Patient Registration Form (Please use clear legible print)

ALL FIELDS ARE REQUIRED

Patient Information: (Please use full legal name, no nicknames)

First Name _____**MI** ___**Last Name**:_____
Birth date:_____ **Gender:** (circle one) Male Female
Age:_____ **Social Security** #:_____
Home Street Address:_____
City:_____ **State**:_____ **Zip Code**:_____
Race (circle one): Am. Indian/AK Native Asian Black or African American
Prefers not to answer White Native Hawaiian/Pacific IS
Ethnicity (circle one): Hispanic or Latino Not Hispanic or Latino Prefers not to say
Preferred Language:_____
Religion/Spirituality/Faith:_____
Smoking Status (patients 13 years and older):
___Current every day smoker
___Current some day smoker
___Former smoker
___Never smoker
___Smoker, Current status unknown
___Unknown if ever smoked
Pharmacy Name: _____ **Pharm Number**:_____
Allergies to Medication:_____

Parent/Guardian Information:

Mother First Name: _____**MI** ___**Last Name**:_____
Birth date:_____ **Social Security** #:_____
Address(if differs from patient)_____
Occupation:_____**Employer**:_____
Cell Phone #:_____ **Home Phone**#:_____
Work Phone #: _____
Email Address:_____
Highest Education Completed:_____

Father First Name: _____**MI** ___**Last Name**:_____
Birth date:_____ **Social Security** #:_____
Address(if differs from patient)_____
Occupation:_____**Employer**:_____
Cell Phone #:_____ **Home Phone** #:_____
Work Phone#:_____
Email Address:_____
Highest Education Completed:_____
Parent's relationship status (circle one): Married Divorced Separated Never Married
If parents are separated /divorced, who has legal custody of the child?_____
Emergency Contact:
Contact Name:_____ **Relationship to Patient**:_____
Cell Phone #:_____ **Home Phone** #:_____
Work Phone #:_____
Do we have permission to contact them in an emergency and leave messages if necessary?
Yes_____ No_____

The above information is true to the best of my knowledge
Signature: _____ Date: _____
Print: _____

Patients Name:_____ **Date**: _____

Insurance and Billing Information:

Patients Primary Care Physician: _____

Primary Health Insurance:_____
ID# _____**Effective Date**:_____
Subscriber Name:_____ **Subscriber DOB**:_____

Secondary Health Insurance*:*_____
ID# _____**Effective Date**:_____
Subscriber Name:_____ **Subscriber DOB**:_____

Your insurance card(s) are required to be presented at every office visit.

Assignment of Insurance Benefits:
I hereby authorize direct payment of my insurance benefits to Pediatrics Day and Night for services rendered to my dependents by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services my child receives are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance that Pediatrics Day and Night is unable to collect from my insurance carrier for whatever reason. _____ **Initial**

Authorization to Mail, Call, or Email:
I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a Pediatrics Day and Night representative or my physician to mail, call, or e-mail me with communications regarding my child's healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. _____**Initial**

Authorization to release non-public personal information:
With my consent, Pediatrics Day and Night may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). I authorize Pediatrics Day and Night or the physician individually to release any of my child's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Pediatrics Day and Night may decline to provide treatment to me. I may request a copy of Pediatrics Day and Night's privacy policy at any time.
_____**Initial**

Consent to Treatment:
I hereby consent to evaluation, testing, vaccines, and treatment as directed by my Pediatrics Day and Night physician(s) or his or her designee.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Print: _____

Patients Name:_____ **Date**: _____

My Name (adult completing form) _____

BIRTH

Birth Weight _____
Was the baby full term? Yes No
How many weeks early/late? _____
Did mom use alcohol/drugs during pregnancy? Yes No If yes, List _____
Did you have a (circle one) Vaginal C-section delivery?
Did the baby stay in NICU? Yes No If yes, for how long? _____
Did the baby go home with mom? Yes No
Did mom have problems during pregnancy? Yes No
If yes, list _____

Is your child up to date on their vaccines? Yes No Not Sure
Where has your child gotten vaccines? _____
Has your child been diagnosed with any medical problems? Yes No _____
_____

