Craig Ranch Pediatrics

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New Patient Enrollment

Welcome! We thank you for choosing us to serve your healthcare needs. The information requested on this form will enable us to serve you better. Thank You.

PLEASE FILL OUT FORM COMPLETELY, INITIAL, SIGN AND DATE

Patient's Name _____D.O.B._____ M / F
Home Address_____
City_____ State_____ Zip Code_____
Cell Phone#_____ Home Phone#_____
Email Address_____
Pharmacy _____ Ph. _____
Emergency Contact Name: _____Ph._____

SIBLING INFORMATION

Name_____ D.O.B._____ M / F
Name_____ D.O.B._____ M / F
Name_____ D.O.B._____ M / F

PARENT INFORMATION

Mother's Name_____ Father's Name_____
Cell #_____ Cell #_____
Occupation _____ Occupation_____
Employer_____ Employer _____
Driver's Lic. State/#_____ Driver's Lic. State/#_____
SSN: _____ DOB: _____ **SSN: _____ DOB: _____**
Please Circle Parents Status: Married Single Widowed Separated Divorced
PRIMARY Insurance Holder Name: _____
How did you hear About Our Office? _____

Craig Ranch Pediatrics will not provide health care to minors without a parent/legal guardian*, parent's written consent or contact from the parent/legal guardian giving said consent. I give consent to the following people to seek medical treatment and receive information regarding my child in my absence:

Name _____ Relation _____Tel _____
Name _____ Relation _____Tel _____

Medical History Form

A. Birth History: Birth Weight:_____ Birth Length:_____ Obstetrician:_____

Prenatal Problems? __No __Yes (e.g. diabetes, high blood pressure)
Labor/Delivery: __Normal Vaginal Birth __C-section
__Other Problems_____

Newborn Problems? __No __ Yes (e.g. premature, jaundice, infection)
Hearing Screen: __Pass __Fail
Newborn Screen: __Normal __Abnormal:_____

B. Past Medical History:

Date of last check-up: _____ Where? _____
Date of last dental check-up: _____ Where? _____
Previous Hospitalizations: _____
Previous Surgeries: _____
Medical Illnesses: (e.g. asthma) _____
Allergies: (medications, foods) _____
At what age did your child: Sit alone____ Walk____ Talk____ Toilet (potty) train_____
Grade in School: _____ Where: _____

C. Social & Family History

MEMBER	NAME	AGE	SEX	HEALTH	OCCUPATION
Mother					
Father					
Siblings					

Family Medical History: Are any family members with the following diseases? (Please circle)
Asthma, Allergies, Cancer, Seizures, Birth Defects, Heart Disease, Liver Disease, Diabetes, High Blood Pressure.
Other? If so, who & which disease _____
_____

Home Environment:
Live in: __own house __own apartment __shared home __shared apartment
Smokers in household: __no __yes:_____
Animals in household: __no __yes:_____
Is child in daycare: __no __yes:_____

Consent to Payment/financial policies

- Patient or Person responsible must present insurance card at the time of visit. It is your responsibility to ensure all patients including newborns are covered under the insurance plan.
- While we will put in our best effort to validate eligibility, it is your responsibility to ensure that the providers are contracted and in-network with your insurance plan prior to the visit.
- If you do not have any insurance or we are unable to validate eligibility, payment in full is expected at the time of service.
- Co-payments, deductibles and any outstanding balance are due upon check in.
- Based on the services provided, additional money may be due at check out.
- If office is not notified of insurance changes within 30 days of service, payment in full is expected.
- For claims denied by insurance due to non-covered services, patient or responsible party is accountable and is expected to pay the denied amount for the services already provided.
- Payments can be made in the form of cash, credit cards or personal checks. There will be a $ 25 charge for returned checks.
- Forms of payment (credit card, health savings card etc.) may be stored on file to charge for payments due.
- There is a 2% interest fee for all balances over 60 days.

Due to contract language between the physician and the insurance company, I understand that I am financially responsible for all charges deemed to be "non-covered benefits" by my insurance company even if the insurance's Explanation of Benefits state the procedure is a "non-covered benefit" and "patient is not responsible".

I have read and agreed to the above financial policies. I assign insurance benefits to be paid directly to Craig Ranch Pediatrics. I authorize release of all medical information to the insurance company for purposes of filing insurance claims. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this Sheet and have completed the answers to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Late/Missed Appointment/No Show Policies

If you arrive for your appointment more than 15 minutes late, there is a chance that we will not be able to accommodate you due to the length of time it takes to provide service. If you are running late, please call us ahead of time so that we will be able to determine if your child can still be seen despite a late arrival or if it is necessary for us to reschedule your appointment.

Our No Show policy is for all patients. Each confirmed appointment that you miss or arrive late over 15 mins, you will be charged $25 per child per visit. This charge is not covered by insurance and is patient responsibility. To avoid these charges PLEASE call us to cancel your scheduled appointment 24 hours in advance before the appointment. If your appointment is early in the morning, please call the previous day to avoid the NO Show charge. This will allow us time to fill the appointment time with other children who need to be seen. For any unscheduled appointments (Walk Ins) that we accommodate there will be a $15 charge out of respect for our scheduled patients.

Advertising/Promotion of goods or products Policy

Based on the Provider's prior experience with certain health related products, Patient's feedback on the product's effectiveness, direct observations of health improvements or Supplier's Supplemental facts/information, we promote/sell certain health related products such as Dietary Supplements, Oils and Vitamins at the office and/or on our website as a normal course of business. While we do receive financial remuneration, the products are sold at a very low cost and are primarily for the convenience of our Patients. The same or equivalent products are available at the local stores/online. The Patient/Customer is under no obligation to purchase these products from us. Purchasing or not purchasing products from us will not change how we treat them.
I have read, understand and hereby agree with the Promotion/Sale of goods/products policy. I understand that purchasing products at the office or their website is completely optional. I also understand that I am not being forced nor required to purchase in order to receive any special treatment or provide favors to the Providers. If I do purchase, it is out of my own free will and decision.

I have read, agree and provide consent to Craig Ranch Pediatrics'
(Initial here)_____ Privacy Policy
(Initial here)_____ Consent to Treatment Policy
(Initial here)_____ Advertising/Promotion of Goods or Products Policy
(Initial here)_____ Missed/Late Appointment/No Show Policy
(Initial here)_____ Payment/financial Policy
(Initial here)_____ Release of Patient Medical Information

I have read and agree to the financial policies stated herein. I assign insurance benefits to be paid directly to Craig Ranch Pediatrics and/or Dr. Nagaratina Salem. I authorize release of all medical information to the insurance company for purposes of filing insurance claims.

Printed name of Parent/Guardian _____
Signature of Parent/Guardian _____ Date: _____

Medical Records Release Form

By signing this form, I authorize you to release confidential health information about the patient named below, by releasing a copy of the medical records, or a summary or narrative of the protected health information, to the person(s) or entity listed below.

FILL IN YOUR PREVIOUS DOCTOR'S INFORMATION BELOW:

FROM: _____
(Physician or Facility Name)

_____
Address City St Zip

_____
Phone Number Fax Number

I hereby request that my child's complete records or specific information as listed below be released to:

TO: Craig Ranch Pediatrics
Nagaratina Salem, M.D, MBA
Adriane Nelson, RN, MSN, CPNP
6850 TPC Drive, Suite 100,
McKinney, TX 75070
Ph: 214-383-4400
Fax: 214-383-4403

_____
Patient's Name Patient's Date of Birth

_____
Parent's Signature Phone number Today's Date

Information Requested

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.