CHILD - UNDER 18
NEW PATIENT QUESTIONNAIRE
TO BE FILLED OUT BY PARENT FOR CHILD

REVIEWED
DATE: _____
DR. _____

Today's Date _____

Child's Name _____

Mother's Name _____ Age _____ Blood Type _____

Occupation _____ Date of Birth _____

Father's Name _____ Age _____ Blood Type _____

Occupation _____ Date of Birth _____

If adults in the household work outside the home, what child care arrangements are made for this child? _____

A. PREGNANCY AND BIRTH:

1. Mother's age at birth _____
2. Did Mother have any illness during pregnancy?
   ❑ No ❑ Yes
3. Did she take any medications other than vitamins and iron?
   ❑ No ❑ Yes
4. What was the due date? _____
   date of birth _____
5. What was the birth weight? _____
   birth height? _____
6. Did the baby have any trouble starting to breathe?
   ❑ No ❑ Yes
7. Circumcision ❑ Yes ❑ No
8. Did the baby have any trouble while in the hospital? (jaundice, infections, other?) ❑ No ❑ Yes
   What kind? _____
9. If newborn, was first Hepatitis B given in hospital?
   ❑ Yes Date given _____ ❑ No

B. PAST MEDICAL HISTORY

1. Where has your child gone for check-ups until now? _____
2. Date of last check-up: _____
3. Date of last dental check-up: _____
4. Has your child had allergic reactions to any medications, food, insect bites? ❑ No ❑ Yes
   Which ones? _____
5. Has your child had reactions to any immunizations?
   ❑ No ❑ Yes
   Which ones? _____
6. Any hospitalizations other than for birth? ❑ No ❑ Yes
   For what? _____
7. Any serious injuries? ❑ No ❑ Yes
   What kind? _____
8. Are any medications taken regularly? ❑ No ❑ Yes
   Which ones? _____
9. List any serious childhood diseases and age acquired (requiring a lot of tests, repeated specialist visits)
   _____
   _____

C. FAMILY HISTORY:

1. Are the child's parents both in good health? ❑ No ❑ Yes
   Any chronic or long-term health problems with child's parents?
2. Race of parents:
   Mother _____
   Father _____
3. Check any diseases that the child's parents, grandparents, brothers, sisters, or aunts and uncles have had:

❑ anemia	❑ asthma	❑ allergies
❑ diabetes	❑ high blood pressure	❑ heart trouble
❑ tuberculosis	❑ mental illness	❑ drug problems
❑ alcohol problems	❑ inherited illness	❑ venereal
❑ kidney disease	❑ cancer	❑ AIDS
❑ others _____	❑ on chemotherapy	

4. And general health of brothers and sisters:
   Name _____ DOB _____
   Healthy Y / N Decribe: _____
   Name _____ DOB _____
   Healthy Y / N Decribe: _____
5. Have any of your children died? ❑ No ❑ Yes

D. FEEDING AND NUTRITION:

1. Is your child's appetite usually good? ❑ No ❑ Yes
2. Is it good now? ❑ No ❑ Yes
3. Was there severe colic or any unusual feeding problem during the last 3 months? ❑ No ❑ Yes

4. Do any foods disagree with him/her? ❑ No ❑ Yes

5. For the first 6 months is he/she (was he/she) breast fed or bottle fed? _____

6. If still on formula, which one do you use?_____

_____

7. Does he/she take vitamins? ❑ No ❑ Yes

E. REVIEW OF SYSTEMS:

1. Has your child had frequent ear infections? ❑ No ❑ Yes
2. Any eye problems? ❑ No ❑ Yes
3. Has he/she had any problems with teeth? ❑ No ❑ Yes
4. Does he/she have frequent colds or sore throats? ❑ No ❑ Yes
5. Is there asthma, pneumonia, or recurrent cough? ❑ No ❑ Yes
6. Does he/she have a heart murmur or any heart problems? ❑ No ❑ Yes
7. Any problems with urination? ❑ No ❑ Yes
   a. Does your child wet the bed at night? ❑ No ❑ Yes
   b. Does your child wet his.her pants in the daytime? ❑ No ❑ Yes
8. Any problems with diarrhea or constipation? ❑ No ❑ Yes
9. Have there been any convulsions or other problems with the nervous systems? ❑ No ❑ Yes
10. Any eczema, hives, or other skin conditions? ❑ No ❑ Yes
11. Has your child ever been anemic? ❑ No ❑ Yes
12. Please list any other medical problems: _____

