PEDIATRICS at OYSTER POINT

DATE: _____

Patient Registration

Patient Information

Patient Name: _____

Social Security #: _____ Birth Date: _____

Address: _____ City, State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Emergency Contact: _____ Telephone #: _____

Sex: ☐ F ☐ M MEDICINES/ ALLERGIES TO _____

Responsible Party Information

Email address: _____

Responsible Party Name: _____

Social Security #: _____ Birth Date: _____

Address: _____ City, State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Employed By: _____

Primary Insurance

Subscriber's Name & Address: _____

Employer Name & Address: _____

Social Security #: _____ Birth Date: _____

Insurance Company: _____

Subscriber #: _____ Group #: _____ Plan #: _____

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other, describe: _____

Secondary Insurance

Subscriber's Name & Address: _____

Employer Name & Address: _____

Social Security #: _____ Birth Date: _____

Insurance Company: _____

Subscriber #: _____ Group #: _____ Plan #: _____

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other, describe: _____

Brothers & Sisters *(who will be followed here)*

Name		Birthday
	☐ Boy ☐ Girl	
	☐ Boy ☐ Girl	
	☐ Boy ☐ Girl	

0001 (7/12) 20705 **PLEASE COMPLETE THE BACK, THANK YOU.**

PEDIATRICS at OYSTER POINT

Today's Date: _____

Patient History

Patient's Name _____ D.O.B. _____ Sex ___ Date first seen _____

Mother's Name _____ Father's Name _____

Child lives with: ___ *Mom* ___ *Dad* or ___ *Legal Guardian* _____

BIRTH HISTORY *(Please circle yes or no)* Has current custody paperwork been filed with our office? Y / N

Birth Weight: _____ Full Term: *Y N* Premature: *Y N* *Reason:* _____

Normal Vaginal Delivery: *Y N* C-Section Delivery: *Y N* *Reason:* _____

Complications at Birth: _____

Hearing Screen: *Right ear passed: Y N* *Left ear passed: Y N*

Did your child receive a Hepatitis B vaccine at birth? *Y N*

Was a Newborn Blood Screening preformed? *Y N* Was Screening: *normal* or *abnormal*

PAST MEDICAL PROBLEMS / CHRONIC MEDICAL CONDITIONS *(Please circle yes or no)*

Allergies to Medications *Y N* Name of Medication: _____

Type of Allergic Reaction: _____

Hospitalizations: _____ Date: _____ Surgeries: _____ Date: _____

Are child's Immunizations up to date? *Y N*

Frequent Ear Infections *Y N*

Urinary / Kidney *Y N*

Asthma / Bronchitis / Reactive Airway Disorder *Y N*

ADD / ADHD *Y N*

Seizures *Y N*

Mental Health Problems *Y N*

Other Medical Conditions _____

FAMILY MEDICAL HISTORY *(Please include extended family)*

Check where appropriate **(Please note which family member has condition)**

___ Asthma / Allergies
___ High Blood Pressure
___ Cancer
___ Hearing Loss
___ Stomach / Bowel Problems
___ Thyroid Disorder
___ Diabetes
___ Kidney Disorder
___ Seizures
___ Mental Health Problems
___ Drug Abuse
___ Alcohol Abuse
___ Exposure to Tuberculosis
___ Exposure to HIV / AIDS
___ Other

SOCIAL HISTORY *(Please circle yes or no)*

Name of School or Day Care _____ Grade _____

Does your child have problems at school / daycare? _____

Is your child exposed to cigarette smoke at home, daycare or in the car? *Y N*

Are guns kept in your child's home? *Y N* Are they locked away from child? *Y N*

Does your child always wear a safety helmet while riding a bike, skateboard or scooter? *Y N*

Is your child always secured in the car by a safety belt or in a car seat? *Y N*

Are there smoke detectors in your child's home and place of daycare? *Y N*

Do you have any social concerns you would like to discuss with your pediatrician? *Y N*

PLEASE FEEL FREE TO MAKE ANY ADDITIONAL COMMENTS ON THE BACK OF THIS PAGE

PATIENT/GUARANTOR AGREEMENT

1. On my own behalf and on behalf of my spouse and minor children, including stepchildren ("my family"), I hereby authorize treatment by Pediatrics at Oyster Point, PLLC and affiliated medical staff members

2. I accept responsibility and guarantee payment for all services rendered to me and my family and upon default on any payment due Pediatrics at Oyster Point, PLLC, I agree to pay all cost of collections including collection agency fees of up to 33⅓ percent or an attorney's fee of up to 33⅓ percent plus a returned check fee should a check be returned for any reason.

