GENERAL CONSENT & DEMOGRAPHIC INFORMATION FORM

Patient Name:_________________________________ DOB:______________

Parent Information:

Mother's information:	**Father's information:**
Name: ______________________ DOB:____________	Name: ______________________ DOB:____________
Maiden Name: _________________________________	
❍Cell Phone: _________________________________	❍Cell phone: _________________________________
❍Home Phone: ________________________________	❍Home Phone:_________________________________
❍Work Phone: ________________________________	❍Work Phone: ________________________________
❍E-mail: ____________________________________	❍E-mail: ____________________________________

Primary Caregiver(s): ❍Mother ❍Father ❍Both ❍Other: ______________________
Legal Guardian(s): ❍Mother ❍Father ❍Both ❍Other:

<u>Consent for preferred method of contact</u>: select below how you would like us to contact you with results (labs tests, Radiology testing, etc.) and clinical reminders (annual physical, vaccines due, follow up visits, etc.). **We recommend that you choose more than one method of communication so that we can reach you without delay:**

❍Phone:_____________________ ❍Text:_________________________ ❍E-Mail:______________________
❍Mail to address on record

Name: __________________________ Signature: ________________________ Date: _____________

Consent for others to bring your child to office

Please list below the persons whom you consent to bring the above named child to our office for sick and well visits, and whom you give authority to consent for any testing, treatment, evaluation and vaccines in your place:

Name	**Relationship to child**
_______________________________________	_______________________________________
_______________________________________	_______________________________________
_______________________________________	_______________________________________

Name: __________________________ Signature: ________________________ Date: __________

Prescription consent

I ❍Do ❍Do not give Brentwood Pediatric & Adolescent Associates, P.C. authorization to obtain all prescription history from any participating pharmacies for the above named child.

Name: __________________________ Signature: ________________________ Date: __________

Primary Care Provider selection:

Please select the provider you would like your child to have as their primary care provider*

❍Juan Espinoza, MD ❍Mayra Nadal, MD ❍Michael Lee, MD ❍Elizabeth Sill, CPNP

***Please be aware that we cannot guarantee that your child will be seen by the provider of your choice at every visit. We will do our best to comply with your choice of provider based on scheduling availability.**

BRENTWOOD PEDIATRIC & ADOLESCENT ASSOCIATES, P.C.

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

Patient Name: ________________________________ **DOB**: _____________________

1. FINANCIAL AGREEMENT & INSURANCE INFORMATION

I hereby agree to pay all charges due or that become due to the Practice for care and treatment provided to me (the patient) by the Practice. I understand the benefits, if any, paid by a third party on my (the patient's) behalf will be credited to my (the patient's) account and that I will be responsible for any remaining balance including any copayments, co-insurance sums (deductibles, etc.) or other fees required by insurer, HMO or other health benefit plan. I understand that if I have not provided the Practice with accurate and current information regarding my (the patient's) insurer, HMO or other health benefit plan (e.g., Medicare of Medicaid), which provides me (the patient) with health care coverage, I will be personally responsible for the cost of all care rendered to me (the patient) by the Practice.

2. ASSIGNMENT OF INSURANCE

I hereby assign, transfer and set over to the Practice all monies and/or benefits to which I (the pateint) may be entitled from government agencies, including Medicare and Medicaid programs, insurance carriers, HMOs or others who are financially liable for my (the patient's) hospitalization and/or medical care to cover the costs of the care and treatment rendered.

3. USE AND DISCLOSURE OF INFORMATION

I authorize the Practice, my treating physicians and their respective designees, to use and disclose my (the patient's) health information for all purposes necessary for treatment, payment, and health care operations, including but not limited to: release of information requested by my (the patient's) insurance company (or carrier) and any information necessary for discharge planning purposes.

4. UNDERSTANDING THIS FORM

I confirm that I have read and fully understand this form, and that all questions have been answered fully and to my satisfaction.

