

SOUTHFIELD PEDIATRIC PHYSICIANS, PC. Acct#: \_\_\_\_\_  
Patient Information Form

Patient's Name: \_\_\_\_\_  male  female DOB: \_\_\_\_\_

**Father/Guardian's Name**

**Mother/Guardian's Name**

\_\_\_\_\_  
Last First

\_\_\_\_\_  
Last First

\_\_\_\_\_  
Birthdate:

\_\_\_\_\_  
Birthdate:

\_\_\_\_\_  
Social Security#

\_\_\_\_\_  
Social Security #

\_\_\_\_\_  
Address:

\_\_\_\_\_  
Address:

\_\_\_\_\_  
Apt/Bldg# City:

\_\_\_\_\_  
Apt/Bldg# City:

\_\_\_\_\_  
State Zip

\_\_\_\_\_  
State Zip

\_\_\_\_\_  
Home Phone: ( )

\_\_\_\_\_  
Home Phone: ( )

\_\_\_\_\_  
Cell Phone: ( )

\_\_\_\_\_  
Cell Phone: ( )

\_\_\_\_\_  
Employer:

\_\_\_\_\_  
Employer:

\_\_\_\_\_  
Work Phone: ( )

\_\_\_\_\_  
Work Phone: ( )

\_\_\_\_\_  
Email Address:

EMERGENCY Contact Other than Parent \_\_\_\_\_ Relationship to child \_\_\_\_\_

Phone \_\_\_\_\_ Alternate: \_\_\_\_\_

*We will bill your insurance only if we participate with that company. You are responsible for any and all charges that your insurance company does not cover for any reason, including all HMO's. **ALL payments and copays are due at the time of service. There is a \$50.00 charge for appointments not cancelled 24 hours in advance and must be paid prior to your next visit.** The person who brings the child or children in is responsible for payment. Our office will not accept responsibility for a disputed claim and all bills are to be paid upon receipt of your statement. Copays not paid at time of service will incur a \$5 statement fee and repeated failure to pay would be considered for possible patient dismissal. I authorize insurance payment for all medical care to be made to Southfield Pediatric Physician, PC.*

1. Insurance Name \_\_\_\_\_ Subscriber \_\_\_\_\_

2. Insurance Name \_\_\_\_\_ Subscriber \_\_\_\_\_

If your child/ren is/are insured by multiple insurances they must **all** be presented **prior** to receiving services. Failure to provide this information will result in my financial responsibility for those services regardless of coverage.

*Sibling's Full Names – First M. Last*

1. \_\_\_\_\_ birthdate \_\_\_\_\_ M F

2. \_\_\_\_\_ birthdate \_\_\_\_\_ M F

3. \_\_\_\_\_ birthdate \_\_\_\_\_ M F

4. \_\_\_\_\_ birthdate \_\_\_\_\_ M F

please continue on back if more than 4 children

Signature\_X \_\_\_\_\_ Date \_\_\_\_\_

## CONSENT TO EXAMINE AND TREAT A MINOR

1. I, \_\_\_\_\_, do hereby consent and authorize Southfield Pediatric Physicians, and/or such associates, assistants or designees as may be selected by him/her, to examine

and treat my child/children: \_\_\_\_\_

- 
2. I affirm that I have the legal right to consent to this.
  3. This consent is binding until specifically revoked by myself or another person who has the right to sign or revoke this form.
  4. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of examinations and treatments.
  5. I give the physicians of Southfield Pediatric Physicians permission to treat my child in my absence in case of emergency or when accompanied by a designated representative.

## PAYMENT POLICIES

**I understand and promise payment of all copays, deductibles and non-covered services and agree to payment at time of service; and understand that this is a contingency of our continued patient/physician relationship.**

### Insurances/HMO/POS/PP0

I understand that due to the uncertainty of eligibility and/or primary care physician assignment, that **if denied by insurance for services or treatment for myself, or my dependents, I am financially responsible for all balances.** This includes all HMO plans (*Aetna, BCN, BCN, Cofinity, Cigna, GreatLakes, HAP, Molina, PHCS, United Health, and/or any other insurance companies not stated*). **I understand that the assignment of a Primary Care Physician to a Southfield Pediatric Physician for my dependents is my responsibility.** Any visits without authorization from that Primary Care Physician are at my expense and will be paid at time of service.

