



Chandler Pediatrics

Patient Information

Name: _____ Middle: _____ Last: _____ DOB: _____
Address: _____ City: _____ State: _____ Zip: _____
Sex: M / F Home #: _____ Cell #: _____ Other #: _____
Name of Child's Previous Physician: _____ Tel #: _____
How did you hear about Chandler Pediatrics? _____

Parents/Guardian Information

Parent/Guardian # 1

Relationship to Patient: _____
Name: _____ Middle: _____ Last: _____ Suffix: _____
Address: _____ City: _____ Zip: _____
SSN: _____ - _____ - _____ Sex: M / F Marital Status: _____ DOB: _____
Occupation: _____ Employer: _____
Mobile: _____ Work: _____ email: _____
Preferred method to contact you or leave messages: ☐ Cell or ☐ email
Is it okay to leave lab result on phone ☐ yes ☐ No Phone #: () _____

Parent/Guardian # 2

Relationship to Patient: _____
Name: _____ Middle: _____ Last: _____ Suffix: _____
Address: _____ City: _____ Zip: _____
SSN: _____ - _____ - _____ Sex: M / F Marital Status: _____ DOB: _____
Occupation: _____ Employer: _____
Mobile: _____ Work: _____ email: _____
Preferred method to contact you or leave messages: ☐ Cell or ☐ email
Is it okay to leave lab result on phone ☐ yes ☐ No Phone #: () _____

Insurance Information:

Primary:

Insurance Company: _____ Employer: _____
Patients ID: _____ Group #: _____ Tel: _____
Policy Holders Name: _____ DOB: _____ SSN: _____ - _____ - _____
Relationship to patient: _____

Secondary:

Insurance Company: _____ Employer: _____
Patients ID: _____ Group #: _____ Tel: _____
Policy Holders Name: _____ DOB: _____ SSN: _____ - _____ - _____
Relationship to patient: _____

Emergency Contact (other than parent):

Name: _____ Relationship: _____

Phone: () _____ Cell Phone: () _____

CONSENT TO TREAT/PRIVACY POLICY ACKNOWLEDGEMENT:

I _____ give permission to Chandler Pediatrics to care for and treat my child. I understand my child can not be treated without my permission unless I have given written consent to an adult OVER THE AGE OF 18YRS to seek such care or treatment. In my absence the following adults may seek medical attention for my minor.

Name: _____ relationship to child: _____

Name: _____ relationship to child: _____

Name: _____ relationship to child: _____

Pharmacy Information:

Does Chandler Pediatrics have consent to e - prescribe medication? [] Yes [] No

Name of Pharmacy: _____ Phone: _____

_____ Cross Streets: _____

Administrative Fee's

Copies of medical records: \$1 per page up to 25pgs and 0.25 per each page after

Special request physicians' letters/forms: \$10.00 to \$25.00 (charge is based on letter/ forms)

Appointment No show fee: \$25.00 must call 24hrs before appointment time.

Consent to treat/Privacy policy acknowledgment:

I, acting as a guardian to above named patient, hereby give consent for the above patient to receive medical evaluation and treatment by the providers at Chandler Pediatrics. I acknowledge that I may obtain The Notice of Privacy Polic: (located at the front desk)

"I acknowledge that I received and read the Notice of Health Information Practices. I understand that my healthcare provider participates in Health Current, Arizona's health information exchange (HIE). I understand that my information may be securely shared through HIE, unless I complete and return an Opt Out Form to my healthcare provider."

Signature: _____ Date: _____

Patient Name: _____ DOB: _____ Sex: _____

Please list all people in the household:

NAME	DATE OF BIRTH	OCCUPATION	EDUCATION
<u>Father</u>			
<u>Mother</u>			
<u>Other</u>			
<u>Other</u>			
<u>Other</u>			
<u>Other</u>			

Have there been any recent major changes or stresses in the child's life? ☐ YES ☐ NO

If YES, Explain

Does child go to a baby sitter, preschool or day care regularly? ☐ YES ☐ NO

BIRTH HISTORY:

Birth Weight _____ Length _____ Place _____

During the pregnancy did the mother see a doctor regularly? ☐ YES ☐ NO

(If YES, Explain) Explanation _____

Have any medical problems? ☐ YES ☐ NO _____

Smoke or drink? ☐ YES ☐ NO _____

Use any medications? ☐ YES ☐ NO _____

Use alcohol or other drugs? ☐ YES ☐ NO _____

Have problems with labor/delivery? ☐ YES ☐ NO _____

How long did the baby stay in the hospital after birth?

PAST MEDICAL HISTORY:

Is the child's general health: ☐ GOOD ☐ FAIR ☐ POOR

Does the child have any allergies? ☐ YES ☐ NO

Is the child taking any medications? ☐ YES ☐ NO

(If YES, Explain) Explanation _____

Please list any hospitalizations, operations, serious illnesses or accidents with dates:

_____ Date: _____

Has the child ever had any problems with the following. If YES, please explain.

