JEANNE M. SCHAEFER, M.D.
FIRST CHOICE PEDIATRICS

Patient Information

Last Name _____ First Name _____ Middle I _____

Nickname: _____ Date of Birth: _____ Sex: M / F

Ethnicity: Hispanic or Latino / Not Hispanic or Latino Preferred Language: _____

Race: American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian or Other Pacific Islander / White

Guarantor / Parent Information

Mother Last Name _____ First Name _____ Middle I _____

Social Security: _____ Date of Birth: _____

Place of Employment: _____ Job Title: _____

Father Last Name _____ First Name _____ Middle I _____

Social Security: _____ Date of Birth: _____

Place of Employment: _____ Job Title: _____

Home Address _____ City _____ State _____ Zip _____

Marital Status: S / M / W / D / SEP Email: _____

Primary Contact Number: ( ) _____ For Reminder Calls Alt. Contact Number: ( ) _____

Insurance Information * **We will also need to make a copy of your insurance card(s)**

Primary Insurance: _____ Insured: _____

Policy #: _____ Group #: _____

Secondary Insurance: _____ Insured: _____

Policy #: _____ Group#: _____

Emergency Contact Information

Emergency Contact (someone in different household): _____

Relationship: _____ Phone Number: ( ) _____ Work / Home / Cell

I verify the above information is correct and complete to the best of my knowledge. I also authorize Jeanne M. Schaefer, MD, PLLC to file claims and for the release of medical records to the insurance company for claims purpose. The records authorized for release may include information which may indicate the presence of a venereal or other communicable disease. This includes, but is not limited to, Hepatitis, Syphilis, Gonorrhea and the Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

Signature: _____ Date: _____

First Choice Pediatrics
Patient's Health History
12 month to 18 years

Name: _____ Date of Birth: _____

Previous Physician: _____ How did you hear about us? _____

Medical History:

Please list your child's medical problems: _____

_____

Hospitalizations: _____

Surgeries: _____

Allergies or reactions to medications: _____

Current Medications: _____

_____

***PLEASE GIVE THE NURSE A COPY OF THE PATIENT'S IMMUNIZATION RECORD.**

School:

Does your child go to a sitter or daycare? _____ In preschool? _____
If yes, where? _____
Current Grade: _____ Special education? _____
Name of School: _____ Any problems in school? _____

Family:

Please list those who currently live in the home, their age, and relationship.

_____
_____

Other:

Please provide any other medical history that you think might be helpful.

_____
_____
_____

First Choice Pediatrics
Family Health Screening

Please circle any of the **child**'s family members if they have or had any of the medical conditions listed below.

Medical Conditions

Heart Attack / Heart Problems	Father	Mother	Sister	Brother	P. Grandpa	P. Grandma	M. Grandpa	M. Grandma
High Chlosterol	Father	Mother	Sister	Brother	P. Grandpa	P. Grandma	M. Grandpa	M. Grandma
High Blood Pressure	Father	Mother	Sister	Brother	P. Grandpa	P. Grandma	M. Grandpa	M. Grandma
Asthma	Father	Mother	Sister	Brother	P. Grandpa	P. Grandma	M. Grandpa	M. Grandma
Intestinal Problems / Colitis	Father	Mother	Sister	Brother	P. Grandpa	P. Grandma	M. Grandpa	M. Grandma
Urinary Tract Infections / Kidney Problems	Father	Mother	Sister	Brother	P. Grandpa	P. Grandma	M. Grandpa	M. Grandma
Migraines	Father	Mother	Sister	Brother	P. Grandpa	P. Grandma	M. Grandpa	M. Grandma
Seizures	Father	Mother	Sister	Brother	P. Grandpa	P. Grandma	M. Grandpa	M. Grandma
Diabetes	Father	Mother	Sister	Brother	P. Grandpa	P. Grandma	M. Grandpa	M. Grandma
Hyperthyroidism	Father	Mother	Sister	Brother	P. Grandpa	P. Grandma	M. Grandpa	M. Grandma
Hypothyroidism	Father	Mother	Sister	Brother	P. Grandpa	P. Grandma	M. Grandpa	M. Grandma
Allergies	Father	Mother	Sister	Brother	P. Grandpa	P. Grandma	M. Grandpa	M. Grandma
Eczema	Father	Mother	Sister	Brother	P. Grandpa	P. Grandma	M. Grandpa	M. Grandma
Depression	Father	Mother	Sister	Brother	P. Grandpa	P. Grandma	M. Grandpa	M. Grandma
Death of a Sibling / SIDS	Father	Mother	Sister	Brother	P. Grandpa	P. Grandma	M. Grandpa	M. Grandma
Smoke Cigarettes	Father	Mother	Sister	Brother	P. Grandpa	P. Grandma	M. Grandpa	M. Grandma
Cancer: _____	Father	Mother	Sister	Brother	P. Grandpa	P. Grandma	M. Grandpa	M. Grandma

