Patient Information (Confidential)

Today's Date ___________________

Name____________________________ Date of Birth_______________________

SSN _______________________________ Male or Female

Address _______________________City _________________State _______Zip ____________

Home Phone __________________

Work Phone__________________

Cell Phone____________________

Email Address_____________________

Emergency contact name/phone: ____

Whom may we thank for referring you

____

Responsible Party Information

Party Responsible for this account _______________________________

Relationship to patient _______________________________

Address (if different from patient) _______________________________

City _______________________________ State: ________Zip __________

Mothers Name ___________________Date of Birth _________

SSN _______________________________Employer_______________________________

Fathers Name: ___________________Date of Birth _________

SSN _______________________________Employer_______________________________

Insurance Information

Name of Policy Holder ___________________________________

Date of Birth: ________________________________SSN: ________________________________

Relationship to Patient: ________________________________

Name/Address of Employer________________________________

Insurance Company ____

Policy/Member ID ________________________________

Group ________________________________

Patient's Medical History

Patient Name ______________________________

Date of Birth ___________________ SSN________________________________

1. Is the patient allergic to or had any reactions? Yes / No

to the following?

Medications_________________________________

Foods______________________________________

Insect Bites_________________________________

Bee Stings__________________________________

Immunizations_______________________________

If "Yes", Please List

____

Other (please list)

____

2. Are both parents and siblings in good health? Yes/No

If "No", Please explain

____

3. Do you use tobacco products in the home? Yes/No

4. Do both parents live at home? Yes/No

5. If "No", with whom does the patient live?

____

6. Any hospitalizations or serious injuries? Yes/No

7. Is the patient taking any medication(s) including

non-prescription medicine? Yes/No

Please list medications____________________________________

8. Was the patient born premature? Yes/No

If "Yes", at how many weeks was the baby born? _________

9. What was the patient's birth weight? _____________________

10. Mothers age at patients' birth? ___________________________

11. Did mother have any illness during pregnancy? Yes/No

If "Yes", please explain___________________________________

12. Did mother take any medications other than vitamins? Yes/No

If "Yes", which? ___________________________________

13. Please List-

Mothers Name____________ Date of Birth_______________

Employer_________________ Employer Phone_______________

Please check if any of the following run in your family

High Blood Pressure ___	Heart Disease ___	Chest Pains ___
Heart Attack ___	Cardiac Pacemaker ___	Easily Winded ___
Rheumatic Fever ___	Heart Murmur ___	Stroke ___
Swollen Ankles ___	Angina ___	Hay Fever / Allergies ___
Fainting/Seizures ___	Frequently Tired ___	Tuberculosis ___
Asthma ___	Anemia ___	Radiation Therapy ___
Low Blood Pressure ___	Emphysema ___	Glaucoma ___
Epilepsy/Convulsions ___	Cancer ___	Recent Weight Loss ___
Leukemia ___	Arthritis ___	Liver Disease ___
Diabetes ___	Heart Trouble ___	Respiratory ___
Joint Replacement or Implant ___		Kidney Diseases Respiratory ___
Hepatitis/Jaundice ___	AIDS or HIV Infections ___	Sexually Transmitted Disease ___
Thyroid Problem ___	Stomach Troubles/Ulcers ___	

Any other related information about your child?

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Any special requests for your child?

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FINANCIAL POLICY

For your convenience we accept cash, personal checks, Master Card, Visa, and debit cards for payment on your account. If you have insurance, which we do not contract with, you will be expected to make a full payment on the day of your visit. If your insurance is one we do contract with, you are expected to pay your full copay/deductible at the time of your visit. As a courtesy, we will be happy to file your insurance for you. You will be required to provide a copy of your insurance card and all necessary billing information. All insurance payments that are paid directly to you must be endorsed and paid to this office. It is your responsibility to contact your insurance in the event of non-payment or discounted payments. In the event of non-payment, or after 30 days you will be responsible for paying the office (Baldwin Pediatrics) for the full amount of the visit. **Returned checks: In the event your bank returns your check to our office unpaid, there will be a $25.00 return check fee charged to your account. Non-Payment: In the event your account becomes delinquent, you will be responsible not only for charges incurred but also any cost involved in collection on your accountant.** These include but are not limited to; interest charges, re-billing fees, court costs, attorney fees, and collections costs. A collection agency may be used to collect on delinquent accounts. Insurance benefits are a matter between you and your insurance company. You are ultimately responsible for the payment on your account. If your insurance doesn't pay for any of the services, you will be responsible for the full balance on your account. If you have any questions regarding our payment policies, please ask us before your visit. Thank you!

SERVICE FEE POLICY

If your account is 60 days past due, a service fee of $25.00/per patient will be added every month to your bill. We recommend that you pay your bill in a timely manner to avoid the service fee.

NO SHOW POLICY

To help accommodate the needs of our patients, and to able to offer appointments to all patients requesting to see our doctors, we charge a **No Show Fee of $25.00 for each child for each appointment missed that are scheduled with Dr. Khaled. We charge a No Show Fee of 50.00 for each child for each appointment missed that are scheduled with Dr. Azam. After 2 "No Shows", the patient/family will be discharged from our office, Baldwin Pediatrics.** An appointment is considered a no show if: appointment is not canceled or rescheduled at least 24 hours prior to the scheduled appointment time.

NO SMOKING POLICY-Baldwin Pediatrics is a non-smoking facility.

We do not allow any smoking in the vicinity of the office or in the parking area for the health of our staff and pediatric patients. Because we care for the health of our patients, we also ask that you do not smoke before coming in for your appointments at Baldwin Pediatrics. Smoke particles stay on your clothes for quite some time even if you smoke outside and it may flare up asthma and allergy symptoms in a person exposed to smoke particles. Any smoke odor from a parent may result in discharge of that family from the practice without any further warning.

I AGREE TO THE FINANCIAL POLICY TERMS STATED ABOVE

________________ Please Initial

I certify that I have read and understand the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my child's health. I also certify that the information provided regarding the health insurance coverage is correct. I authorize that payments for services rendered should be made payable to Baldwin Pediatrics. I authorize release of medical information necessary to process this, these, claims. I have read all the terms and conditions contained in this agreement and agree to be bound by these terms and conditions

Signature of the parent or guardian

____ Date _______________