PEDIATRIC ASSOCIATES

Initial History Questionnaire

_____

Patient Name

_____ _____ _____ _____

Form Completed By | Date Completed | Patient Birth Date | Age

Household Information

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

Name	Relationship to Child	Birth Date	Health Problems	Occupation

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

_____

What is the child's custody status if the parents are not living together or if the child does not live with either parent? _____

_____

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

_____

Birth History

Birth weight: ____ Pounds ____ Ounces

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

If early, how many weeks gestation? ____ Weeks ____ Days

Did mother have any illness or problem with her pregnancy? Yes / No **If yes, explain:** _____

_____

During pregnancy, did mother:

Smoke? Yes / No **Drink Alcohol?** Yes / No

Use drugs or medications? Yes / No

What and when? _____

Was the delivery Vaginal? ____ Cesarean? ____

If cesarean, why? _____

Did your baby have any problems right after birth?

Yes / No

If yes, explain: _____

Was initial feeding Breast? ____ Bottle? ____

Did your baby go home with mother from hospital?

Yes / No

If 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 surgery? Yes ____ No ____ Explain: _____

Has your child ever been hospitalized? Yes ____ No ____ Explain: _____

Is your child allergic to any medications 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 resources 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 50yrs old)	Yes ____ No ____ Who _____ Comments: _____
High Blood Pressure (before 50yrs 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 50yrs old)	Yes ____ No ____ Who _____ Comments: _____
Bed-Wetting (after 10yrs 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: _____
Intellectual Disability	Yes ____ No ____ Who _____ Comments: _____
Immune Problems, HIV or AIDS	Yes ____ No ____ Who _____ Comments: _____
Eye problems in childhood (congenital cataract, glaucoma, strabismus, amblyopia)	Yes ____ No ____ Who _____ Comments: _____

Additional family history: _____

Past History

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

Chickenpox	Yes ____ No ____ Explain: _____
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 5yrs old)	Yes ____ No ____ Explain: _____
(For girls) Has she started her menstrual periods	Yes ____ No ____ Explain: _____
(For girls) Are there problems with her periods	Yes ____ No ____ Explain: _____
Any Chronic or Recurrent Skin Problem	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: _____

Pediatric Associates New Patient Intake Form

Thank you for choosing Pediatric Associates of Hampton and Portsmouth! To help us better serve you and your child, please provide us with the information requested below. Please bring completed form to the check-out window after your visit.

Patient Information:

Patient's Name: _____ Date of Birth: _____

Nickname: _____

Is the patient Hispanic or Latino? _____ Yes or _____ No

What is the patient's race? Check one or more:

_____ American Indian or Alaska Native _____ Asian

_____ Black or African American _____ Native Hawaiian or Other Pacific Islander

_____ White ____ Prefers Not to Answer

Parent Information:

Parent Name: _____ Phone Number:_____

Address: _____

Email Address: _____

Would you like to be signed up for our patient portal? _____ Yes _____ No

If you wish to sign up for the portal, your username will be your phone number.

Parent Name: _____ Phone Number:_____

Address: _____

Email Address: _____

Would you like to be signed up for our patient portal? _____ Yes _____ No

If you wish to sign up for the portal, your username will be your phone number.

Emergency Contact Name: _____ Phone Number: _____

Relationship to patient: _____

Does this individual have consent to bring your child to appointments and make medical decisions in your absence? ____Yes or _____No

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PEDIATRIC ASSOCIATES

What you can expect at an appointment

We want you and your child to be as comfortable as possible at each visit. One way we can do this is by minimizing surprise. Here is a brief description of a typical appointment so you can prepare yourself and your child for the visit.

We require that all our patients be accompanied by a parent or legal guardian to every appointment. In the event a parent or legal guardian is not able to accompany the child we will accept a written note with your contact number and signature allowing a friend or family member to authorize care for your child. Patients between the ages of 16-18 years may be seen unaccompanied by an adult with the parent's written permission. We must receive written permission prior to seeing your child.

All patients under the age of 16 years must be accompanied by an adult to be seen.

Arrival: Upon your arrival we will ask for your insurance card to verify your coverage (for returning patients we will offer you the opportunity to update your contact information). All copays and balances are due at the time of service.

Getting Started: After you and your child are called back to one of our exam rooms by one of our Nurses or Medical Assistants, your child will be weighed, and temperature taken.

Physicals: Depending on the age of your child, in addition to height and weight, we will evaluate hearing and vision and take a blood pressure reading. During the appointment your child will need to remove clothing down to underwear so that we may perform a thorough exam. If your child is particularly self-conscious, we are happy to provide a gown. For older children and teenagers, a gown will be provided. For patients 13 years and older, your physician may ask to be alone with your child to give them an opportunity to discuss any issues in confidence.

Vaccines: The most common question we get is whether there will be any vaccines at a check-up. Due to the extensive and complicated vaccine schedule our reception staff may not be able to provide you with accurate information. Therefore, we suggest that you prepare your child for the possibility of vaccines for every check-up.

Urgent and follow-up visits: Depending on the problem, your child may be asked to put on a gown. We understand that putting on a gown can be stressful for many kids but sometimes it is required. This can often be avoided by dressing your child in only one layer of loose-fitting clothing such as shorts or sweats.

Questions: You will be given enough time to ask any questions you may have. Take a few moments before the appointment to gather your thoughts and develop your questions for the doctor. We suggest you write down your questions, so you don't forget them. We are not able to discuss by phone what happened in the visit for the parent/guardian that does not attend the visit. Please be prepared to update family that is not present.

