

# Demographic Information



Suburban Pediatrics  
Phone: (716) 565-9030 | Fax: (716) 565-9038  
[www.suburbanpediatrics.com](http://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 forth 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)							

<b>OFFICE USE ONLY</b>
Reviewed/Entered: _____ (Initials)                      (Date)

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



SUBURBAN PEDIATRICS  
Phone: (716) 565-9030 | Fax: (716) 565-9038  
[www.suburbanpediatrics.com](http://www.suburbanpediatrics.com)

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.



## Patient Responsibility Agreement: Page 2

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.

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**Parent/Guardian Signature**

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**Date**

---

**Printed Name of Parent/Guardian**

---

**Witness**

---

**Date**

# Patient Responsibility Agreement Over 18 HIPAA Release and Consent



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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

# Asthma Control Test™ (ACT): 12 Years and Older

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Today's Date: \_\_\_\_\_

FOR PATIENTS:

**Take the Asthma Control Test™ (ACT) for people 12 yrs and older.**

Know your score. Share your results with your doctor.

**Step 1** Write the number of each answer in the score box provided.

**Step 2** Add the score boxes for your total.

**Step 3** Take the test to the doctor to talk about your score.

1. In the past **4 weeks**, how much of the time did your **asthma** keep you from getting as much done at work, school or at home?

**SCORE**

All of the time ①	Most of the time ②	Some of the time ③	A little of the time ④	None of the time ⑤
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2. During the past **4 weeks**, how often have you had shortness of breath?

More than once a day ①	Once a day ②	3 to 6 times a week ③	Once or twice a week ④	Not at all ⑤
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3. During the past **4 weeks**, how often did your **asthma** symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night or earlier than usual in the morning?

4 or more nights a week ①	2 or 3 nights a week ②	Once a week ③	Once or twice ④	Not at all ⑤
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4. During the past **4 weeks**, how often have you used your rescue inhaler or nebulizer medication (such as albuterol)?

3 or more times per day ①	1 or 2 times per day ②	2 or 3 times per week ③	Once a week or less ④	Not at all ⑤
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5. How would you rate your **asthma** control during the past **4 weeks**?

Not controlled at all ①	Poorly controlled ②	Somewhat controlled ③	Well controlled ④	Completely controlled ⑤
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**TOTAL**

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**If your score is 19 or less, your asthma may not be controlled as well as it could be.**

FOR PHYSICIANS:

**The ACT is:**

- A simple, 5-question tool that is self-administered by the patient
- Clinically validated by specialist assessment and spirometry<sup>1</sup>
- Recognized by the National Institutes of Health

# 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



# Adolescent Questionnaire

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Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Please circle your answer to each of the following questions:

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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

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## 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

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Office Use Only

I have reviewed the above information with my patient.

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Initials: \_\_\_\_\_