Demographic Information

Suburban Pediatrics
Phone: (716) 565-9030 | Fax: (716) 565-9038
www.suburbanpediatrics.com

Ensuring the delivery of high-quality, patient-centered care requires understanding the needs of the populations served. In accordance with federal categories and definitions, insurance companies have adopted a policy that requires the collection and recording of race, ethnic background and language preference. Suburban Pediatrics understands the sensitive nature of this information and assures you that it is kept secure and confidential in accordance with all State and Federal privacy acts.

➢**PATIENT**

Patient Name: ______________________________ **DOB:** ______________

Patient's Birth Mother's Maiden Name: ______________________________

Patient Lives With (Name): ______________________ **Relationship:** ______________

Does this patient live with both parents? **YES:** ______ **NO:** ______*

*If **NO**, please provide the Name/DOB/Phone # of the other parent:

Name: ______________________________ **DOB:** ______________

Phone: (_______) ______________ **Alt. Phone:** (_______) ______________

➢**RESPONSIBLE PARTY**

Name: ______________________ **Primary Phone #:** (_______) ______________

Address: ______________________ **Work Phone #:** (_______) ______________

City/State/Zip: ______________________ **Alt Phone #:** (_______) ______________

E-Mail Address: ______________________________________

Marital Status: Never Married · Married · Domestic Partnership · Annulled · Divorced · Legally Separated · Widowed
(**Please Circle**)

➢**PRIMARY PHYSICIAN**: ______________________________________

PRIMARY INSURANCE	
Plan Name:	
Policy #:	
Group #:	
Eff. Date:	
Subscriber:	

SECONDARY INSURANCE	
Plan Name:	
Policy #:	
Group #:	
Eff. Date:	
Subscriber:	

➢**EMERGENCY CONTACT**

Name: ______________________________________

Phone #: (_______) ______________ **Relationship:** ______________________

➢**PLEASE ANSWER THE FOLLOWING 3 QUESTIONS (Circle Your Response):**

1. **Race**: White · Black/African American · Asian · Other (Please Specify): _______________ Decline/Unknown
2. **Ethnicity**: Spanish/Hispanic Origin · Not of Spanish/Hispanic Origin · Decline/Unknown
3. **Primary Language**: English · Other (Please Specify): _______________ · Decline/Unknown

➢I have reviewed the above information, and confirm it to be accurate. I understand that I am financially responsible for charges not covered by my insurance carrier if I fail to follow the policies set froth in my insurance plan, or if charges are denied because my insurance coverage is cancelled or not in effect at the time services are provided.

Parent/Guardian Signature: ______________________________________

OFFICE USE ONLY
Verified and entered: _________ _________
(Initials) (Date)

FAMILY MEDICAL HISTORY

Patient's Last Name______________________ First Name _____________________________

Date of Birth ___________________________

Please complete the following with the name of consultants for this child.

Dentist: ______________________________ Eye doctor: ______________________________

Gynecologist __________________________ Other: __________________________________

☐ **Check here if adopted.** ☐ **Check here if there has been no change in any family history.**

Please check the box for any changes in medical history pertaining to the mother, father, siblings, (MGM) maternal grandmother, (MGF) maternal grandfather, (PGM) paternal grandmother or (PGF) paternal grandfather.

	Mother	Father	Siblings	MGM	MGF	PGM	PGF
Allergies							
Asthma							
Attention Deficit Disorder							
Autism/developmental issues							
Blood disorders/hemophilia							
Cancer (please specify type)							
Cardiac conditions (ie. murmurs, strokes, hypertension (please specify)							
Diabetes (please specify type)							
High Cholesterol							
Kidney Disease							
Mental Health/Substance Use (please specify)							
Obesity							
Strabismus (lazy eye)							
Stomach Issues (ie. Celiac/Crohns/IBD) (please specify)							
Thyroid disease							
Any other family history							
Deceased (Age/cause of death, if known)							

OFFICE USE ONLY

Reviewed/Entered: ____________________
(Initials) (Date)

Patient Responsibility Agreement
Over 18 HIPAA Release and Consent

SUBURBAN PEDIATRICS
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I understand and acknowledge that as of my 18th birthday, my parents and/or guardians will no longer be permitted access to my medical records, information, providers, or appointment status without my specific written permission. Suburban Pediatrics will not speak with my parents, permit my parents to schedule appointments or provide medical information to my parents unless in accordance with this document.

