

# NURTURE PEDIATRICS PATIENT SIGN-IN SHEET

Please bring insurance card, copay, co-insurance and deductibles to your visit and if any information has changed, please

Appointment Time: \_\_\_\_\_ Arrival Time \_\_\_\_\_ Date: \_\_\_\_\_

Provider  Langone  Bottoms  Fuller  Webb

Patient Name \_\_\_\_\_

Address \_\_\_\_\_

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

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Other Emergency Number \_\_\_\_\_

Primary Insurance \_\_\_\_\_

Secondary Insurance \_\_\_\_\_

Insurance Card For Presentation  Yes  No

\_\_\_\_\_  
PARENT/GUARANTOR RESPONSIBLE PARTY SIGNATURE

CONSENT FOR TREATMENT/AUTHORIZATION TO FILE INSURANC

I have provided the above insurance and understand that I am responsible for all charges not paid by my insurance. In case default of payment, I will be responsible for any collection / attorney fees incurred to collect this account.

\_\_\_\_\_  
Office Use

**PATIENT NAME** \_\_\_\_\_ Social Security# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Last First MI

Street Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

County \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email Address \_\_\_\_\_ Language \_\_\_\_\_

\*\* Understanding a patient's race and ethnic background helps your provider identify potential health risk factors. Medical conditions may affect persons of some races and ethnic backgrounds differently. Please check all that apply.

Race(s)  Asian  American Indian or Alaska Native  Black or African American  
 Hawaiian Native or Pacific Islander  White  Unknown/Declined

Ethnicity  Hispanic or Latino  Not Hispanic or Latino  Unknown/Declined

**MOTHER'S NAME** \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Last First MI

Street Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

County \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Marital Status \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email Address \_\_\_\_\_ Language \_\_\_\_\_

Employer \_\_\_\_\_ Employer Phone \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**FATHER'S NAME** \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Last First MI

Street Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

County \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Marital Status \_\_\_\_\_

Home phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email Address \_\_\_\_\_ Language \_\_\_\_\_

Employer \_\_\_\_\_ Employer Phone \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**EMERGENCY CONTACT NAME** \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Work phone \_\_\_\_\_

**PRIMARY INSURANCE** \_\_\_\_\_ Phone # \_\_\_\_\_  
 Policy Holder's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
 Policy Holder's Employer \_\_\_\_\_ Employer's Phone \_\_\_\_\_  
 Subscriber ID# \_\_\_\_\_ Group# \_\_\_\_\_ Plan# \_\_\_\_\_

**SECONDARY INSURANCE** \_\_\_\_\_ Phone # \_\_\_\_\_  
 Policy Holder's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
 Policy Holder's Employer \_\_\_\_\_ Employer's Phone \_\_\_\_\_  
 Subscriber ID# \_\_\_\_\_ Group# \_\_\_\_\_ Plan# \_\_\_\_\_

**Please initial each statement listed below that applies to you:**

- \_\_\_\_\_ I do have Commercial Private Insurance
- \_\_\_\_\_ I do NOT have Commercial Private Insurance
- \_\_\_\_\_ I do have Amerigroup, Americhoice, BlueCare or TennCare Selec
- \_\_\_\_\_ I do NOT have Amerigroup, Americhoice, BlueCare or TennCare Select nor have I applied for it
- \_\_\_\_\_ I do NOT have any health insurance and will be self-pay

- \*\* I understand that I must show my valid insurance ID card at every doctor's visit with the correct PCP listed.**
- \*\* I understand that if my insurance information changes I must notify the office within 30 days of change.**
- \*\* I understand that copayments are paid at the time of each visit.**
- \*\* I understand there will be a charge for all missed visits unless given 24 hour notice.**

\_\_\_\_\_  
 If you have an answering machine or voice mail, may we leave messages regarding your appointments, treatment, and/or other information pertinent to your health care?

Yes     No     N/A

Please list any other restrictions regarding messages or reminders about your healthcare: \_\_\_\_\_

**Patient/Parent Preferred Contact Method:**

Medical Issues:     No Contact     Home Phone     Cell Phone     Work Phone     Mail Home Address

Appointment Reminders:  No Contact     Home Phone     Cell Phone     Work Phone     Mail Home Address

Recalls:     No Contact     Home Phone     Cell Phone     Work Phone     Mail Home Address

Billing Statement:    Mail to Home Address

General Notices:     No Contact     Home Phone     Cell Phone     Work Phone     Mail Home Address

**\*\* I am fully aware that a cell phone is not a secure and private line.**

Please list the names of those authorized to seek medical attention for your child/children:

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How did you hear about our office? \_\_\_\_\_

### Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Nurture Pediatrics, PLC Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice and I request the following restriction(s) concerning the use of my personal medical information:

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Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

I hereby assign medical benefits due to me to be paid directly to Nurture Pediatrics, PLC. I hereby consent to the release of medical information necessary to process any insurance claims and to any other doctor for the continuation of my medical care. I understand that a photocopy of this release is as valid as the original.

\_\_\_\_\_  
Signature of Patient, Parent or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Witnessed By

### Internal Use Only

If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient/representative and sign below.

Presented On (date and time) \_\_\_\_\_

By (name and title) \_\_\_\_\_

## Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or HealthCare Operation

I understand that as part of my child/children’s healthcare, Nurture Pediatrics, PLC originates and maintains paper and/or electronic records describing their health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning their care and treatment
- A means of communication among many health professionals who contribute to their care.
- A source of information for applying diagnosis and surgical information bill
- A means of information for outside collection procedures
- A means by which a third party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of their health information for directory purposes, and,
- The right to request restrictions as to how their health information may be used or disclosed to carry out treatment, payment, or healthcare operations.

