Bottenfield Pediatric Associates

Gerald Bottenfield, M.D.
207 That Way A-1 Lake Jackson, TX 77566
Ph# 979-297-7337 (PEDS)
Fax# 979-266-9076

CHILDREN'S INFORMATION-PLEASE LIST ALL CHILDREN TO BE REGISTERED UNDER THIS ACCOUNT

Child's Legal Name	DOB:		Preferred Language:
Child's Legal Name Last: ____________________ First: ________________	**DOB:**	Male Female	**Preferred Language**: English Spanish
Child's Legal Name Last: ____________________ First: ________________	**DOB:**	Male Female	**Preferred Language**: English Spanish
Child's Legal Name Last: ____________________ First: ________________	**DOB:**	Male Female	**Preferred Language**: English Spanish
Child's Legal Name Last: ____________________ First: ________________	**DOB:**	Male Female	**Preferred Language**: English Spanish

PARENT/GUARDIAN INFORMATION

Parent/Guardian	Address	Primary Number
Father/Mother/Other (Circle One) **If other:**__________________________ Name:_____________________________________ DOB: ___________________________	**Address:**	**Primary Number:** ______________________ **Cell** **Home**
Father/Mother/Other (Circle One) **If other:**__________________________ Name:_____________________________________ DOB: ___________________________	**Address:**	**Primary Number:** ______________________ **Cell** **Home**

PREFERRED METHOD OF CONTACT

Home/Cell phone (circle) ____________________________ Text Y/N. If yes, then you do agree to your phone carrier charges.

Email address ____

INSURANCE INFORMATION

Insurance Carrier _____________________________ **Name of Insured** __________________________________

Group # _____________________________________ **ID #** ____

EMERGENCY CONTACTS

Name: ______________________________ **Telephone Number:** ____________________________	**Relationship to Child:** ________________________

Financial Policy

Bottenfield Pediatric Associates is dedicated to providing excellent care and understanding overall service to every patient at every visit. In the interest of avoiding misunderstandings that may arise due to any financial matters, please take note of our financial policy.

Our office participates in most major health plans, but please remember:

- It is your responsibility to verify that Bottenfield Pediatric Associates is a participating health care provider in your health plan. This should be done prior to making an appointment.
- It is your responsibility to know your benefits and to understand that if services rendered are applied to your deductible or considered non-covered services; you will be responsible for payment.
- Co-pays are due at the time of service.
- Insurance cards must be brought to each visit so that we can ensure that we are billing the most current insurance plan.
- Return check will incur a $30 fee.

Cancellation/No Show Policy & Late Arrival Policy

- BPA strives to accommodate as many same day appointments as possible in order to provide the best possible care to all our patients. Therefore, if you need to cancel an appointment, please provide 24 hours notice so we can offer the time to another patient. If sufficient notice is not provided, you could be considered a "no show." There is a $25.00 administration fee for each missed appts and appt cancelled less than 24 hours.
- We ask that every patient arrives 10 minutes prior to their scheduled appointment to allow time for the check-in process. If you miss your appointment, we may have to reschedule you to accommodate all other patients on the schedule.
- Repeat violators of these policies could be dismissed from our practice.

By signing this form, I acknowledge that I have read and understood the above policies.

____

Printed Name

____________________________________ ________________

Signature Date

HIPAA Acknowledgment

I acknowledge that I have received or have been given the opportunity to receive a copy of the HIPAA Notice of Policy Practices for Bottenfield Pediatric Associates.

__________________________________ __________________

Signature Date

This acknowledgment will be scanned into the patient's permanent electronic medical record.

CONSENT FOR TREATMENT

I give my permission for Bottenfield Pediatric Associates to treat my child, _________________________________ (Please Print), according to the standards of care defined by the American Association of Pediatrics (AAP) and the realm of medical necessity as deemed appropriate by the treating Provider.

Please list all children being treated by our office that this release applies to: (please print)

Child: ________________________ Child: ____________________________

Child: ________________________ Child: ____________________________

Child: ________________________ Child: ____________________________

Please list all family members that may seek medical treatment and receive medical information for these children. (please print)

Family: _______________________ Family: _____________________________

Family: _______________________ Family: _____________________________

_______________________________ __________________________________

Parent/Guardian Name **Date**

THIS ACKNOWLEDGEMENT WILL BE SCANNED INTO THE PATIENT'S PERMANENT ELECTRONIC RECORD.

Date	Child's Name	Nickname	DOB	M F
Previous Physician		Date of Last Physical	Request for Record Request Completed Y N	
Mother's Name Occupation Age		Father's Name Occupation Age		

Birth History

Birth Wt ____________ Birth Length ____________ Preg #_________ Mom's Age _________________

Vaginal/Cesarean (circle) If Cesarean, why ____

How many weeks _____________

Any complications with pregnancy or delivery? Y or N Explain ______________________________________

Breastfeed/Bottle (circle)

Current and Past History (BLANK PAGE ON BACK IF MORE ROOM NEEDED)

Is your child currently on any medications? Yes/No Explain____________________________________

Does your child have any serious/chronic illnesses Yes/No Explain ____________________________________

Has your child had serious injuries/accidents? Yes/No Explain ____________________________________

Any surgeries Yes/No Explain ____________________________________

Hospitalizations Yes/No Explain ____________________________________

Any allergies to medications? Yes/No Explain ____________________________________

Does your child have or ever had:

Asthma, recurrent cough, bronchitis, or pneumonia Yes/No Explain ____________________________________

Nasal allergies or eczema Yes/No Explain ____________________________________

Frequent ear infections or sore throats Yes/No Explain ____________________________________

Frequent headaches or other neurologic problems Yes/No Explain ____________________________________

Problems with ears or hearing Yes/No Explain ____________________________________

Problems with eyes or vision Yes/No Explain ____________________________________

Frequent abdominal pain Yes/No Explain ____________________________________

Constipation Yes/No Explain ____________________________________

Bladder/kidney infection Yes/No Explain ____________________________________

Bed wetting after 5 yrs old Yes/No Explain ____________________________________

Heart problems/murmur Yes/No Explain ____________________________________

Anemia or bleeding problems Yes/No Explain ____________________________________

Thyroid/Endocrine Problem Yes/No Explain ____________________________________

Diabetes Yes/No Explain ____________________________________

ADHD Yes/No Explain ____________________________________

Mental Health Issues Yes/No Explain ____________________________________

Use of alcohol/drugs Yes/No Explain ____________________________________

Any other medical/mental health issues

____

Does your child see a specialist? Yes/No If Yes, Who? ____

For what reason/diagnosis? ____

Family medical History

Diabetes _________ Who? __________________ Hay fever _________ Who? ______________________________

TB __________ Who? ____________________ Bleeding Tendencies __________ Who? ______________________

Asthma __________ Who? _______________Heart Problems __________ Who? _________________________

Other Diseases (birth defects, CF, Etc.) ______________ Who? ____

EXPLAINATIONS CONTINUED