I wish to grant my parents and/or guardians access to my healthcare providers and/or medical information as follows: (**You must select only ONE option and initial**)

PRINT THE NAME(S) BELOW OF THOSE WHO MAY ACT ON YOUR BEHALF

____
(PRINT NAME OF PARENT OR GUARDIAN, INDICATE RELATIONSHIP)

____
(PRINT NAME OF PARENT OR GUARDIAN, INDICATE RELATIONSHIP)

- ☐ I give the above named individual(s) permission to act on my behalf with no limitations. I understand that they may contact any physician or member of the staff at Suburban Pediatrics to schedule appointments, discuss my healthcare and access my medical records. **THEY HAVE NO RESTRICTIONS**.
- ☐ I give the above named individual(s) permission to contact and speak with any physician or member of the staff at Suburban Pediatrics to discuss my care and schedule any needed service or appointments. **I DO NOT GRANT ACCESS TO MY MEDICAL RECORDS**.
- ☐ I give the above named individual(s) permission to contact and speak with any physician or member of the staff at Suburban Pediatrics for the sole purpose of scheduling an appointment. No access to my medical records or information regarding my care can be discussed or provided. **APPOINTMENT ONLY ACCESS**.
- ☐ **I DO NOT GRANT ANY ACCESS TO MY PARENTS OR GUARDIAN. NO MEDICAL INFORMATION, RECORDS OR APPOINTMENT INFORMATION CAN BE RELEASED**.

This consent is valid for one (1) year from the date signed. I understand that I can withdraw consent at any time by providing Suburban Pediatrics with a written consent indicating the changes in access.

____ PATIENT NAME (Print Legibly)	________________________ PATIENT DOB
(__________) ______________________________ PATIENT CONTACT # / CELL PHONE	(__________) ______________________________ ALTERNATE PHONE #
____ PATIENT E-MAIL ADDRESS	
____ PATIENT SIGNATURE	________________________ DATE
____ SUBURBAN PEDIATRICS WITNESS	________________________ DATE

NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Immunization

Consent For Participation in NYSIIS for Individuals 19 Years of Age or Older

The New York State Immunization Information System (NYSIIS) is a confidential, computerized system that contains immunization records and allows authorized users access to a person's shot record. Strict federal and state laws protect the privacy of your personal information in the system. The benefits of participating in NYSIIS include:

- Your health care provider can use NYSIIS to be sure that you receive the needed immunizations, and proper medical treatment is received when needed.
- There will be a permanent and easily accessible record of your immunizations.

Participation in NYSIIS for people 19 years of age and older is voluntary, so your consent is needed. If you want to participate, please carefully read the consent below and sign in the space provided. For additional information about this consent, please call (518) 473-2839.

I give my consent for Suburban Pediatrics **(name of doctor or organization) to release my immunization(s) and identifying information to the New York State Immunization Information System (NYSIIS). I understand the purpose of NYSIIS is to assist in my medical care and to record the immunizations that I have had or will receive in the future. My immunization information may potentially be used by the Department of Health for quality improvement purposes, epidemiologic research, and disease control purposes. Information used for quality improvement or any research purposes will have my personal identifying information removed.**

The immunization information in NYSIIS may be released to the following: myself, my health insurance plan, the state and local health departments, the school that I am registered to attend, and authorized medical providers that deliver my medical care.

I understand that there will be no effect on my treatment, payment, or enrollment for benefits if I choose not to enroll in NYSIIS. This consent may be withdrawn at any time by using the form provided. Information about immunizations received by NYSIIS with my consent will remain in NYSIIS if I later choose to withdraw my consent. However, future immunizations will not be recorded in NYSIIS.

Print Name ______________________ Date of Birth ______________

Signature ______________________ Date ______________

Patient Responsibility Agreement

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PATIENT NAME: ____

DATE OF BIRTH: ____

We request that you assist us with the following:

1. **Demographic Information**. It is your responsibility to provide accurate and up-to-date personal information to our office no less than annually, and also when any changes occur. Required demographic information includes a reliable residential address (not a P.O. Box) for the patient as well as reliable residential information for both parents if not residing at the same address; current telephone numbers for both parents; an emergency contact and telephone number of someone not residing with you; and a current reliable email address. An individualized form for each child is required.
2. **Insurance Information**. It is your responsibility to provide accurate and up-to-date medical insurance information and to notify us immediately of any changes in your insurance coverage. Please note that you are personally responsible for all charges incurred. To the extent that you fail to provide timely or accurate insurance information that results in non-payment for services, or your insurance denies coverage, you will be invoiced directly and payments are expected within 30 days.
3. **Payments**. You are responsible for, and expected to promptly pay all copayments, coinsurance payments, or unpaid deductibles at the time service is provided. The person bringing the patient in is responsible for payment. Failure to pay at the time service is provided will result in a billing fee of $15 to cover the cost of a statement being sent to you.
4. **Appointments**. We ask that you cancel any appointment you must change with at least 24 hour notification to our office. No-show appointments are very costly to everyone – we staff based on schedule needs and we can't see other patients who may need or want a visit at that time. Therefore, we have implemented a $50 charge for any visit not canceled with enough notice to use that appointment slot. This means that for each patient that does not come as scheduled, a $50 fee will be charged.
5. **Medical Care**. Our medical providers want to provide the best possible care for your child. There may be times when the standard of care or the physician's medical judgment determines that your child needs a service or test that may not be covered by your insurance carrier. The office will make every effort to notify you when we are aware of possible coverage issues. Unfortunately, we are unable to know which insurance carriers may deny services usually covered OR services that the physician or medical provider feels are necessary for your child. You agree to be responsible for payment of any/all non-covered services rendered by Suburban Pediatrics' physicians or medical staff.
6. **Forms**. We will provide each patient with a Health Assessment Form (HAF) at the end of their annual well visit. This form is good for one year from the date of the exam and can be used for most school, sports and camp activities. Any additional forms, special forms or motor vehicle accident forms will be completed at a charge of $10 per form.