3. I hereby authorize the release of any and all medical and/or charge information as is necessary for third party reimbursement and/or any other agency involved in this payment of my treatment.

   I also direct and assign payment from third parties to Pediatrics at Oyster Point, PLLC, I understand that my insurance policy is a contract between me and my insurance company and that I am responsible to Pediatrics at Oyster Point, PLLC for any charges not covered by insurance. If payment from my insurance is not received within 60 days, my account will become due and payable by me. Any balance remaining on the account after insurance pays will be due upon receipt of my statement. Charges not billed to my insurance carrier are due immediately.

4. The possibility exists (during treatment) for healthcare workers to become directly exposed to a patient's blood or body fluids. In the event of such exposure, State law requires a sample of the patient's blood to be tested for the presence of infectious disease. The results of these tests will be released to the patient or legal guardian and to the healthcare workers who suffered the exposure, to which I consent.

5. The assignments, obligations and authorizations set forth in this statement and the Insurance Assignment shall be binding upon me both for the present treatment and treatment that may be rendered to me and my family in the future of Pediatrics at Oyster Point, PLLC.

6. Billing inquiries may be directed to our Central Billing Office between the hours of 9:00 a.m. and 4:30 p.m. Monday through Friday at **(757) 599-4090.**

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Pediatrics at Oyster Point, PLLC may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Pediatrics at Oyster Point, PLLC's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Pediatrics at Oyster Point, PLLC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Pediatrics at Oyster Point, PLLC's Privacy Officer at 895 Middle Ground Blvd., Suite 200, Newport News, VA 23606.

With my consent, Pediatrics at Oyster Point, PLLC may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Pediatrics at Oyster Point, PLLC may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Pediatrics at Oyster Point, PLLC may e-mail to me appointment reminder cards and patient statements. I have the right to request that Pediatrics at Oyster Point, PLLC restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Pediatrics at Oyster Point, PLLC's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Pediatrics at Oyster Point, PLLC may decline to provide treatment to me.

I, _____, have received a copy of Pediatrics at Oyster Point, PLLC's Notice of Privacy Practices.
PATIENT NAME (PARENT/GUARDIAN IF UNDER 18)

RELEASE

I authorize the release of any medical information necessary to process this claim and any future claims. I also authorize payment of medical benefits to this provider

SIGNATURES

SIGNATURE OF PATIENT OR LEGAL GUARDIAN _____ DATE _____

PRINT NAME OF PATIENT OR LEGAL GUARDIAN _____

PATIENT'S NAME(S) _____

Pediatrics at Oyster Point

895 City Center Boulevard, Suite 200 -- Newport News, VA 23602 Phone (757) 599-4090 -- (757) 599-4093

Brian K. Butcher, M.D., F.A.A.P., Nakeshia Brown Hunter, M.D., F.A.A.P.
Angela Spears, PNP-C, Morgan Bennett, MSN, FNP-BC, Michelle Wise, NP-C, Danielle Calabrese, NP

PERMISSION SLIP

The purpose of this form is to allow you to have someone else bring your child(ren) to see our doctors. By signing this form you are allowing **Pediatrics at Oyster Point** to share any information about your child(ren) to the below listed person(s), if they bring your child in for the appointment. **Pediatrics at Oyster Point** is in no way responsible for any information given out to this person(s).

The doctors and staff at **Pediatrics at Oyster Point** are not obligated to inform the parent(s)/guardian(s) of any information that was given to the person(s) listed. ***It is the responsibility of the person(s) who brings the child in, to report to the parent/guardian the diagnosis, medication information and any additional information given during this visit.***

NAME	RELATIONSHIP	PHONE NUMBER
	Parent	
	Parent	

IF YOU HAVE A COURT ORDER IN PLACE, PLEASE PROVIDE A COPY FOR OUR OFFICE.

I have read and understand this permission slip and give the above person(s) permission to bring my child(ren) to Pediatrics at Oyster Point for treatment.

PLEASE PRINT YOUR NAME	SIGNATURE	RELATIONSHIP	DATE
PATIENT NAME (if more than one child, please list them)		DATE OF BIRTH	

****PLEASE COMPLETE A SEPARATE FORM FOR EACH PATIENT**

At your request, you may add or take away from this list at anytime.