Other:_____

Parent's Signature: _____ Date:_____

FIRST CHOICE PEDIATRICS

Identification Verification

Federal law requires patients/guarantors to validate their identity before services are provided. Section 114 of the Fair and Accurate Credit Transaction (FACT) Act of 2003, mandates implementation of a Red Flag Program that is consistent with the policies and procedures issued under section 326 of the USA PATRIOT Act, 31 U.S.C. 5318(1), requiring verification of the identity of persons opening new accounts. In order to be in compliance with the Federal regulations, please provide your photo identification and the policy holder's social security number when required by your insurer. This information will be maintained in a secure location and used only for identity validation. If you are unable to provide a photo ID, your account will be flagged for possible identity theft.

◯ Guarantor was unable to provide photo ID

◯ Guarantor refused photo ID to be copied.

◯ Guarantor was unable to provide social security number of policy holder as required by insurer.

◯ Guarantor was able to provide photo ID

◯ Guarantor was able to provide social security number of policy holder as required by insurer.

ID was viewed and verified by:_____ (employee signature)

Print Patients Name:_____

Patient/Guarantor Signature:_____Date:_____

FIRST CHOICE PEDIATRICS

AUTHORIZATION FOR TREATMENT OF A MINOR

I/We parent(s) or legal guardian, do hereby give permission for medical treatment of:

_____

Signature: _____Date: _____

The following person(s) is/are authorized to bring the above named minor to the physician's office for medical treatment.

	NAME	PHONE NUMBER	RELATIONSHIP
1.)	_____	_____	_____
2.)	_____	_____	_____
3.)	_____	_____	_____

FIRST CHOICE PEDIATRICS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,______________________________________, have received a copy of Notice of Privacy Practices.

______________________________________ Signature of Parent/Guardian

______________________________________ Date

____Address of Parent / Guardian

______________________________________ Phone Day/Evening numbers

^^

FOR OFFICE USE ONLY

^^

An attempt was made to obtain written acknowledgement of receipt of our Notice of Privacy Practices, however, acknowledgement could not be obtained because:

- ⬭ An emergency situation prevented First Choice Pediatrics from obtaining acknowledgement
- ⬭ The Patient declined to sign the acknowledgement
- ⬭ Other (Please Specify)

____

____

Patient name ________________________________

Patient DOB _________________________________

Staff Member ________________________________

Date __________________________

First Choice Pediatrics

Acknowledgement of Receipt of Financial Policy

I, _____, have received a copy of the Financial Policy.

_____ Signature of Parent/Guardian

_____ Relationship to Patient

_____ Date

I certify that I have read, understand and will comply with the Financial Policy for First Choice Pediatrics. I acknowledge full financial responsibility for the services provided to me or my minor children by First Choice Pediatrics. I understand that I am responsible for prompt payment of any portion of the charges not covered by my insurance, including co-pays, co-insurance, deductibles and non-covered services. I understand that I am responsible for prompt payment of all charges in the event that I do not have health insurance, or that First Choice Pediatrics is not a participating provider with my health insurer. I consent to the assignment of authorized insurance benefits by my health insurer to First Choice Pediatrics for any services furnished to my minor children.

If the patient is under 18 years old or is otherwise incompetent to consent, this document must be signed by the patient's parent, legal guardian, or other duly authorized representative.