_____

_____

_____

F. DEVELOPMENT / BEHAVIOR:

1. At what age did your child sit alone?_____
2. At what age did he/she walk alone? _____
3. Did he/she say any words by the time he/she was 1-1 1/2 years old? ❑ No ❑ Yes
4. How does this compare to others his or her age?_____

_____

5. Does he/she have any trouble sleeping? ❑ No ❑ Yes
6. What grad is he/she in?_____
7. Has he/she had any trouble in school? ❑ No ❑ Yes
8. Does he/she get along with other children? ❑ No ❑ Yes
9. Check if your child has had any of the following:
   ❑ Nail Biting ❑ Thumb Sucking ❑ Bed Wetting
   ❑ Problems with discipline ❑ Others.

G. SAFETY / ENVIRONMENT:

1. Do you live in a private house, apartment, mobile home, other? ❑ No ❑ Yes
2. Do you know the hottest temperatures of the water in your pipes? ❑ No ❑ Yes
3. Is there a working smoke alarm on each floor in the house? ❑ No ❑ Yes
4. Is there a gun in the house? ❑ No ❑ Yes
   Is it locked? ❑ No ❑ Yes
5. Does your child always use a car seat/seat belt when riding in a car? ❑ No ❑ Yes
6. Are there any smokers in the household? ❑ No ❑ Yes
7. Are there any problems with the condition of your home (peeling paint, insects, rats or mice)? ❑ No ❑ Yes
8. Does your child always wear a helmet when riding his/her bicycle? ❑ No ❑ Yes
9. Does your child live in or regularly visit an old house built before 1960? Was your child's day care center/preschooler/ babysitter's home built before 1960? Does the house have peeling or chipping paint? ❑ No ❑ Yes
10. Does your child live in a house built before 1960 with recent, ongoing or planned renovation or remodeling? ❑ No ❑ Yes
11. Have any of your children or their playmates had lead poisoning? ❑ No ❑ Yes
12. Does your child frequently come in contact with an adult who works with lead? Examples are construction, welding, pottery, or other trades practiced in your community? ❑ No ❑ Yes
13. Does your child live near a lead smelter, battery recycling plant, or other industry likely to release lead such as (give examples in your community)? ❑ No ❑ Yes
14. Do you give your child any home folk remedies which may contain lead? ❑ No ❑ Yes
15. Does your child live near a heavily traveled major highway where soil and dust may be contaminated with lead? ❑ No ❑ Yes
16. Does your home's plumbing have lead pipes or copper with lead solder joints? ❑ No ❑ Yes

H. DO YOU HAVE A RECORD OF IMMUNIZATIONS?
❑ No ❑ Yes
If so, give to Medical Asst.

PATIENT REGISTRATION

TODAY'S DATE_____

Patient's Name: _____M___F__ Date of Birth_____Age_____

Address:_____ City_____St_____Zip_____

Cell Phone/Primary_____ Secondary_____

Email Address_____

Pharmacy:_____

Referred By:_____ **"DRUG ALLERGIES"**:_____

****

Fathers Name: _____SS#_____Birthdate_____

Mothers Name:_____SS#_____Birthdate_____

****

EMERGENCY CONTACT (Other than parent)

Name:_____Relationship:_____Ph#_____

****

INSURANCE

1st INSURANCE_____**Policyholder**_____
ID# or Policy#_____

2nd INSURANCE_____**Policyholder**_____
ID# or Policy#_____

PLEASE GIVE INSURANCE CARDS AND DRIVERS LICENSE TO RECEPTIONIST FOR COPYING

AUTHORIZATION TO TREAT/ASSIGNMENT OF INSURANCE BENEFITS/AUTHORIZE TO RELEASE INFORMATION

I hereby authorize Brentwood Pediatrics P.C. physicians and/or staff to provide medical care to my minor child or children in my absence.
I hereby authorize direct payment of surgical/medical payments to Brentwood Pediatric Assoc. P.C.
I hereby authorize Brentwood Pediatric Assoc. P.C. to release medical or incidental information at their discretion.
I understand there is a minimum charge of $20.00 to copy medical records and transfer to a parent, physician, insurance company or attorney.
I certify that the above information given by me is correct.
A photocopy of these assignments shall be valid as the original.