Eyes/Vision	☐ YES ☐ NO	_____
Feet	☐ YES ☐ NO	_____
Digestion/Nutrition	☐ YES ☐ NO	_____
Ears/Hearing	☐ YES ☐ NO	_____
Urine/Kidneys	☐ YES ☐ NO	_____
Joints	☐ YES ☐ NO	_____
Skin	☐ YES ☐ NO	_____
Lungs	☐ YES ☐ NO	_____
Teeth	☐ YES ☐ NO	_____
Heart	☐ YES ☐ NO	_____
Seizures	☐ YES ☐ NO	_____
Repeated Infections	☐ YES ☐ NO	_____

IMMUNIZATIONS Up to date? ☐ YES ☐ NO

Any deceased siblings? ☐ YES ☐ NO

If YES, give age and cause

FAMILY HISTORY

Have any of the child's blood relatives had the following diseases? If YES, please list family member.

Heart Disease	☐ YES ☐ NO	_____
Tuberculosis	☐ YES ☐ NO	_____
High Blood Pressure	☐ YES ☐ NO	_____
Kidney Disease	☐ YES ☐ NO	_____
Allergies/Asthma	☐ YES ☐ NO	_____
Cancer	☐ YES ☐ NO	_____
Diabetes	☐ YES ☐ NO	_____
Mental/Emotional Problems	☐ YES ☐ NO	_____
Sickle Cell	☐ YES ☐ NO	_____
Seizures	☐ YES ☐ NO	_____

DEVELOPMENT

Do you have any concerns about the following? If YES, please explain.

Development	☐ YES ☐ NO	_____
Behavior	☐ YES ☐ NO	_____
Eating Habits	☐ YES ☐ NO	_____
Sleeping Habits	☐ YES ☐ NO	_____
School Experience	☐ YES ☐ NO	_____
Bathroom/Toilet Habits	☐ YES ☐ NO	_____
Discipline	☐ YES ☐ NO	_____
Other (explain)	☐ YES ☐ NO	_____



CHANDLER PEDIATRICS FINANCIAL POLICY

Thank you for choosing Chandler Pediatrics. We are committed to providing our patients with the highest quality medical care. This financial policy is an important part of your child's care. Due to increased insurance company demands, we ask you to read and agree to the following:

We make every attempt to accept a wide range of insurance plans. For the patient's convenience we file medical claims with insurance plans with which we have an agreement, as long as the valid insurance information is provided to us. However, all policies have different benefits, and we cannot know the specific details of each individual policy. **You as the guarantor are responsible to know the individual policy and to verify all benefits and coverage information prior to having any services rendered. Also, the Guarantor is responsible for notifying us of any changes to the patient's insurance plan or policy prior to his or her visit.**

Co-pays and Deductibles: Insurance policies are an agreement between the policy holder and the insurance company. Contracting with health insurance companies requires us to collect co-pays and deductibles. You as the Guarantor must pay this amount prior to seeing any of our healthcare providers. If you have an outstanding balance and have made no attempt to making a payment you will be asked to reschedule your appointment.

Additional Fees: If the patient does not have medical insurance or if Chandler Pediatrics is not a contracting provider with his or her insurance carrier, all charges incurred during treatment will be due and payable at time of service.

If a patient is unable to keep a scheduled appointment, we must be notified 24 hours in advance. Appointments cancelled after the time frame may be subject to a cancellation fee.

Timely payment: If for any reason the patient incurs an account balance, we will mail a statement. Payment is due from the Guarantor upon receipt of the first statement from our office. If the balance is not paid in full, Chandler Pediatrics reserves the right to send the patients account to collections and an additional 33% collection fee will be added. Please be aware that any delinquent account balance may prohibit the patient from scheduling future appointments.

Divorce Policy: The guarantor is financially responsible regardless of who carries the insurance for the child.

Financial Hardship: We will work collaboratively with patients who are under financial hardship to develop fair and reasonable payment plans. Financial hardship is determined by policy and is a formal process that must be a joint effort between our financial counselor and you as the Guarantor. We will ask the Guarantor to provide documentation and a full explanation of extenuating circumstances regarding their hardship. Extenuating and/or special circumstances will not include those that have over extended themselves financially. A Guarantor who has the ability to pay and has not been formally determined to be in a financial hardship is expected to pay at the time of service and maintain no outstanding balance.

I have read and understand the Chandler Pediatrics Financial Policy. I authorize Chandler Pediatrics to obtain and/or release medical information necessary for filing insurance claims on my behalf and for the purposes of healthcare management. I assign all benefits to which the patient or insured is entitled for my treatment and medical services provided to me to be paid directly to Chandler Pediatrics. Should insurance payment be made directly to the insured, I agree to immediately pay these funds to Chandler Pediatrics.

Patient Name (Please print)

Signature

Date