BPC Patient Information Form

Date:

Patient Information:

Patient's Name: DOB: M F

Patient's Name: DOB: M F

Patient's Name: DOB: M F

Patient's Name: DOB: M F

Contact:

Primary Phone: Secondary Phone:

Address:

Primary email: Secondary email:

Parent/Guardian Information:

Parent/Guardian #1 Name:

Address (if different):

Home Phone:

Cell Phone:

Work Phone:

SS#:

DOB:

Employer:

Parent/Guardian #2 Name:

Address (if different):

Home Phone:

Cell Phone:

Work Phone:

SS#:

DOB:

Employer:

Insurance:

Primary Insurance Plan Name:

Policy Holder Name:

Policy #:

Group #:

Insurance Company Phone #:

Secondary Insurance Plan Name:

Policy Holder Name:

Policy #:

Group #:

Insurance Company Phone #:

Emergency Contact (other than parent):

Name: Phone #: Relationship to patient:

Name: Phone #: Relationship to patient:

BLOOMFIELD PEDIATRIC CARE
43205 Woodward Avenue
Bloomfield Hills, MI 48302
(248) 451-0600
Fax (248) 451-0700

FAMILY SAFETY CHECKLIST

	YES	NO
1. Our family buckles up on every car ride.	___	___
2. Our family wears bike helmets when bicycling.	___	___
3. Kids under 10 never cross streets alone.	___	___
4. Kids are always supervised in or near water.	___	___
5. Our home has working smoke and CO detectors.	___	___
6. Our water heaters are set no higher than 120 degrees to prevent scald burns.	___	___
7. If guns are in our home, they are kept unloaded and locked away.	___	___
8. Kids are protected against falls from windows, stairs, furniture and playground equipment.	___	___
9. Household cleaners, medicines and vitamins are stored out of young children's reach.	___	___
10. Our home has emergency numbers near telephones and first aid supplies.	___	___

_____

Parent Signature

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FINANCIAL AGREEMENT

1. Payment is due at the time of service. We accept cash, checks, and credit cards.

2. All co-payments, deductibles and non-covered services must be paid in full at the time of service.

3. A schedule of fees for our services is available at the reception desk. Our office will submit claims to your insurance company as a service to you. It is important that you know what your insurance plan covers. Services not covered by your insurance are your responsibility.

4. If your insurance company requires laboratory specimens to be sent to a specific lab, it is your responsibility to know the participating lab. Please make us aware before specimens are sent out.

5. If your insurance is a managed care plan, please review your coverage. If your child requires services that require a referral – adequate planning is essential. Referrals MUST be authorized by your primary care physician and require an office visit first in order to be evaluated. Authorization from managed care plans for your referrals may take one or more days. Please be aware that we are often unable to accommodate call in requests for same-day referrals. Upon receipt of a referral to a specialist or ancillary service it is your responsibility to be aware what has been authorized. Subsequent visits, procedures, surgeries and hospitalizations typically require additional referrals. Do not expect the referred specialist or service to obtain approval for these additional services, this is your responsibility. Failure to obtain necessary authorizations often lead to out of pocket expense. We are happy to assist you in any way with your managed care plan, however, our experience with these plans has demonstrated that planning and adequate lead time are essential. Your knowledge of your plans regulations and benefits as well as adequate planning will help to avoid delays and denied claims.

6. If you cannot provide adequate proof of insurance, you will be responsible for the entire visit at the time services are rendered.

7. In the case of estranged or divorced parents, the parent accompanying the child to the visit is responsible to pay for services rendered – regardless of coverage arrangements. We will gladly furnish you with necessary statements for reimbursement.

8. Your pediatrician is here to handle your child's medical care and well-being. The physicians are not experts on insurance and cannot be aware of all financial arrangements. Please discuss insurance problems and financial arrangements with the business office staff.

9. If you are experiencing financial difficulties, please discuss this with the business office staff. We will gladly work with you to make payment arrangements. Accounts over 90 days past due may be referred to a collection agency.

We sincerely appreciate your cooperation and are happy to assist you in any way we can.

Sincerely,

Maureen A. Kelly, M.D., and Staff

I understand and accept the above statements

_____ _____

Parent Signature Date

BLOOMFIELD PEDIATRIC CARE
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GENERAL HEALTH QUESTIONNAIRE

PATIENT'S NAME _____ D.O.B._____

A. HEALTH CARE STATUS

1. Where has your child gone for checkups until now? _____

2. What is the date of your child's last checkup? _____

3. What is the date of your child's last dental checkup? _____

4. Is your child under treatment now for an illness or medical condition? Yes No

   If yes, for what? _____

   With whom? _____

5. Has your child had allergic reactions to any medications, food or bee stings? Yes No

6. Has your child had reactions to any immunizations? Yes No

   If yes, please list: _____

7. Any hospitalizations other than birth? Yes No

   If yes, please list: _____

8. Does you chills take any medications regularly, including over the counter medications such as Tylenol or vitamins? Yes No

B. PREGNANCY AND BIRTH

1. Mother's age at birth of this child. _____

2. Did mother have any illnesses during this pregnancy? Yes No

3. Did mother use any medications other than vitamins / iron? Yes No

4. Was the baby born on time? Yes No

5. What was the baby's birth weight? _____

6. Did the baby have any trouble starting to breathe? Yes No

7. Did the baby have any trouble in the hospital? Yes No

   (Jaundice, infections, other?) What kind? _____

C. FAMILY HISTORY

1. Are the child's parents in good health? Yes No

2. Circle any diseases that this child's parents, grandparents, brothers, sisters, aunts, uncles have had:

Anemia Asthma Allergies AIDS Alcohol Problems Cancer Diabetes Tuberculosis High Blood Pressure Heart Trouble Drug Problems Mental Illness Inherited Illness

