Pleasant Pediatrics New Patient Information

Date:_____

Patient Name:_____Male/Female

Last First Middle

Patients Social Security#:_____ Age_____ Date Of Birth_____

Address:_____City:_____State:_____Zip:_____

Phone #:_____

Race: American/ Indian/ Asian/ Native Hawaiian/ Black; African American/ White/ Hispanic/ Other/ Refuse

Ethnicity: Hispanic or Latino/ Not Hispanic or Latino/ Refuse

Language: English/ Indian (include Hindi)/ Spanish/ Chinese/ Other:_____

Patient(s) or Guardian(s) Guarantor Information

Parent/ Guardian Name:_____DOB:_____

Relationship to patient: Mother/ Father/ Grandparent/ Foster Parent/ Other:_____

Phone:_____

Address:_____City:_____State:_____Zip:_____

Email for patient portal access:_____

Parent/ Guardian Name:_____DOB:_____

Relationship to patient: Mother/ Father/ Grandparent/ Foster Parent/ Other:_____

Phone:_____

Address:_____City:_____State:_____Zip:_____

Insurance Information

Primary Ins:_____Member ID:_____Group#:_____

Subscriber Name:_____DOB:_____SSN:_____

Employer:_____Relationship to Patient:_____

Secondary Ins:_____Member ID:_____Group #:_____

Subscriber Ins:_____DOB:_____SSN:_____

Employer:_____Relationship to Patient:_____

In case of emergency, please provide the name of a relative or friend we may contact at a **DIFFERENT ADDRESS**:

Name:_____Phone:_____

Address:_____Relationship to Pt:_____

Pediatric Health History

Patient:_____ DOB:_____

Name of Person Completing Form:_____

Relationship to child:_____

Signature:_____

Are the patients immunizations up to date (circle one): YES NO UNKNOWN

When was the patients last well child exam or physical:_____

Medical Conditions: if either the patient or family member has or had any of these conditions, mark an (X) in the box by the condition listed. For family members, indicate their relationship to the patient. (Please specify which side Mom or Dad)...Ex: Grandma on mom's side

Condition	The patient	Family Member	Relationship to child
Allergies/ Hay Fever			
ADD/ADHD			
Asthma			
Cancer (Type)			
Depression			
Diabetes			
Hearing Loss			
Heart Problems			
High blood pressure			
High Cholesterol			
Kidney Problems			
Migraine Headaches			
Panic Attacks/ Anxiety			
Seizures			
Skin Problems			
Thyroid Problems			
Cystic Fibrosis			
Cerebral palsy			
Sickle Cell Anemia			
Developmental Disability			
Muscular Dystrophy			
Other			
Other			

Nurse Signature:_____ Date:_____

Providers Signature:_____ Date:_____

Pediatric Health History

Name:_____

Birth History

Birth Weight: _____ Length:_____
Hepatitis B given at Hospital? YES NO Number of Weeks Gestation:_____
Was the patient born prematurely? YES NO If Yes, how early?_____
How was the patient born? VAGINALLY BY C-SECTION , IF SO WHY?_____
Did the patient have Cyanosis or Jaundice after birth?_____
Male Patients only: Circumcision? YES NO
How many days did baby stay in the hospital?:_____

Before the Patient was born, did mom have any complications during pregnancy? (see below)

Gestational Diabetes YES NO High Blood Pressure/Preeclampsia YES NO
Urinary Tract Infection YES NO Alcohol/ Drug Use, if yes, specify:_____
Sexually Transmitted infection(s), If yes, specify:_____
Other complications Prenatal or Postnatal:_____

Family Information:

Mother DOB:_____ Age:_____ Fathers DOB:_____ Age:_____
Childs Sibling:_____ Age:_____ Full sibling YES NO
Childs Sibling:_____ Age:_____ Full sibling YES NO
Childs Sibling:_____ Age:_____ Full sibling YES NO
Childs sibling:_____ Age:_____ Full sibling YES NO

Hospitals

Has the patient been re-admitted to the hospital since birth and/ or have been see for any reason? YES NO
If YES, please specify substance(s) and reaction(s):

_____

Surgeries

Has the patient ever had surgery? YES NO
Please list any surgeries or procedures your child has had with approximate dates:

_____

Allergies

Is the patient allergic or intolerant to any medications, food or any environmental? YES NO
If YES, please specify substance(s) and reaction(s):

_____

Other

Exposed to a Communicable Disease? YES NO If YES, explain:_____
Traveled outside of U.S? YES NO If YES, where:_____

Nurse Signature:_____ Date:_____

Provider Signature:_____ Date:_____

Medications

Please list any medications the patients is using including Over the Counter Medications, Vitamins, and Herbal Supplements and Contractor's:

Medications	Dose/Amount	How many times per day

Symptom Check List:

If the patient has had any of the following problems, please circle the condition listed:

