VIPediatrics
Seema Sharma MD

Patient Information:

First Name _____ **Middle** _____ **Last Name** _____

Date of Birth _____ Gender: _____

Complete Address: _____

Mobile Phone: _____ Home Phone: _____

Race/Ethnicity: (Circle one) American Indian/Alaska Native, Hispanic/Latino, Asian

Black/African American, Native Hawaiian/Pacific Islander, Caucasian

Other: _____

Parent Information

Mother's Name: _____ DOB: _____

Father's Name: _____ DOB: _____

Language Spoken _____

Insurance Information: PRIMARY Plan Type: HMO, PPO, POS EPO Other

Insurance Name: _____ ID: _____

Group: _____ Subscriber's Name: _____ DOB: _____

Employer: _____ Work Phone: _____

SSN: _____ Address: _____

SECONDARY Plan Type: HMO, PPO, POS EPO Other

Insurance Name: _____ ID: _____

Group: _____ Subscriber's Name: _____ DOB: _____

Employer: _____ Work Phone: _____

SSN: _____ Address: _____

Emergency Contact

Contact Name: _____ Relationship: _____

Home Phone: _____ Mobile Phone: _____

Medications

Preferred Pharmacy: _____ Address: _____

Phone Number: _____ Crossing Streets: _____

Medication Name _____Dose (mg)_____times/day_____

Medication Name _____Dose (mg)_____times/day_____

Allergies

Does the child have any allergies to food? _____

Does the child have any allergies to drugs? _____

Does the child have any Environmental allergies? _____

Is the child allergic to Latex? _____ Has the child had allergy testing? _____

Birth History (Children under 2 Only)

Method of Delivery: (Circle one) Vaginal / Caesarian Section Weeks Pregnant at delivery: _____

Birth Weight: _____ Birth Hospital: _____ Days in Hospital: _____

Mother's age at Patient's birth: _____ Father's age Patient's birth: _____

Mother's 1st, 2nd,3rd Pregnancy: _____ Problems during delivery? _____

Did the child pass the hearing Screening? _____

Any problems in the first month? _____

Feeding History:(Circle one) Breastmilk / Formula / Both Special Diet? _____

Any Feeding Issues or Intolerance? _____

Development (Children Under 5 Only)

Please input the age when your child first:

Rolled _____ Walked _____ Sat _____ Crawled _____ First Word_____

Talked _____ Toilet trained _____ Any Known delays? _____

School History

My child is in: (Circle one) Daycare/ Preschool / Public School/ Private School/ Home School

School Name: _____ Year: _____ School Problems? Yes /No

Is your child in Special Classes? _____ Discipline or Behavior Problems? _____

Has your child been seen by Psychologist, Speech Therapist or Special Teachers? _____

Medical History

Past Medical History

Does your child have any chronic medical conditions or serious injuries_____

Has your child ever been hospitalized (including NICU at birth) ?_____

Has your child had any surgeries?_____

Family History

Diabetes	YES/NO	Relationship to Child _____
Convulsions	YES/NO	Relationship to Child _____
Cancer	YES/NO	Relationship to Child _____
Asthma	YES/NO	Relationship to Child _____
Heart Disease	YES/NO	Relationship to Child _____
Other	YES/NO	Relationship to Child _____

Family Profile

Parent Name _____ Age_____ Health _____

Parent Name _____ Age _____ Health _____

Sibling Name _____ Age_____ Health _____

Sibling Name _____ Age_____ Health _____

Sibling Name _____ Age_____ Health _____

Child's Parents are : (*Circle one*) Married / Seperated / Divorced / Other

Number of people living with you? _____ Are your child's Immunizations up to date? YES /NO

Any Smokers in your house? YES/NO Outside? YES/NO Pets? YES/NO What Kind?_____

Within the last week has your child had any of the following symptoms: (Please check mark if they apply)

General: Fever _____ Night sweats/chills _____ Decreased appetite _____ Increased crying _____

Respiratory: Cough _____ Wheezing _____ Difficulty breathing _____

Neurologic: Headaches _____ Seizures _____ Weakness _____

Cardiovascular: Shortness of breath _____ Chest Pain _____ Excertion _____

Gastrointestinal: Abdominal pain _____ Vomiting _____ Diarrhea _____ Constipation _____

Eyes/Ears/Nose/Throat: Red eyes _____ Earache_____Runny nose _____ Nasal Congestion_____Sore throat_____

VIPediatrics Financial/Office Policies

We Would like to welcome you to our office. The following information is provided to avoid any misunderstanding concerning payments for services. Please take a moment to read this information sheet concerning our financial and office policies.