Has your child been hospitalized since birth? Yes No List _____
Has your child had surgery? Yes No List _____
Has your child had any serious accidents? Yes No List _____
Is your child **allergic** to medication? Yes No List _____
Is your child **allergic** to bee stings or foods? Yes No List _____
Does your child take any prescription medicines regularly? Yes No
List _____
Does your child see any special doctor's (CHOP, St. Chris., RWJ@ NB, etc..)? Yes No
List _____

Does your child have?
Developmental problems? Yes No _____
Asthma? Yes No _____
Seasonal Allergies? Yes No _____
Diabetes? Yes No _____
Problems seeing? Yes No _____
Problems hearing? Yes No _____
Heart murmur/problem? Yes No _____
Bladder/kidney infections? Yes No _____
Epilepsy/seizures? Yes No _____
(Girls) Started periods? Yes No When _____
(Girls) Period problems? Yes No Describe _____

Do you have any concerns about how your child is doing in school? Yes No
Describe _____

Patients Name: _____ Date: _____

FAMILY HISTORY

Do any family members (blood relatives) have: (list relative and medical problem)

Asthma? Yes No _____
Tuberculosis? Yes No _____
Sickle Cell? Yes No _____
Cystic fibrosis? Yes No _____
Seasonal allergies? Yes No _____
Cancer? Yes No _____
Heart Disease (<50yrs) Yes No _____
Heart Arrhythmia? Yes No _____
High Blood Pressure? Yes No _____
High Cholesterol? Yes No _____
Diabetes (<50yrs) Yes No _____
Seizures or epilepsy? Yes No _____
Kidney disease? Yes No _____
Liver disease? Yes No _____
Depression? Yes No _____
Anxiety? Yes No _____
Bipolar? Yes No _____
ADHD? Yes No _____
Mental retardation? Yes No _____
Thyroid problems? Yes No _____
Deafness? Yes No _____
Anemia? Yes No _____
Bleeding problems? Yes No _____
Alcohol abuse? Yes No _____
Drug Abuse? Yes No _____
Immune prob/HIV/AIDS? Yes No _____
Unexplained death? Yes No _____

Any other family history you would like us to know about?

_____
_____
_____

Please list those who live in the same home as the child

Name Relationship Age Health Problems

_____
_____
_____
_____
_____
_____
_____
_____

Does anyone in the household smoke tobacco? Yes No List _____

Pediatrics Day and Night
will now require a
Federally Approved Picture Identification
to be presented at every office visit.

A consent form must be filled out and signed by the mother or father in the event neither parent is available at the time of the visit.

If the picture ID presented at the time of service does not match the person(s) listed on this consent form, a letter must be provided from the parent stating they are permitting us to treat the child with the adult present.

Consent Form:

Patients Name: _____ Date of Birth:_____

Pediatrics Day and Night may treat the above named patient when accompanied by the following adults. Please provide us with the first and last name, so we may verify against their ID.

Mother **(Name Required)**	
Father **(Name Required)**	
Step Mother	
Step Father	
Grandmother	
Grandfather	
Sister	
Brother	
Aunt	
Uncle	
Foster Parent	
Other (specify relationship)	

Signature:_____ Date: _____
Print:_____
Relationship to Patient: (circle one) mother/father

(ema)

Pediatrics Day & Night
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 Pediatrics Day & Night 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:**

By 18 months of age, your child will receive the following:

Type of Immunization

Hepatitis B: 3 doses
Diptheria, Tetnus and Pertussis (DTaP): 4 doses
Inactivated Polio Vaccine (IPV): 3 doses
Haemophilus influenza (HIB): 4 doses
Pneumococcal conjugate vaccine (Prevnar): 4 doses
Varicella vaccine (Chicken Pox): 1 dose
Measles, Mumps and Rubella(MMR): 1 dose
Hepatitis A: 2 doses, beginning at 18 months of age

By the age of 5 years your child will receive these additional vaccines:

A fifth dose of **DTaP**
A fourth dose of **IPV**
A second dose of **MMR**
A second dose of **Varicella (Chicken Pox)**

For Preteen/Teens: 1 dose of **MeningococcalVaccine**, and 1 dose of **Tetanus, Diphtheria, Pertussis (TdaP)**.