Signature of Patient (if over 21)_____ **Date**_____

Signature of Parent/Guardian_____ **Date**_____

****

****PLEASE READ AND SIGN THE BACK OF THIS FORM****

Brentwood Pediatric Associates, P.C.
33215 West 7 Mile Rd. Livonia, Mi. 48152
24 Hour Phone 248-478-3200

BPA #1012

(OVER)

YOUR OBLIGATION AS A PATIENT, OR PARENT OF A PATIENT AT BRENTWOOD PEDIATRICS P.C. IS AS FOLLOWS:

1. All co-pays and deductibles are due at time of service.

2. You have read and understand the terms, conditions and benefits of your health insurance. We cannot be responsible to interpret each individual policy, as copays, deductibles and benefits constantly change. All amounts rejected by your insurance (for any reason) are your responsibility and payable to Brentwood Pediatrics P.C. within 10 business days of receiving our statement.

3. Unpaid insurance claims over 60 days old will be automatically rejected and billed to you. Payment is due for all rejected services within 10 business days of receiving our statement.

4. All well-child visits and immunizations, including school exams, not covered by insurance, are payable in full at time of service. **SCHOOL FORMS WILL NOT BE RELEASED UNTIL SERVICES ARE PAID IN FULL.**

5. Emergency or urgent visits may be charged to your Brentwood Pediatrics P.C. account once credit has been established with us. However, a payment must be made every 30 days to keep your account in good standing.

6. Account balances must not exceed $200.00 at any time.

7. In divorce situations, where one parent is responsible for medical services, that parent must present themselves in our office and sign proper forms prior to treatment. Otherwise, the parent who registers and accompanies the child for treatment is responsible.

8. All patient balances must be paid in full before a new insurance will be accepted. I agree to immediately notify the billing department at Brentwood Pediatrics P.C. of any change or termination of coverage.

9. Should my account be turned over to a collection agency or attorney, I agree to pay for all costs including collection and attorney fees and all legal expenses incurred, which will be substantially more than my original balance.

10. I understand there will be a $35.00 charge for each returned check from your bank.

11. **NO SHOW APPOINTMENTS WILL BE CHARGED $25.00**

Failure to comply with all of the above will result in a stop service policy and no services will be rendered until your account is current.

I have fully read the above obligations and agree to abide by them.

DATE: _____ PARENT SIGNATURE: _____

BRENTWOOD
PEDIATRIC
ASSOCIATES, P.C.

33215 W. SEVEN MILE RD.
LIVONIA, MI 48152
(248) 478-3200
FAX (248) 478-3316

PEDIATRIC AND ADOLESCENT MEDICINE

AJEY GODBOLE, M.D. F.A.A.P.

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessment and physician certification.

I have received, and/or reviewed the Notice of Privacy Practices containing a more complete description of the uses and disclosers of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

Patient Name: _____

Parent/guardian signature: _____

Relationship to Patient: _____

Date: _____

BRENTWOOD
PEDIATRIC
ASSOCIATES, P.C.

33215 W. SEVEN MILE RD.
LIVONIA, MI 48152
(248) 478-3200
FAX (248) 478-3316

PEDIATRIC AND ADOLESCENT MEDICINE

AJEY GODBOLE, M.D. F.A.A.P.

Dear Patient,

Due to many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these things changes it is not always possible. Therefore, we urge you, as the patient, to please check with your insurance company prior to the start of any office visit. **IT IS YOUR RESPONSIBILITY TO KNOW YOUR INDIVIDUAL COVERAGE**. Failure to comply with this suggestion could result in you, the patient, being held responsible for all costs incurred. Please remember that your insurance policy is between you and your insurance company and **NOT** the insurance company and Brentwood Pediatrics, P.C.

Sincerely,

Brentwood Pediatrics, P.C.

Print parent/guardian Name:_____

Signature of parent/guardian:_____

Patient Name:_____

Date:_____