____________________________________ _____________________ ______________

Signature of Patient (or Responsibe Party) **(Relationship to Patient)** **Date**

____________________________________ ____

Signature of Interpreter (if required) **Print Name of Interpreter**

PATIENT SOCIAL & FAMILY HISTORY FORM

Patient Name:_______________________________________ DOB: _________________

In order to continue to provide the best medical care we can, we need to maintain our records with the most up-to-date information. Please answer the following questions as best you can:

About the family

What Medical conditions exist in the family ? check all that apply: For any entry marked "yes" indicate relation to patient (Example: sister, grandmother, uncle, etc.)							
Asthma	❍yes	❍no		Kidney problems	❍yes	❍no	
Diabetes	❍yes	❍no		Thyroid disease	❍yes	❍no	
High blood pressure	❍yes	❍no		Mental health or depression	❍yes	❍no	
High Cholesterol	❍yes	❍no		Substance abuse	❍yes	❍no	
Heart disease	❍yes	❍no		Cancer	❍yes	❍no	
Other :							

About the home

1.) **Does anyone at home have:** ❍ Hearing impairment ❍Vision impairment ❍Mental impairment ❍ None
If yes, who? ____

2.) **Is there any exposure to any of the following at or around the home (check all that apply):**

❍ Tobacco smoke ❍ Toxic chemicals/fumes ❍ Pets: _____________ ❍ Mold ❍ None

3.) **Does the patient/family participate in any of the following: (check all that apply)**

❍Church/Religious organization ❍Community organizations ❍sports/recreational activities ❍None

4.) **Are there any concerns about any of the following at or around the home (check all that apply):**

❍ Domestic Violence ❍ Verbal abuse ❍ Physical abuse ❍ Drug abuse ❍ Safety concerns ❍ None

5.) **We live in:** ❍Ground floor or above apartment ❍Basement apartment ❍Shared home

❍ Own home ❍ Shelter ❍ Other: ____

6.) **Who lives with the patient:** ❍Mother ❍Father ❍Brother ❍Sister ❍Other:_______________________________

7.) **Who do you rely on for emotional/financial support:** ❍Family ❍Friends ❍Government programs ❍None

8.) **Any concerns about:** ❍Transportation ❍Insurance ❍Nutrition help ❍Day care needs ❍Communication needs

9.) **Who are the people who care for this patient:** ❍ Mother ❍ Father ❍ Baby sitter

❍Day care center ❍ Other family (grandparent, aunt, etc.) ❍Other:________________________________

Patient Name:_______________________________________ DOB: _________________

About the patient

For New Patients:

Does the child take any medications on a regular basis?	❍ No	❍Yes
If yes, list any medications: ____		
Is the child allergic to any foods, environmental factors or medicines?	❍No	❍Yes
If yes, list any allergies: ____		
Does the child have any medical problems?	❍No	❍Yes
❍Asthma ❍Seizures ❍Heart condition ❍Other: ______________________________		
Has the child ever been seen by a specialist or had a special test done in the past?	❍No	❍Yes
If yes. Please specify:____		
Has the child ever been hospitalized?	❍No	❍Yes
If yes, please specify approximate date and reason:______________________________		
Has the child ever had any surgery?	❍No	❍Yes
If yes, please specify approximate date and reason:______________________________		

For Established patients:
Since the patient's last visit here:

Has the patient seen a specialist or another doctor since last visit here?	❍No	❍Yes
(please check below all that apply)		
❍Emergency room ❍Urgent care center ❍Specialist ❍Was hospitalized ❍Had surgery ❍Other:____		
Has the patient been prescribed any medication or treatment by another doctor outside of our office?	❍No	❍Yes
(IF YES, PLEASE BE SURE TO INFORM THE MEDICAL STAFF SO THE CHILD'S RECORD CAN BE UPDATED)		

Name of person providing information on this form: ______________________________

Relationship to child: ❍Mother ❍Father ❍Legal guardian ❍Foster parent ❍Other:________________

Signature: ______________________________ Date: ________________