TOWN CENTER PEDIATRICS

New Patient Questionnaire
To Be Filled Out By Parent

Today's Date_____

Childs Name_____

Date of Birth_____

PREGNANCY AND BIRTH

Mother's age at birth_____
Did mom have any illness during pregnancy? Yes No
Any medications other than pre-natal vitamins? Yes No
Was baby on time? Yes No
Birthweight _____
Did the baby have any trouble while in hospital? Yes No
(jaundice, infections, etc.)_____
Baby was _____ breast fed _____ formula fed
Unusual feeding problems during infancy? Yes No
(colic, reflux, etc.) _____

PAST MEDICAL HISTORY

Where has your child been going for checkups?
_____
Date of last check up_____
Date of last dental check up_____
Allergy to medications, foods, insect bites? Yes No
If so what_____
Reactions to immunizations? Yes No
If so which ones_____
Any hospitalizations (other than ER visits)? Yes No
_____
Any surgeries? (Tubes, tonsils etc.) Yes No
_____
Medications taken regularly? Yes No
_____

FAMILY HISTORY

Are the child's parents both in good health? Yes No

Circle any of the medical conditions that this child's Parents, grandparents, siblings, aunts, uncles have:

Allergies, asthma, auto-immune diseases, diabetes, high blood pressure, heart problems, inherited illness, mental illness, migraines

Who lives in the child's home? _____
_____

REVIEW OF SYSTEMS

Frequent ear infections	Yes No
Eye Problems	Yes No
Dental problems	Yes No
Asthma, pneumonia, recurrent cough	Yes No
Heart murmur or problems	Yes No
Urination	Yes No
Diarrhea or constipation	Yes No
Good appetite	Yes No
Nervous system (seizures, convulsions)	Yes No
Skin conditions (hives, eczema)	Yes No

DEVELOPMENTAL/BEHAVIOR

What grade is your child in? _____?
Does he/she have trouble in school? Yes No

SAFETY

Smoke alarms on each floor of house?	Yes No
Always use car seat/belt when in the car?	Yes No
Any smokers in the household?	Yes No
Wear a helmet when riding a bike?	Yes No

Is your child seeing any other doctor, specialist or therapist? If so please list names Yes No
_____
_____
_____

Do you have a record of immunizations? Yes No

Any specific concerns that you would like to discuss with provider? _____
_____
_____

2015

TOWN CENTER PEDIATRICS PATIENT REGISTRATION FORM

THIS FORM MUST BE COMPLETED AND SIGNED FOR REGULATORY AND QUALITY ASSURANCE COMPLIANCE

Patient Name: _____ M ____ F ____ D.O.B. _____

Race: _____ Allergies: _____

Street Address: _____

City/State/Zip: _____

Phone: Home_____ Cell: Mom_____ Dad_____

Patient Cell if over 16yrs: _____ Work: Mom _____ Dad_____

Email Address for Patient Portal: _____ Mom ___ Dad ___

***Mother/Guardian**: _____ D.O.B. _____

Address: ____same as above Street: _____ City/State/Zip: _____

Employer: _____ Occupation: _____

***Father/Guardian**: _____ D.O.B. _____

Address: ___ same as above Street: _____ City/State/Zip: _____

Employer: _____ Occupation: _____

***PRIMARY INSURANCE COMPANY**: _____ Eff. Date: _____

POLICY ID#: _____ Policy Holder: _____ Relationship: _____

If other than parent, Policy Holder D.O.B., Address and Phone: _____

***SECONDARY INS. COMPANY**: _____ Eff Date: _____

POLICY ID #: _____ Policy Holder: _____ Relationship: _____

If other than parent, Policy Holder D.O.B., Address and Phone: _____

***PREFERRED PHARMACY**: _____

I give Town Center permission to leave messages such as appointment information or laboratory results on my home or cell phone answering machine. Y ___ N___ Preferred phone # for contact: ____home _____cell

Siblings: _____ DOB_____

_____ DOB_____

_____ DOB_____

_____ DOB_____

_____ _____

Signature of Parent/Guardian or Patient if 18 Yrs. Or Older Date

_____

Printed name of above signature

Town Center Pediatrics

Authorization & Acknowledgement Form

Patient Name: _____ DOB: _____

ASSUMPTION OF RESPONSIBILITY: I, the undersigned, have read and fully understand the financial policy. I understand that I am responsible for this account regardless of the presence or absence of any medical insurance, divorcee decree, or separation agreement. By affixing my signature below, I understand and agree that I am responsible for all charges upon this account.

ASSIGNMENT OF INSURANCE: I authorize Town Center Pediatrics to release any medical information required by my insurance company or its designated claims processing agent in order to obtain payment of claims submitted on my behalf. I certify that the information I have reported with regard to my insurance coverage is correct.

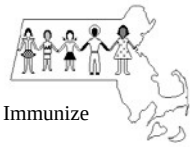
ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE: I acknowledge that I have read a copy of Town Center Pediatrics notice of privacy policies. I consent to Town Center Pediatrics use of protected health information as described in the notice for treatment, payment, or health care operations. I understand that I must provide a separate authorization before any other disclosures may be made.

I agree to Town Center Pediatrics policies and to notify of any changes in my billing address, telephone number and/or my insurance information. This entire authorization is valid for all episodes of care rendered at Town Center Pediatrics.

By signing below I have read and understand all the information described above.

	Signature	**Printed name**	**Date**
2015			
2016			
2017			
2018			

For Healthier Lives



MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
IMMUNIZATION PROGRAM
VACCINES FOR CHILDREN PROGRAM (VFC)

Patient Eligibility Screening Form

For use in all Provider Sites, except Federally Qualified Community Health Centers

Initial screening

Initial screening date _____ Child's date of birth _____

Child's full name _____

Parent, guardian or legal representative's full name _____

Health care provider's full name _____

Check only one box below:

This child is eligible for immunizations through the federal VFC program because he/she*:

- ❑ is enrolled in Medicaid (includes MassHealth and HMOs, etc., if enrolled in Medicaid)
- ❑ does not have health insurance
- ❑ is American Indian (Native American) or Alaska Native

This child is not VFC-eligible because he/she:

- ❑ has health insurance (that covers all recommended childhood and adolescent vaccinations) and is not American Indian (Native American) or Alaska Native

This form must be completed for all children under 19 years old at their initial visit, updated every time a vaccine is given and kept in the child's medical record or on file in the office.

The form may be completed by the parent, guardian, or legal representative, or by the health care provider.

Verification of responses is <u>not</u> required.

*This form identifies which children are eligible for vaccines through the federal Vaccines for Children (VFC) program. If one of the first three boxes in the section above is checked, the child is VFC eligible.