BETHESDA PEDIATRICS

PATIENT INFORMATION SHEET

2175 N. Alma School Rd. Ste. C104 – Chandler, AZ

Today's Date: _____ / _____ / _____ **REVISED DATE** _____ / _____ / _____

Child's Name: _____ **DOB:** _____ **Sex:** ___ M ___ F
Last First Middle

SSN#: __ __ __ - __ __ - __ __ __ __ **Patient's Insurance ID#:** _____ **Grp #:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Secondary Phone:** _____ **Email Address:** _____

HOW DID YOU HEAR ABOUT OUR CLINIC? _____

Name of Child's Previous Doctor: _____ **Phone #:** _____ **Fax #:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Mother's Name (who is legal guardian): _____
Last First Middle

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

DOB: _____ **SSN#:** __ __ __ - __ __ - __ __ __ __ **Phone:** _____ **Cellphone:** _____

Marital Status: Single Married Widowed Divorced **Are you the Listed insurance subscriber for this patient:** ___ **Y** ___ **N**

Employer: _____ **Occupation:** _____ **E-Mail:** _____

Work Phone: _____ **Cellular Phone:** _____

Insurance Company's Name: _____ **Group:** _____ **ID:** _____

Father's Name (who is legal guardian): _____
Last First Middle

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

DOB: _____ **SSN#:** __ __ __ - __ __ - __ __ __ __ **Phone:** _____ **Cellphone:** _____

Marital Status: Single Married Widowed Divorced **Are you the Listed insurance subscriber for this patient:** ___ **Y** ___ **N**

Employer: _____ **Occupation:** _____ **E-Mail:** _____

Work Phone: _____ **Cellular Phone:** _____

Insurance Company's Name: _____ **Group:** _____ **ID:** _____

Emergency Contact: _____ **Relationship to child:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____ **Phone:** _____

Name of Person completing form: _____ **Relationship to child:** _____

Signature of Parent/Legal Guardian: _____ **Date:** _____

Please complete both sides

Revised: 06-2014

BETHESDA PEDIATRICS

Kelly Hughes, D.O Eric Nyman, M.D. Sara Emerick, M.D.
2175 N. Alma School Rd Ste C104 – Chandler, AZ 85224

Release of Protected Health Information

For Billing/Medical Claims Purposes

I _____ authorize **ASSIGNMENT OF BENEFITS** from any and all insurance payable for
(name of parent/responsible party)
Medical care rendered to my child. **Photocopies** are valid as originals. **I authorize release of my PROTECTED HEALTH INFORMATION** required by insurance carriers to **BETHESDA PEDIATRICS/AINSWORTH CONSULTING GRP, LLC** for purposes of submitting claims and collecting payment. If any proceedings or actions shall be brought against me to recover any outstanding balance, the undersigned agrees to pay all costs and expenses acquired including reasonable attorney's fees. I understand by signing this physical form I am giving permission for the Practice for electronic signatures when sending, rebilling and any claim related activity.

I am aware of the **Notice of Privacy Practices** which has been given to me or posted with the office for my review. I further understand that I can request that my **Protected Health Information** be limited by requesting so in writing to the Privacy office. I understand that this authorization meets the needs of HIPAA (Health Insurance Portability and Accountability Act) guidelines set forth by the Federal government in regards to patient confidentiality.

_____ _____

Parent/Guardian/Responsible Party's Signature **Date**

Consent For Treatment

I _____, give permission to **BETHESDA PEDIATRICS**
(name of parent/guardian/responsible party)
(Eric Nyman M.D, Dr. Kelly Hughes & any covering Provider) to care for and treat my child. I understand that my child cannot be treated without my presence unless I've given written consent to an adult **OVER THE AGE OF 18** to seek such care or treatment.