I authorize for insurance payments to go directly to the physician and for the release of any and all medical information contained in the medical record as requested by the insurance company in determining benefits.

### Financial Obligation

I understand that Southfield Pediatric Physicians or their associates will not become involved in disputes of parental/guardian medical financial liability. **The parent requesting services is responsible for any and all financial obligations.** Any previous agreements legal or otherwise between the parties will be resolved between the parental/guardian parties and will in no way effect timely payment of the patients account.

### Newborn

**I understand that it is my responsibility to contact my insurance to have my newborn child added to my insurance within the first week of birth. I understand that failure to do so may jeopardize my child's ability to be insured. I will provide Southfield Pediatrics with my child's health care coverage information as soon as the policy is effective to assure timely billing.** Failure to do so will result in non-covered services by my insurance to which **I am responsible for abd guarantee payment.**

In agreeing to have my child/children treated by Southfield Pediatrics Physicians I agree to all terms, policies and conditions set forth by Southfield Pediatric Physicians, whether stated or unstated.

### PRIVACY PRACTICES ACKNOWLEDGEMENT (posted in waiting room)

I understand the Notice of Privacy Practices and I have been provided an opportunity to review it.

X \_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date

# Southfield Pediatrics Physicians Health History Form

Today's Date: \_\_\_\_\_ Child's Name: \_\_\_\_\_

Child's Date of Birth: \_\_\_\_\_ Parent's Name(s) \_\_\_\_\_

Allergies:  none \_\_\_\_\_

Current Medications:  none \_\_\_\_\_

## Delivery History:

Mom's Age at Delivery: \_\_\_\_\_ Delivery:  Vaginal  Caesarean Labor:  Spontaneous  Induced

List and explain and complications during delivery:  None Other: \_\_\_\_\_

List any drugs taken during pregnancy, including prescriptions, tobacco, alcohol, etc:  None

Other: \_\_\_\_\_

Weeks gestation: \_\_\_\_\_ APGAR \_\_\_\_\_ Birth Weight \_\_\_\_\_ Length \_\_\_\_\_ Head Circ \_\_\_\_\_

Hospital delivered at: \_\_\_\_\_ Age at discharge: \_\_\_\_\_

Any prenatal problems:  none \_\_\_\_\_

## Developmental History: At what age did the child reach the following milestones:

Smiled \_\_\_\_\_  Crawled \_\_\_\_\_  Walked \_\_\_\_\_  Said Words \_\_\_\_\_

Rolled Over \_\_\_\_\_  Sat Alone \_\_\_\_\_  Stood Alone \_\_\_\_\_

Spoke Sentences \_\_\_\_\_

## Other Illnesses and Conditions (check all that apply): None

Ear Infections  Strep Throat  Eczema  Chicken Pox

Pneumonia  Arthritis  Psoriasis  Measles/Mumps

Bronchitis  Heart Problems  Allergies  Urinary Problems

Asthma  Tumors  Growth Problems

Sinusitis  Seizures  Mental/Emotional Problems

Surgery \_\_\_\_\_

Hospitalizations \_\_\_\_\_

Other: \_\_\_\_\_

## Family History: Check all that apply and indicate relationship to child (mother, father, sibling, grandparents)

Diabetes \_\_\_\_\_  Kidney Disease \_\_\_\_\_

Heart Disease \_\_\_\_\_  Cancer \_\_\_\_\_

High Cholesterol \_\_\_\_\_  Headaches \_\_\_\_\_

High Blood Pressure \_\_\_\_\_  Seizures \_\_\_\_\_

Mental/Emotional Issues \_\_\_\_\_  Birth Defects \_\_\_\_\_

Asthma \_\_\_\_\_  Lead Poisoning \_\_\_\_\_

Allergies \_\_\_\_\_  Tuberculosis \_\_\_\_\_

Other \_\_\_\_\_  Sickle Cell Disease/Trait: \_\_\_\_\_