- All co-pays and deductibles are due at the time of check in. Payment for services for cash patients are due "IN FULL". For your convenience, we accept cash, checks, Debit and Credit.
- I fully understand VIPediatrics will bill my provided insurance as a courtesy. In the event of non-payment by my insurance carrier. I fully understand that I am financially responsible for payment of my treatment. If my account becomes delinquent I fully understand that I am hereby responsible for all fees related to repaying the amounts owed to VIPediatrics.
- Fees for non-covered services are due at the time of service is rendered.
- If your insurance company changes, you must notify us immediately so that we can obtain a copy of your new card and submit claims to the correct address.
- If your insurance is through Exchange you will be required to show proof of payment before services are provided.
- We require at least 24 hours advance notice for all appointment cancellations. If you miss your appointment or fail to cancel our policy is to charge $50.00 for missed office appointments.
- Returned checks will be subject to $30.00 fee.
- We reserve the right to refuse service (including prescriptions) to patients who repeatedly no show
- FMLA/Disability forms are subject to $30.00 fee. Comprehensive letters or forms are $150.00
- Letters for insurance/ Employer purposes are subject to a $30.00 fee.
- Please allow 72 hours to process prescription refills. To expedite processing your request, ask your pharmacy to fax a refill request to the office.
- Please allow 48 hours to process referral requests. If you are referred to a specialist or a diagnostic testing facility, It is your responsibility to schedule the appointment.

Our practice firmly believes that a good doctor/patient relationship is based upon understanding and open communication. We do understand that temporary hardships may affect timely payment of your balance. We encourage you to communicate with the billing office to assist you in the management of your account if any problems should arise.

I herein authorize payment of medical benefits to Thomas Parisi, MD a Prof Corp when an assigned claim is filed. My signature authorizes VIPediatrics to release any medical information necessary to process insurance claims. My signature below indicates that I understand and accept policies.

Patient Name _____ **Date** _____

Parent/ Legal Guardian (Print Name) _____

Parent/ Legal Guardian (Signature)_____

Privacy Notice

At VIPediatrics, we are committed to treating and using protected health information about you responsibly. The notice of Privacy Policies describes the personal information we collect and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003 and applies to all protected health information as defined by federal regulations. Each time you visit VIPediatrics, a record of your visit is made. This information, often referred to as your health or medical record serves as a:

*Basis for planning your care and treatment

*Means of communication among the many health professionals who contribute to your care and will provide them with reports that should assist them in treating you if needed

*Legal document describing the care you received.

*Means by which you or a third -party payer can verify that services billed were actually provided

*We may disclose your information for payment for the health care services you received

*Source of data for medical records

*Source of information for public health officials charged to improve the health and state of the nation

Although your health record is physical property of Personal Medical Care, the information belongs to you. You have the right to:

*Obtain a paper copy of this notice of privacy policies upon request

*Inspect and obtain a copy of your health record as provided by 45 CFR 164.524(reasonable fees apply)

*Amend your health record as provided by 45 CFR 164.526

*Obtain an accounting of disclosures of your health information as provided by 45 CFR 164.522(b)

Our practice is required to:

*Maintain the privacy of your health information

*Abide by terms of this notice, provided you with our legal duties and privacy practices with respect to information we collect and maintain about you

*Accommodate reasonable requests you may have to communicate your health information, but will also notify you if we are unable to agree to a requested restriction

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. For more information or to report a problem you may contact our Privacy Officer, at 702-898-9191.If you believe your privacy rights have been violated, you can either file a complaint with Debra Livingston or with the office for Civil Rights. There will be no retaliation for filing a complaint.

Office for Civil Rights, U.S Department of Health and Human Rights, 50 United Nations Plaza- Room 322 SF, CA 94102

I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

I agree with the Privacy Notice Act and fully understand my rights regarding my personal medical information.

Patient Name: _____ **Date:** _____

Parent /Guardian Name: _____ **Signature:** _____