mt. sterling pediatrics

REGISTRATION FORM

Section I: Patient Information Date_____

Name:_____ Prefers to be called: _____

Address:_____City:_____State:_____Zip_____

Phone (_____)_____ Date of Birth:_____ Social Security Number:_____

Sex: Male / Female (Circle one) Sibling names:_____

Section II Guarantor

Relationship to Patient: ☐ Parent ☐ Guardian ☐ Other _____

Name:_____ SSN#: _____DOB:_____

Address:_____

City:_____ State:_____ Zip:_____ Phone: (____)_____

Employer_____ Work Phone (____)_____

The best time to contact me is:_____ ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone

Email Address_____ Would you like to receive our e-newsletter? ☐ Yes ☐ No

Other Parent Name:_____ SSN#: _____DOB:_____

Address:(If different from above)_____

City:_____ State:_____ Zip:_____ Phone: (____)_____

Employer_____ Work Phone (____)_____

Person to contact in case of emergency_____ Phone_____

Section III Insurance Information

Name of Insured_____DOB_____Relationship to Patient _____

SSN#:_____ Name of Employer:_____ Work Phone: (____)_____

Address of Employer:_____City_____State:_____Zip _____

Insurance Company_____ Grp #_____ ID#_____

DO YOU HAVE ANY ADDIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING

Name of Insured_____DOB_____Relationship to Patient _____

SSN#:_____ Name of Employer:_____ Work Phone: (____)_____

Address of Employer:_____City_____State:_____Zip _____

Insurance Company_____ Grp #_____ ID#_____

The above information is true to the best of my knowledge.

Name_____Signature_____Date_____

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P.O. Box 1347 ■ 260 Evans Ave. ■ Mt. Sterling, KY 40353 ■ ph: 859.498.5243 ■ fx: 859.498.5396

Initial History Questionnaire

Name

ID NUMBER

FORM COMPLETED BY

DATE COMPLETED

BIRTH DATE

AGE

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 and ages and where they live. _____

If mother and father are not living together or if child does not live with parents, what is the child's custody status? _____

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home? _____

Birth History

Birth weight _____

Was the baby born at term? _____ Early? _____ Late? _____

If early, how many weeks' gestation? _____

Did mother have any illness or problem with her pregnancy?
☐ Yes ☐ No Explain _____

During pregnancy, did mother
Smoke ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No
Use drugs or medications ☐ Yes ☐ No
What _____ When _____

Was the delivery ☐ Vaginal? ☐ Cesarean?

If cesarean, why? _____

Did your baby have any problems right after birth?
☐ Yes ☐ No Explain _____

Was initial feeding ☐ Breast? ☐ Bottle?

Did your baby go home with mother from the hospital?
☐ Yes ☐ No Explain _____

General

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

Does your child have any serious illness or medical condition? ☐ Yes ☐ No Explain _____

Has your child had serious injuries or accidents? ☐ Yes ☐ No Explain _____

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

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

Is your child allergic to any medicines or drugs? ☐ Yes ☐ No Explain _____

Development

Are you concerned about your child's physical development? ☐ Yes ☐ No Explain _____

Are you concerned about your child's mental or emotional development? ☐ Yes ☐ No Explain _____

Are you concerned about your child's attention span? ☐ Yes ☐ No Explain _____

If your child is in school:

How is his/her behavior in school? _____

Has he/she failed or repeated a grade in school? _____

How is he/she doing in academic subjects? _____

Is he/she in special or resource classes? _____

Family History

Have any family members had the following:

