VIPediatrics
Seema Sharma MD

Patient Information

Last Name:_____ First Name:_____ Middle Initial:_____

Date of Birth: ____/____/____ Age:_____ SSN:_____-_____-_____

Gender: Male / Female Marital Status: M S D W

Address:_____ Apt #: _____

City:_____ State:_____ ZIP: _____

Phone Number: ( ) _____ - _____

Cell Number: ( ) _____ - _____

Work Number: ( ) _____ - _____

Race:

- ☐ Caucasian
- ☐ Asian
- ☐ African American
- ☐ Pacific Islander
- ☐ Hispanic/Latino
- ☐ Native American
- ☐ Do not wish to answer
- ☐ Other: _____

Guarantor/Guardian Information (person responsible for payment)

Responsible Party:

Name: _____ Relationship: _____ Male / Female

Date of Birth: ____/____/____ SSN:_____-_____-_____

Address:_____ Apt #: _____

City:_____ State:_____ ZIP: _____

Phone Number: ( ) _____ - _____ Cell Number: ( ) _____ - _____

Employer: _____ Work Number: ( ) _____ - _____

Email Address: _____

Additional Responsible Party:

Name: _____ Relationship: _____ Male / Female

Date of Birth: ____/____/____ SSN:_____-_____-_____

Address:_____ Apt #: _____

City:_____ State:_____ ZIP: _____

Phone Number: ( ) _____ - _____ Cell Number: ( ) _____ - _____

Employer: _____ Work Number: ( ) _____ - _____

Email Address: _____

Emergency Contact

Primary:

Emergency Contact Name: _____ Relationship: _____

Home Phone: ( ) _____ - _____ Cell Phone: ( ) _____ - _____

Work Phone: ( ) _____ - _____

Secondary:

Emergency Contact Name: _____ Relationship: _____

Home Phone: ( ) _____ - _____ Cell Phone: ( ) _____ - _____

Work Phone: ( ) _____ - _____

Primary Care / Referring Physicians

Primary Care Physician: _____ Phone Number: ( ) _____ - _____

Referring Physician: _____ Phone Number: ( ) _____ - _____

Insurance Information

Primary Insurance:

Insurance Name: _____ Plan Type: HMO PPO POS EPO Other

I.D. Number: _____ Group Number: _____

Subscriber's Name: _____ Date of Birth: ____/____/____

Employer: _____ Work Phone: ( ) _____ - _____

Secondary Insurance:

Insurance Name: _____ Plan Type: HMO PPO POS EPO Other

I.D. Number: _____ Group Number: _____

Subscriber's Name: _____ Date of Birth: ____/____/____

Employer: _____ Work Phone: ( ) _____ - _____

Medications					
Name	dose (mg)	times/day	Name	dose (mg)	times/day

Pharmacy information	
Name:	Phone:
	Fax:
Address:	

Past Medical History			
Serious Injuries or Illness:	**Allergies:**		
	Drugs: ☐ Yes ☐ No	Food: ☐ Yes ☐ No	Latex: ☐ Yes ☐ No
	Environmental: ☐ Yes ☐ No		
	Allergy Testing: ☐ Yes ☐ No		
Hospitalizations (including NICU at birth):	Please explain all Yes answers:		
Surgeries:			

Development	
School History:	
My child is in: ☐ Daycare ☐ Preschool ☐ Public School ☐ Private School ☐ Home School	
School Name:	Year in School:
School Problems: ☐ Yes ☐ No	Discipline or Behavior Problems ☐ Yes ☐ No
Has your child been seen by a Psychologist, Speech Therapist or Special Teachers? ☐ Yes ☐ No	
Is your child in any special classes? ☐ Yes ☐ No	
Please explain any yes answers:	

Medical History

Review of Symptoms

Within the last week has your child had any of the following symptoms

	Yes	No
General		
Fever		
Night sweats/chills		
Decreased appetite		
Increased crying		
Skin		
Itching		
Rash		
New lesion		
Excessive sweating		
Eyes/Ears/Nose/Throat		
Red eye(s)		
Excessive tearing		
Eye discharge		
Earache		
Ear discharge		
Runny nose		
Nasal congestion		
Sore throat		
Neck		
Neck stiffness		
Swollen glands		

	Yes	No
Respiratory		
Cough		
Wheezing		
Difficulty breathing		
Cardiovascular		
Shortness of breath		
Chest pain		
Difficulty breathing on exertion		
Sweating while feeding (infants)		
Gastrointestinal		
Abdominal pain		
Vomiting		
Diarrhea		
Constipation		
Difficulty swallowing		
Musculoskeletal		
Decreased range of motion		
Muscle weakness		
Join pain/swelling		

	Yes	No
Neurologic		
Headaches		
Seizures		
Weakness		
Psychiatric		
Change in sleep pattern		
Fussiness		
Endocrine		
Changes in hair		
Hematology		
Easy Bruising		
Enlarged lymph nodes		
Urologic		
Pain with urination		
Blood in urine		

Immunizations		
Are your child's immunizations up to date?		
If possible, please show us your child's vaccine record		
Has your child had: ☐ Chicken Pox ☐ Measles ☐ Scarlet Fever ☐ Mumps ☐ Other:		

Family History

Is there a family history of the following:

	Yes	No	Relationship to Child		Yes	No	Relationship to Child
Diabetes				Cancer			
Allergies				Heart Disease			
Convulsions				Tuberculosis			
Asthma				Other_____			