3. List general health, age and sex of brothers and sisters

_____

_____

4. Have any of your children died? Yes No

D. FEEDING AND NUTRITION

1. Is your child's appetite usually good? Yes No

2. Is it good now? Yes No

3. Was there severe colic or unusual feeding issues during first 3 months of life? Yes No

4. Do any foods disagree with your child? Yes No

5. Is/was your child **Breast** or **Bottle Fed** or **Both ?** (circle one)

6. If still on formula, which one do you use? _____

7. Does your child take vitamins? Yes No

If yes, please list: _____

E. REVIEW OF SYSTEMS

1. Has your child had frequent ear infections? Yes No

2. Has your child had any eye or vision problems? Yes No

3. Has your child had any problems with their teeth? Yes No

4. Does your child have frequent colds or sore throats? Yes No

5. is there asthma, pneumonia or a recurrent cough? Yes No

6. Does your child have a heart murmur or any heart problems? Yes No

7. Any problems with urination? Yes No

8. Any problems with diarrhea or constipation? Yes No

9. Have there been any convulsions or other problems with the nervous system? Yes No

10. Any eczema, hives or other skin conditions? Yes No

11. Has your child ever been anemic? Yes No

12. Please list any other medical problems _____

_____

F. DEVELOPMENT / BEHAVIOR

1. At what age did your child sit alone? _____

2. At what age did your child walk alone? _____

3. Did your child say any words by the time he / she was 1 ½ years old? Yes No

4. How does your child compare to other children his or her age?

_____

5. Does your child have trouble sleeping? Yes No

6. What grade is your child in? _____

7. Does your child get along with other children? Yes No

8. Circle if your child has any of the following:

Nail Biting Thumb Sucking Bed Wetting Problems with Toilet Training Bad Temper

Hyperactivity Nightmares Speech Problems Discipline Problems Other _____

G. SAFETY / ENVIRONMENT

1. Does the child ride in a car seat or always use a seat belt? Yes No

2. Do you live a private house, apartment, mobile home, other? (circle one)

3. Is your home regularly inspected for health hazards such as peeling paint,

insects, rats, or mice? Yes No

4. Do you forbid smoking in your house? Yes No

5. Have any of the child's caregivers been trained in CPR? Yes No

H. IMMUNIZATIONS

1. Do you have a record of vaccines that this child has received? Yes No

If yes, please give immunization record to nurse with this form.

LIST ANY OTHER QUESTIONS OR CONCERNS FOR THE DOCTOR

_____

_____

_____

NAME OF PERSON COMPLETING FORM: _____

RELATIONSHIP _____ DATE _____

PHYSICIANS SIGNATURE _____ DATE _____

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HIPAA AGREEMENT

In our quest to maintain your personal health information as confidential as possible and to meet the federal guidelines under HIPAA regulations, we have implemented the following authorizations.

(Please read and initial each statement)

I authorize the use of my child's personal health information to carry out treatment, payment, or health care operations.

_____

(initials)

I authorize the use of my child's personal health information in order to obtain medical reports from other physicians or hospitals (i.e., laboratory, radiology and outpatient procedures).

_____

(initials)

I authorize the use of my child's personal health information in order to have prescriptions called or e-scribed into my local pharmacy as needed for the treatment of my child.

_____

(initials)

- I may revoke consent in writing, except to the extent that Bloomfield Pediatric Care has taken action in reliance of the prior consent.

- I may request restrictions on the uses or disclosure of health information for the treatment, payment or health care operations.

- I may request to review Bloomfield Pediatric Care's privacy practice prior to signing this consent.

I have read and understand all of the above statements.

_____ _____

(parent/legal guardian signature) (date)

_____

(patient's legal name)

LEAD AND TB RISK FACTOR QUESTIONNAIRE

LEAD

Does your child live in or regularly visit a house built before 1960 with peeling or chipping paint?

This could include a day care, preschool, home of babysitter or relative, etc. Yes No

Does your child live in or regularly visit a house built before 1960 with recent, ongoing or planned renovation or remodeling? Yes No

Does your child have a brother or sister, housemate or playmate with lead poisoning?

Yes No

Does your child live near a busy street or highway?

Yes No

Does your child live with an adult whose job or hobby involves exposure to lead? (See examples below)

Yes No

OCCUPATIONAL AND HOBBY SOURCES OF LEAD POISONING

1. Storage batteries (lead batteries)
2. Plumbing fixture fitting and trim (brass goods)
3. Bridge, tunnel, and elevated highway construction
4. Automotive repair shops
5. Using firing ranges
6. Refinishing furniture
7. Making stained glass or pottery
8. Casting aluminum
9. Making fishing weights
10. Using lead solder
11. Using artists' paint that contain lead
12. Burning wood covered with lead-based paint

If you answered YES to any of these questions, your child is at risk for lead poisoning. The only way to know for sure is to have your child tested.

TB

Has your child had contact with and adult with TB? Yes No

Has your child been to, is from, or has had contact with persons from a region of the world with a high TB prevalence (Central and South America, Africa, Southeast Asia) or are the parents from one of these regions?

Yes No

Is your child HIV positive? Yes No

Does your child have a nanny or caretaker who is from an area with high TB prevalence (include inner city dwellers)? Yes No

Is your child in foster care? Yes No

Has your child had contact frequently with HIV infected individuals, homeless persons, IV/street drug users, poor and medically indigent city dwellers, nursing home residents, migrant farm workers, or a person who has been in prison within the past five years? Yes No