Deafness	☐ Yes	☐ No	Who _____	Comments _____
Nasal allergies	☐ Yes	☐ No	Who _____	Comments _____
Asthma	☐ Yes	☐ No	Who _____	Comments _____
Tuberculosis	☐ Yes	☐ No	Who _____	Comments _____
Heart disease (before 50 years old)	☐ Yes	☐ No	Who _____	Comments _____
High blood pressure (before 50 years old)	☐ Yes	☐ No	Who _____	Comments _____
High cholesterol	☐ Yes	☐ No	Who _____	Comments _____
Anemia	☐ Yes	☐ No	Who _____	Comments _____
Bleeding disorder	☐ Yes	☐ No	Who _____	Comments _____
Liver disease	☐ Yes	☐ No	Who _____	Comments _____
Kidney disease	☐ Yes	☐ No	Who _____	Comments _____
Diabetes (before 50 years old)	☐ Yes	☐ No	Who _____	Comments _____
Bed-wetting (after 10 years old)	☐ Yes	☐ No	Who _____	Comments _____
Epilepsy or convulsions	☐ Yes	☐ No	Who _____	Comments _____
Alcohol abuse	☐ Yes	☐ No	Who _____	Comments _____
Drug abuse	☐ Yes	☐ No	Who _____	Comments _____
Mental illness	☐ Yes	☐ No	Who _____	Comments _____
Mental retardation	☐ Yes	☐ No	Who _____	Comments _____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	Who _____	Comments _____

Additional family history _____

Past History

Does your child have, or has he/she ever had:

Chickenpox	☐ Yes	☐ No	When _____
Frequent ear infections	☐ Yes	☐ No	Explain _____
Problems with ears or hearing	☐ Yes	☐ No	Explain _____
Nasal allergies	☐ Yes	☐ No	Explain _____
Problems with eyes or vision	☐ Yes	☐ No	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	Explain _____
Any heart problem or heart murmur	☐ Yes	☐ No	Explain _____
Anemia or bleeding problem	☐ Yes	☐ No	Explain _____
Blood transfusion	☐ Yes	☐ No	Explain _____
Frequent abdominal pain	☐ Yes	☐ No	Explain _____
Constipation requiring doctor visits	☐ Yes	☐ No	Explain _____
Bladder or kidney infection	☐ Yes	☐ No	Explain _____
Bed-wetting (after 5 years old)	☐ Yes	☐ No	Explain _____
(For girls) Has she started her menstrual periods?	☐ Yes	☐ No	When _____
(For girls) Are there problems with her periods?	☐ Yes	☐ No	Explain _____
Any chronic or recurrent skin problem (acne, eczema, etc)	☐ Yes	☐ No	Explain _____
Frequent headaches	☐ Yes	☐ No	Explain _____
Convulsions or other neurologic problem	☐ Yes	☐ No	Explain _____
Diabetes	☐ Yes	☐ No	Explain _____
Thyroid or other endocrine problem	☐ Yes	☐ No	Explain _____
Any other significant problem	☐ Yes	☐ No	Explain _____
Use of alcohol or drugs	☐ Yes	☐ No	Explain _____

HE0328

Revised 0804
9,52JRep1708

mt. sterling pediatrics

Consent to Treat/ Medical Records/ Privacy

I, _____, the parent/legal guardian of the below named child(ren),

Name of Child	*Date of Birth*	*Sex*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

hereby authorize and consent to the examination and/or treatment of my child(ren) during office and facility visits by the physicians and clinical staff of Mt. Sterling Pediatrics. In addition, I give permission for the following person(s) to bring my child to MSP in my absence and to act in my behalf in authorizing medical care and treatment in my absence. In the event of emergency or other illness, I understand that the physicians and staff of MSP will deliver any medical care deemed necessary regardless of the accompanying adult. Unless we are notified in writing, MSP will assume that a child's biological &/or legal parents are both legal guardians who have access to treatment options and medical information for that child.

Name:_____Relationship:_____Phone #:_____
Name:_____Relationship:_____Phone #:_____
Name:_____Relationship:_____Phone #:_____

Medical Records/Privacy

We are committed to protecting the security and privacy of your child's personal information. Medical records are the property of MSP and are accessed for only purposes outlined by the *Notice of Privacy Practices*. Records may be released or shared with other health care providers for treatment of you child. Patients are entitled to one free copy of their medical records only after an authorization for release is signed.

☐ I have received a copy of the Notice of Privacy Practices from MT STERLING PEDIATRICS..

☐ I understand that MSP may call my home & place of employment for healthcare reasons, appointment reminders and to resolve billing issues.

☐ I understand that MSP may notify me of appointments or other pertinent information.