In addition, we highly recommend (but do not require) the following vaccinations:
Influenza vaccine: 2 doses first year received and 1 dose annually; 3 doses of **HPV vaccine** (**Gardasil)**

We are aware of the concerns about vaccine safety that has been voiced by a small minority. 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 Pediatrics Day & Night's policy to fully immunize my child by 18 months:

_____ _____
Patient Name Printed Name of Parent or Guardian

_____ _____ _____
Patient Date of Birth Date Signed Signature of Parent or Guardian

Pediatrics Day & Night

WELL CHILD VISIT POLICY

THERE IS NO SUCH THING AS A FREE WELL VISIT, despite what your insurance company advertised to you.

- The Affordable Care Act (ACA) legislated that insurance companies cannot charge co-pay for **preventive services**.
- Your visit is charged and submitted to you or your insurance company exactly as it was before the ACA was passed. The difference now is that your insurance company has to pay for all the preventive services and cannot pass co-pay on to you.
- **Insurance companies ARE allowed to charge co-pay to you for services that they consider not preventive.**
- Examples of services that may be provided on the day of your well visit that **are NOT preventive services:**
  - Evaluation and treatment or discussion and management of an illness (like an ear infection, cough, sore throat,etc…)
  - Evaluation and treatment or discussion and management of a chronic problem (like eczema, asthma, headaches, abdominal pain, ADHD, etc…)
  - Procedures that are not part of the routine recommended preventative/well child visit (like draining an abscess or removing impacted ear wax, strep tests, nebulizer treatment, urine dip, pregnancy urine test, etc...)
  - Any services that the insurance company says are not preventative.

If non-preventive services are provided to a patient, we are legally REQUIRED to report those services to your insurance company.

YOUR INSURANCE COMPANY DETERMINES WHETHER OR NOT YOU OWE A CO-PAY once they review the services provided.

If your insurance determines that you owe co-pay**,** we are required to collect it.

If you receive a bill from us for co-pay for the date of your well visit, then that means a non-preventive service was provided to you on that date or your plan did not cover the preventive service at 100%. It is the **INSURANCE COMPANY** who will determine that requirement. You may dispute this with your insurance but the office cannot resubmit the charges.

Pediatrics Day & Night is dedicated to the health and wellbeing of your child. We are more than happy to address ongoing issues during well visits as long as you understand that co-pay may be billed at a later time. We are required to follow the contracts dictated by the insurance company. Please be understanding of this situation.

I have read and understand the above and I understand I may be responsible for co-pay as dictated by the insurance company and their terms for preventive and non-preventive services provided during the well child visit.

_____

Signature of Patient or legal representative Relationship to Patient Date

Pediatrics Day & Night

NO SHOW / CANCELLATION POLICY

Dear parent,

Your child's health is very important to us and it is our goal to provide you with outstanding service. This however requires your cooperation. Keeping your appointment is essential for your child's health. It is also vital for the smooth operation of the office.

Unfortunately we have been experiencing a 25% no show rate at our office on some days! This means that 1/4 of the appointments that are made are not kept, and the office is not notified! This can lead to poor compliance to treatment and can hurt your child. This also leads to disruptions of the schedule. Other patients that really need an appointment that day sometimes cannot be seen, because it looks like we have a full schedule, but then some do not show…

This policy intends to correct this problem so we can provide you with the high quality service you deserve.

We make it our responsibility to call you at least 1 day prior to confirm the date and time of your appointment. If you do not cancel your appointment in a reasonable amount of time (i.e. 24-hrs when scheduled in advance, or at least 2 hours prior when scheduled the same day) and simply fail to show up, the following will apply.

a. A $25 fee will be charged for each missed appointment
b. Patients with Medicaid plans for which we cannot charge no show fees will be dismissed after the 3rd no show
c. Patients who No-show a double appointment: (bringing in 2 children at the same time), will be restricted from scheduling double appointments in the future.