General	Fever	Fatigue	Chills	Weight change		Other
Head	Headaches	Dizziness	Injury			Other
Ears	Ear pain	Ear discharge	Change in hearing			Other
Nose	Congestion	Sinus pressure	Sinus pain			Other
Throat	Sore throat	Snoring	Sleep apnea	Itchy throat		Other
Eyes	Changes in vision	Flashing lights	Eye pain	Eye discharge	Itchy or irritable	Other
Heart	Chest	Palpitations	Racing heart	Chest pressure		Other
Lungs	Trouble breathing	Cough	Wheezing	Pneumonia	Bronchitis	Other
Urinary	Painful urination	Foul smell	Incontinence	Frequency		Other
Digestive	Heartburn/ acid reflux	Abdominal pain	Vomiting/ nausea	Diarrhea	Constipation	Other
Bones & Joints	Back pain	Joint pain	Neck pain	Muscle aches		Other
Neurological	Weakness	Seizures	Numbness	Fainting		Other
Psychological	Anxious	Panic attack	Insomnia	Appetite changes	Self-injury	Other
Skin	Abnormal changes	Bruising	Rashes	Hair or nail changes	Dryness	Other

Pleasant Pediatrics Consent to Treat

Consent for Treatment for a Minor

I,_____ being the parent/ legal guardian of (name of child):_____

DOB:_____, give my consent and authorize the administration and performance of all treatment and diagnostic procedures, which in the judgement of Pleasant Pediatrics licensed physicians and physicians assistants are considered necessary. The minor named in this consent form may receive all medical care provided according to generally and currently accepted standards of pediatric medical care.

In the absence of the legal guardian the following people are authorized to bring this minor for medical treatment and have access to his/her medical information. (You may name relatives, friends, grandparents, stepparents, non-custodian parent, day care provider, foster parent or others.)

Name:_____Relationship_____

Name:_____Relationship_____

Name:_____Relationship_____

If no other person is authorized please circle: NONE

Please initial the following:

_____If a minor is brought by any other person not recorded above, Pleasant Pediatrics will make reasonable attempts to contact me for a verbal consent to treat. I will keep Pleasant Pediatrics notified of any change of my telephone number.

_____If the custody or guardianship of this minor has changed I will furnish Pleasant Pediatrics with legal form that are required to be included in the minor's medical record to explain the change in guardianship. This will alleviate any confusion that may occur over who may not consent to minors treatment.

_____I have the right to revoke or change this consent to treat in writing.

Parent/Legal Guardian Print name Date

_____

Parent/Legal Guardian Signature Date

_____

Patient Payment Agreement

I understand that I will be responsible for all charges related to the services provided to me by Pleasant Pediatrics that my insurance does not cover.

I understand that the chargers presented to me including co-pays are due in full on the day of service, unless arrangements have been made with the physician. I also understand that these charges are solely in relation to professional services provided by the physician, and or other services that are performed in the office. I understand that if I refuse to pay the charges on my account the provider has the right to refuse services to my child/ children.

All other services that require for you to go elsewhere such as x-rays, MRI's, CT's, etc., are not included in your fee. You will be billed separately for these services from the practicing location.

The patient certifies that he/she has read and agreed to the forgoing, and is the patient, the patient's representative or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Parent/ Guardian Print name

Patient/ Child name & DOB

Parent/ Guardian Signature

Date

Pleasant Pediatrics
Acknowledgement of Receipt of Notice of Privacy Practices

The undersigned patient or legally authorized representative (agent) of the patient acknowledges that he or she personally received a copy of the Pleasant Pediatrics Notice of Privacy Policies on the date indicated below.

Signature:_____ Date:_____

Patient Name:_____

Information about Agent (attach appropriate documentation)

Agent:_____ Title:_____

_____

Medication and Pharmacy Consent

The undersigned patient or legally authorized representative (agent) of the patient hereby give consent for Pleasant Pediatrics to access the patients past and present medication history. This is necessary for use of electronic prescription writing.

Childs Name:_____ DOB:_____

Name of Childs Pharmacy:_____

City of Pharmacy:_____

Signature of Guardian:_____

Pleasant Pediatrics Insurance Participation List

Pleasant Pediatrics participates with the following insurance programs:

COMMERCIAL

-Blue Cross Blue Shield (ALL)
-Blue Care Network
-MultiPlan
-ASR Corp
-McLaren Health Plan
-Aetna
-United Health Care/ Golden Rule
-CIGNA PPO
-Physicians Health Plan Comm'1 HMO/PPO
- Tricare
- Key Benefit Administrators
- US Health and Life
- HealthPlus
- Meritain
- Physician Health Plan (PHP)
- Priority Health HMO/PPO

MEDICAID

- Medicaid (State of MI)
- Meridian Health Plan (MI Child)
- Molina (MI Child)
- McLaren (MI Child)

Pleasant Pediatrics participates with a variety of health care plans including many Medicaid plans, BCBS and Children's Special Health Care to name a few. Please talk to our biller to be certain if we par with your plan. As a courtesy to our patients Pleasant Pediatrics submits claims to all carriers, regardless of our participation status with them. Patients are responsible for paying any applicable co-pay and deductible amounts on the day services are rendered. Co-pays must be paid before visit at check-in window.

