New Patients Information Sheet

PATIENT'S NAME: **DOB:** **Age:**

Address: Home Telephone:

City, State & Zip: **Cell Phone:**

Insurance Company Name: **Mother's Name:**

Insured's Name? Insured's DOB: Mother's Employer:

Insured's Address: Group #: **Father's Name:**

ID Number: Father's Employer:

Do you have a Secondary Insurance?

Insurance Company Name:

Insured's Name?

Insured's Address: Insured's DOB:

ID Number: Group #:

PHARMACY PHONE NUMBER AND ADDRESS:

Email:

Race and Ethnicity question now required by CCHIT/CMS. Please circle below:

White, Black of African American, Asian, Hispanic or Latino; American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, Some other Race, Decline to disclose.

Main Reason for Today's Visit:

[ ] Sick Visit [ ] Well Visit

Problem(s):

Curent or Past Medical Problems:

Surgeries:

Hospitalization:

Medication Taken: [ ] None at all [ ] Listed Below:

Any Family health problems: (asthma, alleric rhinitis, diabetes, high blood pressure, ect)?

[ ] NO family medical problems

Mother: Father:

Siblings:

Maternal Grandmother/Father: Paternal Grandfather/Mother:

Allergies to Medication, food or latex?

What happens (rash, itching, swelling?

Immunization UP TO DATE:

Is your child's growth and development normal? If NOT explain your Concerns:

Authorization/Financial Responsibility/Privacy Policy

I acknowledge that I have finacial responsibility for payment of all services rendered even if I have health insurance. I am responsible for any charges. I accept resposibility for all cost incurred in my treatment. I authorize the release of any medical or other information necessary to process claims or bills. I also request payment of government benefits or commerical insurance to the paty that accepts assignment. I authorize payment of medical benefits to Linda Neely M.D. and or Good Health Pedicatrics & Wellness Clinic, LLC for services done.

PRIVACY POLICY: The most common reason why we use or disclose your health information is for treatment, payment, or health care operation. We may call or write to remind you of sheduled appointment or write to notify you of other treatment or "authorized form". The contserces available at out office. We will not make any other uses or disclosures of your health information unless you have sign a written ent of an "authorization form" is determine by federal law. I understand I may request to read the full text of our privacy policy at the time. I acknowledge that I have received notice of Good Health Pediatrics & Wellness Clinic, LLC Privacy Practices.

By signing this form, I am consenting to medical evaluation and office procedures and treatment and agreeing to office policies. I understand this authorization will remain in effect until I revoke it in writing.

Signature of Patient/Responsible Party Relationship to Patient Date