In my absence the following adults **OVER THE AGE OF 18** may seek medical attention for my minor child:

Name: _____ **Relationship to Child:** _____

Name: _____ **Relationship to Child:** _____

Name: _____ **Relationship to Child:** _____

I may be reached at the following phone number to discuss my child's care and/or treatment:

(_____) _____ - _____

_____ _____

Parent/Guardian/Responsible Party's Signature **Date**

Received By (BETHESDA PEDIATRICS): _____

Revised 06-27-2014

BETHESDA PEDIATRICS

2175 N. Alma School Rd Ste C-104 Chandler, Arizona 85224 480.222.6770 (P) 480.222. 6771 (F)

Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including most AHCCCS. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 60 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Missed appointments. Our policy is to charge for missed appointments not canceled within 24 hours prior to your scheduled appointments. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **Date**

BETHESDA PEDIATRICS
Kelly Hughes, D.O. Eric B. Nyman, D

Patient Questionnaire

Child's Name: _____ DOB: _____

PREGNANCY & BIRTH:
Mother's Age at pregnancy: _____
Any illness during pregnancy? ___ Y ___ N
If yes, explain: _____
Medications during pregnancy: (excl. vitamins & iron)
Smoking/Alcohol/Street Drugs during pregnancy?
___ Y ___ N If yes, explain: _____
Was baby early – late – on time? _____
Type of Delivery? _____
Birth Weight: _____ Length: _____
Hospital/Place of Delivery: _____
Complications: ___ Y ___ N
If yes, explain: _____
Problems with baby at birth:
Breathing? ___ Y ___ N Jaundice? ___ Y ___ N
Other: _____

PAST MEDICAL HISTORY:
Allergic Reactions:
Medicine: ___ Y ___ N
If yes, explain: _____
Animals: ___ Y ___ N
If yes, explain: _____
Insect Bites: ___ Y ___ N
If yes, explain: _____
Other allergies (please explain): _____
Immunizations – up-to-date? ___ Y ___ N
Hospitalizations (when-where-why?): _____
Serious Injuries (when-where?): _____
Measles: ___ Y ___ N Mumps: ___ Y ___ N
Chicken Pox: ___ Y ___ N
Whooping Cough: ___ Y ___ N Asthma: ___ Y ___ N
Eczema: ___ Y ___ N Anemia: ___ Y ___ N
Seizures: ___ Y ___ N
Recurrent Infections? (3 or more)
Ear: ___ Y ___ N Throat: ___ Y ___ N Eye: ___ Y ___ N
Problems with:
Hearing: ___ Y ___ N Vision: ___ Y ___ N

Name of Person completing Questionnaire

Signature of Person completing Questionnaire

FEEDING & NUTRITION:
Food Allergies: _____
Appetite usually good? ___ Y ___ N
Colic or feeding problems during the first 3 mos? Y / N
Breast Fed? Y / N Number of Months: _____
Formula? Y / N Brand: _____
Vitamins? Y / N
Special Diet? Y / N explain? _____

FAMILY PROFILE:
Father's Age: _____ Highest School Grade: _____
Mother's Age: _____ Highest School Grade: _____
List child's siblings & ages:

FAMILY MEDICAL HISTORY:
Anemia/Blood Disorder: Y / N
Asthma: Y / N
Mental Retardation: Y / N
High Blood Pressure: Y / N
Cholesterol Problem: Y / N
Cancer: Y / N
Sudden Infant Death: Y / N
Cystic Fibrosis: Y / N
Diabetes: Y/ N
Tuberculosis: Y / N
Depression: Y / N
Epilepsy/Seizures: Y / N
Heart Disease: Y / N
Drug Problem: Y / N
Alcoholism: Y / N
Migraine: Y / N
Birth Defects: Y / N
AIDS: Y / N
Birth Defects: Y / N
Musc. Dystrophy: Y / N
Arthritis: Y / N
Psychiatric Prob: Y / N

