

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

**Patient Information**

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Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle I \_\_\_\_\_  
Nickname: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M / F  
Social Security #: \_\_\_\_\_ Ethnicity: Hispanic or Latino / Not Hispanic or Latino  
Race: American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian or Other Pacific Islander / White

**Guarantor / Parent Information**

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Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle I \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M / F  
Marital Status: S / M / W / D / SEP Email: \_\_\_\_\_ Preferred Method of Contact: Home / Cell / Work  
Home Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_  
Place of Employment: \_\_\_\_\_ Job Title: \_\_\_\_\_

**Insurance Information**

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

Primary Insurance: \_\_\_\_\_ Insured: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Insured's Relationship to Patient: \_\_\_\_\_  
Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Secondary Insurance: \_\_\_\_\_ Insured: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Insured's Relationship to Patient: \_\_\_\_\_  
Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

**Emergency Contact Information**

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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 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
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
Other:	Father	Mother	Sister	Brother	P. Grandpa	P. Grandma	M. Grandpa	M. Grandma

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

FINANCIAL POLICY AND AGREEMENT

First Choice Pediatrics staff is committed to providing you with the best possible care. Your clear understanding of our financial policy is important to our professional relationship. Please review this document, and sign at the bottom, after you've familiarized yourself with this Financial Policy.

**Patients with Insurance:** We are a participating provider with a number of insurance plans. Please bring your insurance card with you to your appointment. All co-payments will be collected upon check in. If your health insurance company does not cover 100% of the services rendered, you will be responsible for any balance due to deductible, co-insurance, termed coverage, or non-covered services. Non-covered services could include, but are not limited to: fluoride, developmental testing, wart removal, strep & flu tests, etc. (Consult your individual plan regarding your specific coverage) You will receive a monthly statement from our office with an accounting of the amount your insurance has paid and the amount owed. Any balance remaining is due within thirty (30) days of receipt of the statement. You will receive up to three statements for the same DOS at no charge. If you do not pay within that time period, a \$10 per month statement fee will be assessed each month going forward, to cover the time and cost involved to collect the balance. We work closely with a credit reporting collection agency and will turn accounts over to them as we feel necessary. It is your responsibility to keep our office up to date with current insurance, phone and address information.

**Patients without Insurance:** If you are uninsured/self-pay at the time of your appointment, you will receive a discount for our services, as long as you do not have an outstanding account balance with us. Because we offer a discount, we ask you pay when services are rendered. Failure to do so will cause us to bill you for the full cost of services provided.

**Separated/Divorced Families:** In a situation where parents are separated or divorced, the parent authorizing treatment and bringing the child to the appointment is responsible for payment. This includes co-pays as well as any outstanding balance. These will be collected at the time of service. If there is a legal agreement stating the parties are to split charges incurred, or if the party not bringing the child is financially responsible, we will still collect the full amounts due from the parent authorizing treatment. **It is the authorizing parent's responsibility to collect from the other parent if necessary.** First Choice pediatrics will not act as a mediator in collecting payments. However, we will gladly provide you with a copy of your receipt to verify your payment.

**FAILURE TO CANCEL A SCHEDULED APPOINTMENT WILL RESULT IN A \$25 NO SHOW FEE.**

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I have read and understand the above Financial Policies of First Choice Pediatrics.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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