

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

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
Newborn to 12 month**

Patient Name: _____ Date of Birth: _____

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

Pregnancy:

Maternal illnesses or problems during pregnancy? _____

Any medications taken? _____

Smoke cigarettes Y / N Drink alcohol Y / N Use recreational drugs Y / N

Birth History:

Birth Weight: _____ Place of Birth: _____ Obstetrician: _____

Vaginal delivery or C-section? Gestational age: _____ wks

NICU admit? _____ If yes, why? _____ How long? _____

If breast fed, how long? _____ If bottle fed, what formula? _____

Was Hep B given in hospital? _____

Circumcised? Y / N If so, how old at time? _____

Medical History:

Surgeries: _____

Allergies or reactions to medications: _____

Current Medications: _____

Family:

Please list **ALL** family members and relationship that live in house.

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 Cholesterol	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
Hypert thyroidism	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 / AIDS	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.

	<u>NAME</u>	<u>PHONE NUMBER</u>	<u>RELATIONSHIP</u>
1.)	_____	_____	_____
2.)	_____	_____	_____
3.)	_____	_____	_____

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.