I understand that my insurance policy is a contact between myself and my insurance company. Therefore, I am responsible for all fees regardless of insurance coverage at the time service are rendered. I agree to be financially responsible for all costs incurred by my dependent child in connection with medical examinations, treatments, referrals, testing and/or procedures ordered by the office, whether conducted in this office or elsewhere, which are not otherwise paid by my insurance.

I hereby authorize Pleasant Pediatrics or its designees to bill and release to my insurance company and/or third payer(s) and or external review agency(s) such information contained in my child's patient record as is necessary for the payment of insurance benefits without regard to any limitations placed on dates, history, illness or diagnostic and therapeutic information.

Signature (Legal Parent/ Guardian):_____ Date:_____

Patient Provider Partnership Agreement

Welcome and thank you for choosing Pleasant Pediatrics. We are committed to providing your children with the best medical care based on their health needs. Our hope is that we can form a partnership to keep them as healthy as possible, no matter what their current state of health. Your commitment to our patient-centered medical home practice will provide you with an expanded type of care. We will work with both you and other health care providers as a team to take care of your child/children.

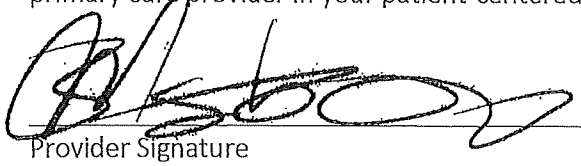
As your primary care provider (PCP), I will:

- Take care of any short-term illness, long-term chronic condition, and all-around well-being.
- Keep you up to date on all their vaccines, well-child visits, and other prevention screening tests.
- Connect you with other members of your care team (specialist) and coordinate your care with them as their health needs change.
- Notify you of test results in a timely manner
- Communicate clearly with you so you will understand any conditions and all the options
- Listen to you questions and feelings, I will respond promptly to you in a way you understand
- Help you make the decisions of your child's care.
- Provide information on community resources.

We trust you, as our patient, to:

- Know that you and your family are a full partner with us in your children's care.
- Let us know when you see other health care providers so we can help coordinate the best care.
- Keep scheduled appointments or call to reschedule or cancel as early as possible.
- Understand your child's health, ask questions about their care, and tell us if you don't understand.
- Learn about their condition(s) and what you can do to keep them as healthy as possible.
- Follow the plan that we have agreed is the best for your child's health.
- Give the prescribed medications as directed.
- All health care providers in your care team will receive all information related to your child's health care.
- Learn about your health insurance coverage and contact your insurance provider if you have any questions about benefits.
- Pay your share of any fees.
- Give us feedback to help us improve our care for your family.
- Ask us about resources you or your family may need.

Dr. Msibi and the care team of Pleasant Pediatrics look forward to working with your family as your child's primary care provider in your patient-centered medical home.



Bhekumusa Msibi

Provider Signature | Print Provider Name | Date

Parent/ Guardian Signature | Printed name | Date

Patient Printed Name | Date Of Birth | Date

NAME_____ COUNTY_____D.O.B_____DATE_____

Social Determinants of Health

Patient Screening Questionnaire

This form is to help assist our providers to determine what form of assistance and what type of resources our office can assist you with, to ensure that you are meeting your basic needs and maintaining a quality of life. Please fill this form out and return to our front desk. Someone will follow up. Thank you!

DOMAIN	QUESTION			
HealthCare	In the past month, did poor physical or mental health keep you from doing your usual activities, like work, school, or hobby?	No	Yes	N/A
	In the past year, was there a time when you needed to see a doctor but could not because it cost too much?	No	Yes	N/A
Food	Do you ever eat less than you feel you should because there is not enough food?	No	Yes	N/A
Employment & Income	Do you have job or other steady source of income?	No	Yes	N/A
Housing & Shelter	Are you worried that in the next few months, you may not have safe housing that you own, rent or share?	No	Yes	N/A
Utilities	In the past year, have you had a hard time paying your utility company bills?	No	Yes	N/A
Child Care	Does getting child care make it hard for you to work, go to school or study?	No	Yes	N/A
Education	Do you think completing more education or training, like finishing a GED, going to college, or learning a trade, would be helpful for you?	No	Yes	N/A
Transportation	Do you have a dependable way to get to work or school, and your appointments?	No	Yes	N/A
Clothing & Household	Do you have enough household supplies? For ex: clothing, shoes, blankets, mattress, diapers, toothpaste and shampoo.	No	Yes	N/A
General	Would you like to receive assistance with any of these needs?	No	Yes	N/A
	Any of your needs urgent?	No	Yes	N/A
Abuse	Do you feel unsafe or scared at home or anyone physically or mentally causing you harm?	No	Yes	N/A