Family Profile

	Name	Age	Health
Parent			
Parent			
Sibling			
Sibling			
Sibling			
Sibling			

Child's Parents are: ☐ Married ☐ Separated ☐ Divorced ☐ Other

Highest level of Education? Occupation

Highest level of Education? Occupation

Number of people living in your house? _____

Any smokers in your house? ☐ Yes ☐ No Outside? ☐ Yes ☐ No

Pets? ☐ Yes ☐ No What kind? _____

Number of people living with your child: _____

Does your child have frequent contact with anyone who is receiving chemotherapy, on medications regularly such as steroids or has had an organ transplant? ☐ Yes ☐ No

Development (continued)

* Children Under Five Only

Age when your child first:				Any known development delays? ☐ Yes ☐ No
Rolled		Walked		If yes, please explain:
Sat		First Teeth		
Crawled		Toilet trained		
First Word		Talked		

* Children Under Two Only

Birth History:

Mother's 1st, 2nd, 3rd pregnancy:		Method of Delivery: ☐ Vaginal ☐ Caesarian section	
Weeks pregnant at delivery:		Birth Weight:	
Mothers age at patient's birth:		Birth Hospital:	
Fathers age at patient's birth:		Days in Hospital	

Problems with: ☐ Sleep ☐ Urination ☐ Stooling ☐ Weight ☐ Height ☐ Behavior

Problems during delivery?

Passed newborn hearing screen? ☐ Yes ☐ No

Problems in the first month?

Feeding history:	☐ Breastmilk ☐ Formula ☐ Both
Age started solid food:	Feeding issues or intolerance:

Special Diet?

Please Explain any yes answers:

Comments/ Concerns/ Extra Space

Authorization to Release Medical Records

I authorize the following entity where I have received care (typically your previous primary care doctor):

Practice or facility name:_____

Physician name:_____

Practice or facility fax number:_____

Practice or facility phone number:_____

To disclose all information concerning my treatment to:

VIPediatrics of Las Vegas
1725 South Rainbow Boulevard
Ste 17 & 18
Las Vegas, NV 89146
702.749.7979

Patient Name (Print): _____

Date of Birth: _____ **Social Security #:** _____

Patient/Guardian Signature: _____

Witness: _____

VIPediatrics
Financial Policy

We would like to welcome you to our office. The following information is provided to avoid any misunderstanding concerning payment for services. Please take a moment to read this information sheet concerning our financial policy.

- All co-pays and deductibles are due at the time of check in. Payment for services for cash patients are due "In full" at the time of check in. For your convenience, we accept Cash, Checks, MasterCard, Visa and Discover, Debit and Care Credit.

- I fully understand that VIPediatrics will bill my provided insurance as a *courtesy*. In the event of non-payment by your insurance carrier, I fully understand that I am financially responsible for the payment of my treatment. If my account becomes delinquent I fully understand that I am hereby responsible for interest fees any subsequent collection and or legal fees related to repaying the amounts owed VIPediatrics."

- Your insurance policy is an agreement between you and your insurance company. It is your responsibility to know what is covered and what is not covered. Fees for non-covered services are due at the time 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 an Exchange you will be required to show proof of payment before services are provided.

- Please help us to better serve you by keeping all scheduled appointments. We require at least 24 hours advance notice for all appointment cancellations. If you miss your appointment or fail to cancel without 24 hours advance notice our policy is to charge $50.00 for missed office appointments.

- Returned checks will be subject to a $30.00 fee.

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 any such problems with the billing office, so that we can assist you in the management of your account.

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 my insurance claims. My signature below indicates that I understand and accept these policies.

Patient Name: _____ DATE: _____
(print name)

Parent/Legal Guardian _____
(print name)

Parent/Legal Guardian _____
(SIGNATURE)

Updated 05/2/2016

VIPediatrics

Seema Sharma, MD

OFFICE POLICIES

Scheduled Visits:

Our office strives on giving our patients the utmost care and service available. Please excuse any and all delays. We will give you the same careful attention.

Missed Physician Appointments:

We reserve the right to charge a $50.00 fee for all missed physician appointments without a 24-hour notice. We also reserve the right to refuse service (including prescriptions) to patients who repeatedly "no call, no show" their scheduled appointments.

Special Forms

We will charge a fee for all special forms filled out by VIPediatrics

These forms include:

- FMLA/Disability Forms
- Letters for insurance / employer purposes.

The cost is $30.00 per form. Payment is due at the time forms (s) are dropped off. Comprehensive letters or forms are $150.00.

Referrals

If you or your insurance company requires a referral to see another physician, please allow 48 hours to process your request. If you are referred to a specialist, or diagnostic testing facility; it is your responsibility to schedule your own appointment.

Prescription Refill Requests

To expedite processing your request, ask your pharmacy fax a refill request. Please allow 72 hours to process your request.

_____ _____

Parent or Legal Guardian Signature Date

ACKNOWLEDGEMENT FORM

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of VIPediatrics ***Notice of Privacy Policies***, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

_____

_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

_____
(Patient Name)

_____
(Parent or Legal Guardian Name)

_____ Date: _____
(Parent or Legal Guardian Signature)

If not signed by patient, please indicate relationship to patient (i.e. mother, father, legal guardian)

Relationship: _____ Witnesses by: _____

If the patient/parent or legal guardian refuses to sign, indicate your attempt to obtain a signature below.

[ ] Patient/Parent or Legal Guardian refused to sign this Acknowledgement.
Date: _____
Time: _____
Employee Name: _____