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7. **Past-Due Accounts**. It is your responsibility to keep your account current with Suburban Pediatrics. A billing fee of $15 will be added to all accounts that must be re-billed. In addition, should your account remain unpaid, it will be flagged for non-payment and you will not be able to schedule appointments until arrangements have been made to clear your outstanding balance. Any account that remains unpaid past 30 days will accrue interest at the rate of 8% per annum.
8. **Collections**. If you fail to make any payment when due, Suburban Pediatrics reserves the right to refer your account to a third party for collection. You will be responsible for all costs associated with collection, including reasonable attorneys' fees.

FINANCIAL/PATIENT RESPONSIBILITY. I have read the above and understand and accept the terms of patient responsibility. I understand that, in the case of non-payment, I will be responsible for any and all collection fees and or attorneys' fees.

____ __________________

Parent/Guardian Signature **Date**

____

Printed Name of Parent/Guardian

____ __________________

Witness **Date**

Suburban Pediatrics

Adolescent Questionnaire

Name: ____ **DOB**: ________________

Today's Date: ________________ **Patient Cell Phone Number**: __________________________

Who do you live with? ____

Please circle your answer to each of the following questions:

1. How often do you use a helmet when you rollerblade, skateboard, bicycle, or ride a motorcycle, minibike or ATV?

Always Sometimes Rarely or never

2. How often do you wear a seat belt when you ride in a car, truck or van?

Always Sometimes Rarely or never

3. Are you having any problems in school?

Rarely or never Sometimes Always

Circle all that apply. . . grades, fighting, missing school

4. Have you ever felt you had a problem with your weight?
(underweight, overweight, anorexia, bulimia)

Rarely or never Sometimes Always

5. Did you ever smoke cigarettes (even if you did not inhale) or chew tobacco?

Never Once or twice 3 or more times

6. Did you ever drink any alcohol? (beer, wine, liquor, other)

Never Once or twice 3 or more times

7. Did you ever use drugs?

Never Once or twice 3 or more times

Circle all that apply. . . marijuana, cocaine, crack, heroin, acid, speed, ecstasy, roofies, sniffed inhalants, steroids, hormones, prescription drugs not ordered for you, or others

8. Have you ever ridden in a vehicle when the driver is under the influence of alcohol or drugs?
(This includes when you were the driver as well as other people).

Never Once or twice 3 or more times

9. Have you ever done something violent because you were angry?

Never Once or twice 3 or more times

10. Have you ever had someone at home, school or anywhere else, who made you feel afraid, threatened you, or hurt you?

Never Once or twice 3 or more times

Continued on page 2

Adolescent Questionnaire

Name: ____ **DOB**: ________________

Please circle your answer to each of the following questions:

11. Have you had sex?

No Yes

Circle all that apply . . . vaginal sex anal sex oral sex

12. If you have had sex, how often do you use condoms (rubbers)?

Never had sex Always Sometimes Rarely or never

13. Were you ever forced to have sex you did not want, or has someone touched you in a way that made you feel uncomfortable? (touching of breasts, buttocks, or genitals)

Never Not sure Yes

14. Have you ever felt sad or down for more than 2 weeks or felt as though you had nothing to look forward to?

Never Once or twice 3 or more times

15. Have you ever thought about killing yourself or made a plan to kill yourself?

Never Once or twice 3 or more times

DO YOU HAVE ANY QUESTIONS ABOUT ANY OF THESE TOPICS?

There may be subjects that you would like to know more about. You may have friends or know people who are making these choices, or you may want more information to help you make choices in the future. CIRCLE any subjects you would like more information about and add any subjects that are not listed below.

tobacco
quitting smoking
alcohol
drugs
steroids (bulking up)
sniffing (glue, aerosol)
sharing needles/works
body piercing/tattoos/branding

abstinence (saying no)
safer sex
birth control
homosexuality (gay/lesbian)
HIV/AIDS
sexual diseases (STDs)
gender issues (transgender/transsexual)
other______________________

depression
suicide
abuse
weight problem
diet pills/laxatives
exercise/fitness

Office Use Only

I have reviewed the above information with my patient.

Date: ____/_____/_____ Initials: __________________

Developed by the Adolescent Quality Improvement Work Group, September 2000.
https://www.health.ny.gov/health_care/managed_care/reports/qui/adolescent/adolescent.htm