Please, remember that all you have to do, if you cannot keep an appointment, is to **CALL and CANCEL!**

Thank you for your understanding and support.

I have read this form in its entirety:

_____ _____

Patient Name Printed Name of Parent or Guardian

_____ _____ _____

Patient Date of Birth Date Signed Signature or Parent or Guardian

My Kids Chart Patient Portal Sign Up

Sign up is Optional and not required

Pediatrics Day and Night now has a patient portal to view your child's records (including but not limited to; shot records, vitals, and upcoming appointments). **The office policy is that we can ONLY allow 2 Users per patient, (mother and father only unless other legal custody documentation is provided to our office).** Please complete the form below and you will be sent an email with your login information within 72 hours. **Please print legibly** so information may be entered correctly. Please be advised that the records are only available starting from June 2013.

Please be advised if a child is 18 years of age or older, we cannot allow portal access to anyone other than the patient themselves.

Form Completed by: _____ Date: _____

Patients Name and **Date of Birth (Both are required):**

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____

1) **(Required) Name of User (First and Last Name): _____**
   Email Address (required): _____
   Telephone Number: _____
   Relationship to patient: Self Mother Father Legal Guardian (complete a&b below)

   If Legal Guardian was circled above, please list your relationship to patient and attach legal documentation of custody, otherwise we will be unable to add user to the portal:
   a) Relationship (complete only if legal guardian is circled above): _____
   b) Documentation provided (required): YES NO

2) **(Optional) Name of User (First and Last Name): _____**
   Email Address: _____
   (Email address must differ from above email address)
   Telephone Number: _____
   Relationship to patient: Self Mother Father Legal Guardian (complete a&b below)

   If Legal Guardian was circled above, please list your relationship to patient and attach legal documentation of custody, otherwise we will be unable to add user to the portal:
   a) Relationship (complete only if legal guardian is circled above) : _____ ____
   b) Documentation provided (required): YES NO

www.mykidschart.com/pbn

(ema 6/2/15)

Please complete form if the following applies:

_____ Patient is a newborn (0-2 months of age)

_____ Patient does not have active health insurance for the date of service

_____ Patients Primary Care Physician is someone other than Pediatrics Day and Night

I hereby allow Pediatrics Day and Night physicians and or clinical staff to see my child today. I am aware that it is my responsibility to pay for today's visit in full at the time of service due to one or more of the following;

1) My insurance plan benefits are not active for today's date
2) My insurance plan does not have Pediatrics Day and Night listed as my child's primary care physician on the date that the eligibility was checked
3) My insurance plan is not one that Pediatrics Day and Night participates with.

I am aware that if I have applied for Medicaid and/or NJ Family Care health benefits and I have not received my insurance cards for my child as of today, that I will be responsible to pay for today's visit in full **IF one or more of the following applies**;

1) My insurance benefits are not retro-active back to today's date
2) Pediatrics Day and Night is not listed as my child's primary care physician when my policy was retro-active back to today's date
3) The HMO that was chosen for my child is not one that Pediatrics Day and Night participates with, when my policy was retro–active back to today's date
4) Benefits are not retro-active back within 60 days from the newborn's date of birth

By signing below, I am responsible for all charges including but not limited to physicals, office visits or consults, vaccinations, administration of vaccinations, strep tests, urine tests, nebulizer treatments, etc.

I am aware that Pediatrics Day and Night will not be able to submit a claim on behalf of my child unless my insurance benefits have been retro-active back to the date of service, and my child's primary care physician has been selected and made effective from today's visit. If my NJ Family Care HMO policy has been retro-active back to today's date and Pediatrics Day and Night does not accept the HMO that was chosen for my child, I am aware that the claims will not be submitted to my plan and I will be responsible for the payment in full.

I have read this form in its entirety and I fully understand that I am responsible for payment to Pediatrics Day and Night for todays visit:

Patient/Child's Name (please print): _____

Parent/Guardian Name (please print): _____

Parent/Guardian Signature: _____Date: _____