CENTRE PEDIATRIC ASSOCIATES, PC
PATIENT INFORMATION FORM

Please name the primary care physician (PCP) you have chosen: _____

Please write the name (s) of any other children currently being seen in this office: _____

Please PRINT CLEARLY the following information:

Child's Last Name: _____First Name: _____MI:_____

Child's Date of Birth: Month: _____Day: _____Year:_____ Sex: M [ ] F [ ]

Guarantor Parent's Last Name:_____ First Name: _____MI: _____

Parent's Date of Birth: _____/_____/_____ Social Security Number: _____/___/_____ Sex: M [[F [ ]

Second Parent's Last Name: _____ First Name: _____MI:_____

Parent's Date of Birth: _____/_____/_____ Social Security Number: ____/___/_____ Sex: M [ ] F [ ]

Phone Numbers: Primary: ( )_____

Secondary: ( ) _____

Address: Number and Street: _____

City, State and Zip Code: _____

Billing Address: (if different) _____

Email address: _____

Are you Native American (American Indian) or Alaskan Native: Yes [ ] No [ ]
Primary language spoken in home: _____ Ethnicity:_____Race:_____

Insurance Information (Please attach a copy of your child's insurance card)

Insurance Carrier Name: _____

Subscriber's Name: _____Subscriber's Date of Birth: _____/_____/_____

Employer's Name and Address:_____

Member # (if applicable) _____ Group Number: _____

Identification Number: _____ Child's Suffix (if applicable) _____

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance due on my account for all services rendered by Centre Pediatric Associates, PC including any late fees and/or service charges. I understand that all co-payments are due and payable at the time of the visit. I have read all the information on this form and have completed all the answers. I will notify you of any changes in my health insurance status or any of the above information.

Parent (Guardian) Signature_____ Date: _____

Centre Pediatric Associates, PC

Notice of Privacy Practices Acknowledgement and Consent

CENTRE PEDIATRIC ASSOCIATES, PC

By signing below, I acknowledge that I have been provided a copy of the Centre Pediatric Associates, PC Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the medical group listed at the beginning of this Notice, and how I may obtain access to and control of this information.

By signing below, I also consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of medical group, its staff, and its business associates.

_____
Signature of Patient or Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Date

Centre Pediatric Associates, PC
One Brookline Place, Ste. 327
Brookline, MA 02445

Patient Financial/Insurance Waiver

Your child's visit for a routine physical exam may or may not require a copay. If your doctor provides any services that are not covered by your plan, your insurance company may not pay the total amount. In the event this happens, you will be billed and be responsible to pay a copay or deductible according to the insurance plan you selected. Please call your insurance company directly for specifics regarding your insurance plan.

As a member of _____ insurance, I agree to take full responsibility for any services provided to my child(ren) by Centre Pediatric Associates, PC. This includes if my insurance company denies payment of my claims for any reason including ineligibility, incorrect primary care provider (PCP) selection, or because the services are not covered by my insurance plan.

Insurance Subscriber: _____

Relationship to Patient: _____

Child/Children's Name (s):

_____ Date of Birth: _____

_____ Date of Birth: _____

_____ Date of Birth: _____

Parent/Guardian signature: _____

Parent/Guardian name (print) _____

Date: _____

CENTRE PEDIATRIC AUTHORIZATION FOR VACCINE ADMINISTRATION

It is the policy of Centre Pediatric Associates, PC; that any child who receives their care at Centre Pediatric Associates, PC, is required to receive all vaccines recommended by the American College of Immunization Practices; American Academy of Pediatrics and the CDC. At each of your child's (children's) well visits the provider will discuss any vaccines to be administered and you will have an opportunity to discuss with your provider. We understand and respect your right to decline these because of personal or religious reasons. However, if you choose to decline these immunizations we may not be able to continue as your child's (children's) pediatricians.

CONSENT TO VACCINATE:

PATIENT'S NAME: _____DOB:_____ SEX: _____

PARENT'S SIGNATURE: _____

I have read or have had explained to me information about diseases and vaccines. I understand the benefits and risks of vaccines and authorize the administration of vaccines as recommended according to the guidelines provided by the American Academy of Pediatrics, the CDC and Centre Pediatric Associates, PC to the above name patient.

NOTE: For patients transferring their care to us, we require a copy of your vaccine records from your previous healthcare provider before you can be seen in our practice.

Medical History

Patient Name: _____ Patient D.O.B.: _____

1.) At approximately how many weeks was your child born? Did your child require extra days in the hospital at birth?

_____

_____

2.) Does your child have any medical problems? (Ie: asthma, eczema, diabetes, etc.) Does/Has your child see any specialists?

_____

_____

3.) Has your child had any medical problems in the past that have now been resolved?

_____

_____

4.) Has your child required any hospitalizations, E.R. visits?

_____

_____

5.) Has your child had any surgeries or procedures?

_____

_____

6.) Is your child on any current/past medications?

_____

_____

7.) Does your child have any allergies?

_____

_____

8.) Has your child ever had any development or behavior issues?

_____

_____

CENTRE PEDIATRIC ASSOCIATES, P.C. FAMILY HISTORY SUMMARY

Child's Name: **Child's Date of Birth:**

Family History: Please indicate with an **(X)** family members who have had any of the following conditions:

Illness/Disease	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad
Anxiety								
Asthma								
Autoimmune Disorder								
Bleeding Disorders								
Cancer: Please specify type_____								
Cancer: Please specify type_____								
Celiac Disease								
Congenital Hip Disorder								
Depression								
Diabetes Type I (childhood onset)								
Diabetes Type 2 (adult onset)								
Genetic Disorder								
Hearing Disorder								
Heart Attack/Coronary Artery Disease								
High Cholesterol (Hyperlipidemia)								
High Blood Pressure (Hypertension)								
Hypercoagulation Disorder or blood clots								
Kidney Disease								
Psychiatric/Mental Illness								
Seizure Disorder								
Thyroid Disorder								
Ulcerative Colitis/Crohn's Disease								
Death before age 56 for reasons not stated above								
Other:_____								
Other:_____								

SOCIAL HISTORY: Please list patient's family and household members:

Name	Age	Relationship	Occupation/Employer	Cell Phone No.

Is violence at home a concern? □Yes □No

Are there guns in the home? □Yes □ No

Do any family members smoke? □ Yes □No

Are there pets at home? □Yes □No