I understand that Morgan Pediatric Group, LLC is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I wish to have the following restrictions to the use or disclosure of my health information:

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I understand that as part of this organization’s treatment, payment, or healthcare operations, it may become necessary to disclose their protected health information to another entity, and I consent to such disclosure for the permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

\_\_\_\_\_  
Patient’s Name ☒

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Parent or Guardian’s Name (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian’s Signature

\_\_\_\_\_  
Relationship To Patient

## Financial Policy

It is our policy to bill your insurance carrier as a courtesy to our patients. Co-pays, coinsurance and deductibles are due at the time services are rendered. If you are not prepared to pay these, you may be asked to reschedule your appointment.

If within 60 days your insurance has not remitted payment on your account, the balance is due in full from you. Excessive payments will be promptly refunded. You recognize an obligation to forward payment to Nurture Pediatrics, PLC for any payment not received by us, but due to us.

If collection efforts must be pursued, you will be held responsible for the collection agency and/or attorney fees.

I have read the above. I agree with and understand its content.

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
DOB

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date

# Initial History Questionnaire

Name \_\_\_\_\_

ID NUMBER \_\_\_\_\_

FORM COMPLETED BY \_\_\_\_\_

DATE COMPLETED \_\_\_\_\_

BIRTH DATE \_\_\_\_\_

AGE \_\_\_\_\_

M F

## Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names, ages, and where they live. \_\_\_\_\_

What is the child's living situation if not with both biological parents?

Lives with adoptive parents    Joint custody    Single custody

Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home? \_\_\_\_\_

## Birth History Don't know birth history

Birth weight \_\_\_\_\_ Was the baby born at term? \_\_\_\_\_ OR \_\_\_\_\_ weeks

Were there any prenatal or neonatal complications?

Yes    No   Explain \_\_\_\_\_

Was a NICU stay required?    Yes    No   Explain \_\_\_\_\_

During pregnancy, did mother

Use tobacco    Yes    No   Drink alcohol    Yes    No

Use drugs or medications    Yes    No    Used prenatal vitamins

What \_\_\_\_\_ When \_\_\_\_\_

Was the delivery    Vaginal    Cesarean   If cesarean, why? \_\_\_\_\_

Was initial feeding    Formula    Breast milk   How long breastfed? \_\_\_\_\_

Did your baby go home with mother from the hospital?

Yes    No   Explain \_\_\_\_\_

## General DK = don't know

Do you consider your child to be in good health?    Yes    No    DK   Explain \_\_\_\_\_

Does your child have any serious illnesses or medical conditions?    Yes    No    DK   Explain \_\_\_\_\_

Has your child had any surgery?    Yes    No    DK   Explain \_\_\_\_\_

Has your child ever been hospitalized?    Yes    No    DK   Explain \_\_\_\_\_

Is your child allergic to medicine or drugs?    Yes    No    DK   Explain \_\_\_\_\_

Do you feel your family has enough to eat?    Yes    No    DK   Explain \_\_\_\_\_

## Biological Family History DK = don't know

Have any family members had the following?

Childhood hearing loss    Yes    No    DK   Who \_\_\_\_\_   Comments \_\_\_\_\_

Nasal allergies    Yes    No    DK   Who \_\_\_\_\_   Comments \_\_\_\_\_

Asthma    Yes    No    DK   Who \_\_\_\_\_   Comments \_\_\_\_\_

Tuberculosis    Yes    No    DK   Who \_\_\_\_\_   Comments \_\_\_\_\_

Heart disease (before 55 years old)    Yes    No    DK   Who \_\_\_\_\_   Comments \_\_\_\_\_

High cholesterol/takes cholesterol medication    Yes    No    DK   Who \_\_\_\_\_   Comments \_\_\_\_\_

Anemia    Yes    No    DK   Who \_\_\_\_\_   Comments \_\_\_\_\_

Bleeding disorder    Yes    No    DK   Who \_\_\_\_\_   Comments \_\_\_\_\_

Dental decay    Yes    No    DK   Who \_\_\_\_\_   Comments \_\_\_\_\_

Cancer (before 55 years old)    Yes    No    DK   Who \_\_\_\_\_   Comments \_\_\_\_\_

(Biological Family History continued on back side.)

American Academy of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

Initial History Questionnaire

## Biological Family History (Continued from front side.) DK = don't know

Liver disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Kidney disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Diabetes (before 55 years old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Bed-wetting (after 10 years old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Obesity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Epilepsy or convulsions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Alcohol abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Drug abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Mental illness/depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Developmental disability	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Immune problems, HIV, or AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Tobacco use	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Additional family history _____					

## Past History DK = don't know

Does your child have, or has your child ever had,

Chickenpox	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	When _____
Frequent ear infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Problems with ears or hearing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Nasal allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Problems with eyes or vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Any heart problem or heart murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Anemia or bleeding problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Blood transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Organ transplant	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Malignancy/bone marrow transplant	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Chemotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Frequent abdominal pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Constipation requiring doctor visits	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Recurrent urinary tract infections and problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Congenital cataracts/retinoblastoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Metabolic/Genetic disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Kidney disease or urologic malformations	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Bed-wetting (after 5 years old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Sleep problems; snoring	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Chronic or recurrent skin problems (eg, acne, eczema)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Frequent headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Convulsions or other neurologic problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Obesity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Thyroid or other endocrine problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
History of serious injuries/fractures/concussions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Use of alcohol or drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Tobacco use	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
ADHD/anxiety/mood problems/depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Developmental delay	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Dental decay	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
History of family violence	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Sexually transmitted infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Pregnancy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
(For girls) Problems with her periods	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Has had first period <input type="checkbox"/> Yes <input type="checkbox"/> No	Age of first period _____			
Any other significant problem _____				

**This American Academy of Pediatrics Initial History Questionnaire is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 3rd Edition.***

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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