☐ I understand that MSP may fax immunization certificates, school excuses, physical/sports forms, and/or medication instructions to my personal or work fax, or may mail to my home. MSP *cannot fax or send these documents to third parties (schools, daycares, etc.) without a separate, signed authorization form.*

☐ I understand that MSP may leave messages on my answering machine regarding appointments and limited lab information.

☐ I understand that MSP may discuss patient information with adults or other minors present during thevisit.

☐ ***I understand and agree to all of the above unless I strike through one of the statements.***

_____ _____

Signature of Parent/Legal Guardian` Date

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mt. sterling pediatrics

Mt. Sterling Pediatrics, PSC

Office Policy

Thank you for choosing Mt. Sterling Pediatrics, PSC. Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. ***Please read each section carefully and initial.*** **If you have any questions, do not hesitate to ask a member of our staff.**

Appointments: **We value the time we have set aside to see and treat your child.** If you are not able to keep an appointment, we would appreciate 24-hour notice, we reserve the right to Charge $20 for a missed appointment.

If you are late for your appointment (>15 minutes), we will do our best to accommodate you However, on certain days it may be necessary to reschedule your appointment.

Three missed appointments are grounds for termination as a patient of Mt Sterling Pediatrics, PSC.

We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.

Initial: _____

Insurance Plans

Please understand

It is your responsibility to keep us updated with your correct insurance information **If the insurance company you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.**

If we are your primary care physician, make sure our name or phone number appears on your card If your insurance company has not yet been informed that we are your primary care physician, you may be financially responsible for your current visit.

It is your responsibility to understand your benefit plan with regard to, for instance, covered services and participating laboratories. For example

a Not all plans cover annual healthy (well) physicals, sports physicals, or hearing and vision screenings. If these are not covered, you will be responsible for payment.

b For children younger than 2 years, there is a limit as to the number of allowable well visits per year. If the number of visits is exceeded, your insurance company will not pay; you will be responsible for payment

It is your responsibility to know if a written referral or authorization is required to see specialists, whether preauthorization is required prior to a procedure, and what services are covered

Initial: _____

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Financial Responsibility

According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.

Co-payments are due at the time of service and are a contractual agreement between you and your insurance. Mt. Sterling Pediatrics is required to collect co-payments at the time of service. I understand that I am responsible for any balance not covered by my insurance.

As a reminder, a portion of the cost of your child's visit is determined by the time the physician spends with you and your child. If cost is a concern please keep this in mind.

Self-pay patients are expected to pay for services in FULL at the time of the visit.

If we do not participate in your insurance plan, payment in full is expected from you at the time of your visit. We will supply you with an invoice that you can submit to your insurance for reimbursement.

Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within **10** business days of your receipt of your bill.

If previous arrangements have *not* been made with our finance office, any account balance outstanding longer than 28 days will be charged a **$10 re-bill fee** for each 28-day cycle. Any balance outstanding longer than 90 days will be forwarded to a collection agency.

For scheduled appointments, prior balances must be paid prior to the visit.

We accept cash, checks, Visa, and MasterCard credit and debit.

A $25 fee will be charged for any checks returned for insufficient funds.

Initial: _____

Forms

At this time there is no charge for the completing of forms. **However,** should we deem this privilege is being abused we will charge $5 per form.
We require 3-day turnaround time. Payment is due when the forms are dropped off.

Initial: _____

Transfer of Records

If you transfer to another physician, we will provide a copy of your child's record, free of charge, as a courtesy to you. We need 48 hours' notice.

We provide records of your child for visits (including consultations from specialists) rendered here at Mt. Sterling Pediatrics only. For any previous records, you must request them directly from your previous doctor(s).

Initial: _____

Referrals

Advance notice is needed for all non-emergent referrals, typically 3 to 5 business days.

It is your responsibility to know if a selected specialist participates in your plan.

Remember, we must approve referrals before they are issued.

Initial: _____

Prescription Refills

For monthly medication refills, we require 48 hours' notice, during regular business hours. Please plan accordingly.

Initial: _____

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s)_____

Responsible Party Member's Name_____**Relationship**_____

Responsible Party Member's Signature _____ **Date**_____

On completion, we will provide you with a copy for your records.