or Guardian Responsible for Patient (Last, First, Middle Initial)		**Relationship to Patient**	
Address		**P.O. Box**	
City	**County**	**State**	**Zip Code**
Email address	**Home Telephone Number** ( )	**Work Telephone Number** ( )	**Extension**
Ok to share immunization data with WIR? ❑ Yes ❑ No	**Is reminder/recall contact allowed?** ❑ Yes ❑ No	**Would you like a reminder/recall sent to you?** ❑ Yes ❑ No	

I have been given a copy and have read, or have had explained to me, information about the disease(s) and vaccine(s) to be received. I have has a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine(s) be given to me or to the person named above for whom I am authorized to make this request.

SIGNATURE Person to receive vaccine or person authorized to sign on patient's behalf	**Date signed**
X	
X	
X	
X	
X	
X	
X	
X	
X	
X	
X	
X	
X	
X	

Initial History Questionnaire

FORM COMPLETED BY

DATE COMPLETED

Name

ID NUMBER

BIRTH DATE

AGE

M F

Household

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

Name	Relationship to child	Birth date	Health problems

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

What is the child's living situation if not with both biological parents?

☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody

☐ Lives with foster family

If one or both parents are not living in the home, how often does the child se the parent(s) not in the home?

Birth History ■ Don't know birth history

Birth weight _____ Was the baby born at term? _____ OR _____ weeks

Were there any prenatal or neonatal complications?

☐ Yes ☐ No Explain _____

Was a NICU stay required? ☐ Yes ☐ No Explain _____

During pregnancy, did mother

Use tobacco ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No

Use drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins

What _____ When _____

Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, why? _____

Was initial feeding ☐ Formula ☐ Breast milk How long breastfed? _____

Did your baby go home with mother from the hospital?

☐ Yes ☐ No Explain _____

General DK = don't know

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

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ DK Explain _____

Has your child had any surgery? ☐ Yes ☐ No ☐ DK Explain _____

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ DK Explain _____

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ DK Explain _____

Do you feel your family has enough to eat? ☐ Yes ☐ No ☐ DK Explain _____

Biological Family History DK = don't know

Have any family members had the following?

Childhood hearing loss	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Asthma	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tuberculosis	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Heart disease (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
High cholesterol/takes cholesterol medication	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Anemia	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bleeding disorder	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Dental decay	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Cancer (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

(Biological Family History continued on back sid

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Biological Family History *(Continued from front side.)* DK = don't know

Liver disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Kidney disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Diabetes (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bed-wetting (after 10 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Obesity	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Epilepsy or convulsions	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Alcohol abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Drug abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Mental illness/depression	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Developmental disability	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tobacco use	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

Additional family history _____

Past History DK = don't know

Does your child have, or has your child ever had,

Chickenpox	☐ Yes	☐ No	☐ DK	When _____
Frequent ear infections	☐ Yes	☐ No	☐ DK	Explain _____
Problems with ears or hearing	☐ Yes	☐ No	☐ DK	Explain _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Explain _____
Problems with eyes or vision	☐ Yes	☐ No	☐ DK	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	☐ DK	Explain _____
Any heart problem or heart murmur	☐ Yes	☐ No	☐ DK	Explain _____
Anemia or bleeding problem	☐ Yes	☐ No	☐ DK	Explain _____
Blood transfusion	☐ Yes	☐ No	☐ DK	Explain _____
HIV	☐ Yes	☐ No	☐ DK	Explain _____
Organ transplant	☐ Yes	☐ No	☐ DK	Explain _____
Malignancy/bone marrow transplant	☐ Yes	☐ No	☐ DK	Explain _____
Chemotherapy	☐ Yes	☐ No	☐ DK	Explain _____
Frequent abdominal pain	☐ Yes	☐ No	☐ DK	Explain _____
Constipation requiring doctor visits	☐ Yes	☐ No	☐ DK	Explain _____
Recurrent urinary tract infections and problems	☐ Yes	☐ No	☐ DK	Explain _____
Congenital cataracts/retinoblastoma	☐ Yes	☐ No	☐ DK	Explain _____
Metabolic/Genetic disorders	☐ Yes	☐ No	☐ DK	Explain _____
Cancer	☐ Yes	☐ No	☐ DK	Explain _____
Kidney disease or urologic malformations	☐ Yes	☐ No	☐ DK	Explain _____
Bed-wetting (after 5 years old)	☐ Yes	☐ No	☐ DK	Explain _____
Sleep problems; snoring	☐ Yes	☐ No	☐ DK	Explain _____
Chronic or recurrent skin problems (eg, acne, eczema)	☐ Yes	☐ No	☐ DK	Explain _____
Frequent headaches	☐ Yes	☐ No	☐ DK	Explain _____
Convulsions or other neurologic problems	☐ Yes	☐ No	☐ DK	Explain _____
Obesity	☐ Yes	☐ No	☐ DK	Explain _____
Diabetes	☐ Yes	☐ No	☐ DK	Explain _____
Thyroid or other endocrine problems	☐ Yes	☐ No	☐ DK	Explain _____
High blood pressure	☐ Yes	☐ No	☐ DK	Explain _____
History of serious injuries/fractures/concussions	☐ Yes	☐ No	☐ DK	Explain _____
Use of alcohol or drugs	☐ Yes	☐ No	☐ DK	Explain _____
Tobacco use	☐ Yes	☐ No	☐ DK	Explain _____
ADHD/anxiety/mood problems/depression	☐ Yes	☐ No	☐ DK	Explain _____
Developmental delay	☐ Yes	☐ No	☐ DK	Explain _____
Dental decay	☐ Yes	☐ No	☐ DK	Explain _____
History of family violence	☐ Yes	☐ No	☐ DK	Explain _____
Sexually transmitted infections	☐ Yes	☐ No	☐ DK	Explain _____
Pregnancy	☐ Yes	☐ No	☐ DK	Explain _____
(For girls) Problems with her periods	☐ Yes	☐ No	☐ DK	Explain _____

Has had first period ☐ Yes ☐ No Age of first period _____

Any other significant problem _____

This American Academy of Pediatrics Initial History Questionnaire is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 3rd Edition.

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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