Credit and Financial Policy

In compliance with the Federal Consumer Protection Act, Pediatric Associates of Hampton and Portsmouth wishes to notify you of its policies regarding the financial responsibilities associated with services rendered to you or a member of your household/family.

Insurance: Co-Payments are due and payable at the time of check-in by whoever brings in the patient. As a courtesy to you, we will bill your insurance company, provided we have the correct billing information at the time of service. If a claim is denied because you have not provided correct information, the charges will transfer to your responsibility. You are financially responsible for charges deemed by the insurance company to be billable to the patient. You must be familiar with your coverage and any requirement for pre-authorization, deductibles and limitations on well child visits, lab services, immunizations, and other procedures.

Cash Account: If proof of insurance is not provided, your account will be considered a cash account and payment in full of all charges will be required at the time of service. If you provide verifiable insurance information, and the time frame for billing the insurance has not expired, we will bill the charges to your insurance company for you. If we then receive insurance payment, we will promptly issue a refund to you of any credit on your account. We give a 30% cash pay discount at time of service if uninsured.

Billing: The billing statement you receive will show patient balance due, in addition to insurance company payments and pending amounts. Patient balances are due from you upon receipt of the statement.

No-Show/Short-Notice Cancellation & Late Arrival to Appointment Policy: Patients arriving 10 or more minutes after their scheduled appointment time may need to be rescheduled to the next available time that is convenient for both the family and the provider. Missed appointments, cancellations with less than 24 hours' notice, and repeated late arrivals result in a fee, as outlined below. These policies help ensure timely care for all patients.

First Occurrence *per Family*: $25.00 Service Charge
Second Occurrence *per Family* within 12 months: $50 Service Charge
Third Occurrence *per Family* within 12 months: $100 Service Charge and possible Patient/Family Discharge

Returned Checks: There is a $25 returned check fee in the event a patient's personal check is returned to us for any reason.

The undersigned has read and agrees to the above financial credit and payment policies of Pediatric Associates of Hampton and Portsmouth.

Parent/Guardian Name Printed: _____ Date: _____

Parent/Guardian Signature: _____

Immunization Policy

Childhood immunization was one of the greatest advances in public health in the 20th century. It has saved millions of children and adults throughout the world from developing meningitis, encephalitis, brain damage, severe respiratory problems, poliomyelitis, paralysis, and other severe illnesses, which can require hospitalization or cause death. And to this day, childhood immunization remains a cornerstone of pediatric care and public health.

Immunizations are most effective when an entire community participates. In recent years, localized outbreaks of mumps, measles, whooping cough, and polio have occurred in the United States in communities with low vaccination rates. When you immunize your child, you are not only protecting your child from serious disease, but you are also helping to protect your entire family, your friends and your neighbors.

At Pediatric Associates of Hampton & Portsmouth we strongly believe in the importance of immunizations and fully support the childhood immunization schedule established by the American Academy of Pediatrics. Therefore, **our policy requires that every patient within our group receive the vaccinations listed below in the time frame indicated:**

Age 2 Weeks: first dose of Hepatitis B if not received in the hospital.

Age 2 Months (must be given by 3 months of age): Diphtheria, Tetanus and Pertussis (DTaP); Inactivated Polio Vaccine (IPV); Haemophilus Influenzae type B (Hib); Pneumococcal Conjugate Vaccine (PCV); Hepatitis B; Rotavirus. *Combination vaccines available*.

Age 4 Months (must be given by 5 months of age): DTaP, IPV, Hib, PCV, Rotavirus. *Combination vaccines available*.

Age 6 Months (must be given by 7 months of age): DTaP, IPV, Hib, PCV, Hepatitis B. *Combination vaccines available*.

Age 12 Months (must be given by 13 months of age): Measles, Mumps, and Rubella (MMR); Varicella Vaccine (Chicken Pox)

Age 15 Months (must be given by 16 months of age): DTaP, Hib, PCV.

Immunization Policy Continued...

Required by the age of 5 years:

A fifth dose of DTaP

A fourth dose of IPV

A second dose of MMR

A second dose of Varicella

Required for Preteens / Teens:

Tetanus, Diphtheria, Pertussis (TDaP): 1 dose at age 11 years

Meningococcal Vaccine: 2 doses at ages 11 and 16 years

In addition, we highly recommend (but do not require) the following vaccinations:

Hepatitis A: 2 doses, beginning at 12 months of age

HPV: 2 or 3 doses, eligible starting at age 9 years

Men B: 2 doses, age 16 and 17/18 years

Influenza Vaccination: 2 doses the first year if under age 9 years, otherwise 1 dose annually

COVID Vaccination: dosing regimens vary by age and manufacturer

We are aware of the concerns about vaccine safety that has been voiced by a **very small** yet vocal community. These claims have no scientific or statistical basis. To date, there have been over 30 scientific studies, which have proven, conclusively, that vaccines are safe.

By signing, I agree to follow Pediatric Associates of Hampton and Portsmouth's policy to fully immunize my child(ren).

Parent/Guardian Name Printed: _____ Date: _____

Parent/Guardian Signature: _____

Patient HIPAA Awareness

With my permission, Pediatric Associates may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Pediatric Associates' Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Pediatric Associates reserves the right to revise its Notice of Privacy Practices and a revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer anytime.

With my permission, the office of Pediatric Associates may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

I have the right to request that Pediatric Associates restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing Pediatric Associates to use and disclose my PHI for TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Parent/Guardian Name Printed: _____ Date: _____

Parent/Guardian Signature: _____