DEVELOPMENT & BEHAVIOR:
Age when: Sat Alone: _____ Walked: _____
Toilet Trained: _____ Bicycled: _____
Development compared to other children?
behind / similar / advanced
Learning problems? Y / N If yes, explain: _____
Behavior problems? Y / N If yes, explain: _____
Bedwetting Problems? Y / N Sleeping Problems? Y / N
Hobbies/Sports/Social Activities: _____

Relationship to Child

Today's Date

PLEASE COMPLETE BOTH SIDES OF THIS FORM

BETHESDA PEDIATRICS
2175 N. Alma School Rd Ste C104 – Chandler, AZ 85224
480.222.6770 (P) 480.222.6771

(F)

VERBAL LEAD SCREENING

Child's Name: _____ DOB: _____

PLEASE ANSWER ALL THE QUESTIONS. THIS WILL HELP THE DOCTOR DECIDE IF YOUR CHILD NEEDS A SPECIAL BLOOD TEST.

	YES	NO
1. Does your child live in or regularly visit a house with peeling or chipping paint built before 1960? This could include a day care center, preschool, the house of a baby-sitter or a relative, etc.	—	—
2. Does your child live in or regularly visit a house built before 1960 with recent, ongoing, or planned renovation or remodeling?	—	—
3. Does your child have a brother or sister, housemate or playmate being treated for lead poisoning?	—	—
4. Does you child live with an adult or frequently come in contact with an adult whose job or hobby involves exposure to lead? (Construction, welding, pottery, brass/copper foundry, automotive repair shops)	—	—
5. Does your child eat food, drink juice or punch that has been stored in pottery from Mexico or that has been stored in open cans, particularly if the cans are imported?	—	—
6. Does your child live near a lead smelter, battery recycling plant, or other industry likely to release lead? (valve and pipe fittings, pottery, chemical and chemical preparations, industrial machinery and equipment)	—	—
7. Do you give your child any home or folk remedies or traditional medicines that may contain lead?	—	—
8. Does your child live near a heavily traveled major highway where soil and dust may contain lead?	—	—
9. Does your home's plumbing have lead pipes or copper with lead joints?	—	—
10. Do you have any questions about this survey for your doctor?	—	—

_____ _____
Name of Person completing Questionnaire Relationship to Child

_____ _____
Signature of Person completing Questionnaire Today's Date

BETHESDA PEDIATRICS

KELLY HUGHES, D.O. ERIC NYMAN, M.D. SARA EMERICK, M.D.
2175 N. Alma School Rd. Ste. C104 Chandler, AZ 85224
(P) 480.222.6770 (F) 480.222.6771

CONSENT FOR MEDICAL RELEASE TO BETHESDA PEDIATRICS

Upon change of physician we recommend that you fill out the following form to have copies of your child's medical records transferred to BETHESDA PEDIATRICS prior to your 1st visit to our office. Having you complete medical history and pertinent records will be very valuable to the Provider.

CHILD'S FULL NAME: _____ **DATE OF BIRTH:** _____

PARENT/LEGAL GUARDIAN NAME: _____

RELATIONSHIP TO PATIENT: _____

PARENT/LEGAL GUARDIAN PHONE #: _____

PARENT/LEGAL GUARDIAN SIGNATURE: _____

DATE OF REQUEST: _____ **EMAIL ADDRESS:** _____

This is a formal request for the following records:

X **All Available medical records including the following :**
Immunization Records
Height/Weight Scale
Any records pertaining to Chronic Health Conditions/Surgeries etc(including specialist notes, labs, xrays, etc)

FROM: _____ (Previous Pediatrician/Physician)

TO: Bethesda Pediatrics FAX: 480-222-6771 PHONE: 480-222-6770
ADDRESS: 2175 N. Alma School Rd. Ste. C104 Chandler, AZ 85224

Previous Pediatrician/Physician information:

Clinic Name: _____ Physician's Name: _____

Address: _____

City, : _____ , State, _____ ,Zip _____

Phone: _____ Fax: _____

Website: _____ General Email Address: _____

Requested on: _____ Completed By: _____