HEALTH ONE, INC. – Patient Information Form

Child's Name: _____ Male / Female Date: _____

Date of Birth: _____/ _____/ _____ Custodial Parent: _____

Address: _____

Parent Information:

Mothers Name: _____ DOB _____/_____/_____ SSN _____/_____/_____

Father's Name: _____ DOB _____/_____/_____ SSN _____/_____/_____

Phone: Primary ( ) _____-_____ Secondary ( )_____-_____ E-Mail: _____

Emergency Contact:

Contact Name: _____Relationship: _____Phone: _____

Statement and Payments:

Address for Billing Statement if different than above: _____

********** INSURANCE INFORMATION **********

A copy of your insurance card will be taken so that we are able to bill your insurance company appropriately. We bill most insurance carriers for you if proper paperwork is provided us at the time of service. Co-payments, deductible and proof of insurance coverage **(your insurance card at every visit)** are due at the time of service. Since your agreement with your insurance carrier is private, we do not routinely investigate why an insurance carrier did not pay, denied or paid less than expected for care. If you have a question regarding how your insurance company paid your claim, you will need to contact them at the telephone number listed on your id card. If an insurance carrier has not paid, professional fees due will be transferred to the patient responsibility and will be due and payable in full from you.

Primary Insurance:

Carrier Name: _____ Eff. Date: _____/_____/_____

Secondary Insurance:

Carrier Name: _____ Eff. Date: _____/_____/_____

********** OFFICE GUIDELINES AND FINANCIAL POLICY **********

BASIC POLICY: Payment for services is due in full at the time service is provided in our office.

INSURANCE CARD: : All patients must provide a current, valid proof of eligibility ID insurance card upon each visit before being seen. This must be presented at every appointment – No exceptions, or the professional fees must be paid at the time of service, or credit card left on file with authorization to charge for that visit. Any future insurance payment would of course be refunded to the patient/responsible party.

NONCOVERED SERVICES: Any Care not paid for by your insurance carrier will require payment in full at the time services are provided or within 30 days of notice of insurance claim denial.

PERSONAL INJURY CASES: This office does not bill for auto accident or other liability or lawsuit-related cases. You are responsible for payment at the time of service. We do not accept liens.

YEARLY HEALTH CHECKS: Our office and most likely your insurance company, requires that ALL patients have a **yearly physical** in order to evaluate and coordinate the overall health and welfare of our patients. Failure to adhere to this policy can prevent necessary care, delay prescription refills and may result in dismissal from our practice.

PARENTAL ATTENDANCE: Patients under the age of 18 may be seen for *sick visits* without a parent/guardian present. Patients under the age of 18 who are scheduled for a well or mental health visit MUST have a parent/guardian present at the time of the appointment.

LATE / MISSED APPOINTMENTS: In fairness to the other patients and to our providers, we require at least 24 hours notice to cancel appointment. A fee of $85 – $150 will be assessed to ALL missed appointments. Patients who miss 3 or more appointments without proper notice may be dismissed from our practice. We reserve the right to reschedule any patients that arrive for their appointment more than **10 minutes after their scheduled appointment** time.

COLLECTION POLICY: We make every effort to contact and work with patients who have an outstanding balance prior to turning the account over to an outside collection agency. Once your account is turned over to collections, we will no longer treat your child and patient records must be transferred to another physician.

**********Please visit our website at www.HealthOneOhio.com for additional guidelines and policies.**********

Primary Pharmacy: _____

(Address & Phone Number)

********** ASSIGNMENT OF BENEFITS **********

I hereby authorize direct payment of benefits to ***South West Pediatrics, Inc.*** for services rendered by him/her in person or under his/her supervision. I understand that financially I am responsible for any balance not covered by my insurance. I herby authorize ***South West Pediatrics, Inc.*** to release any medical or incidental information that may be necessary for either medical care or processing applications for financial benefits, within the limits of HIPPA regulations. A photocopy of these assignments shall be valid as original.

Parent's Signature:

_____ Printed Name: _____

Patient:_____ Sibling:_____

Sibling: _____ Sibling: _____

Social History (Birth to Age 13):

Home situation/Lives with: ☐ Mom & Dad ☐ Mom Only ☐ Dad Only ☐ Mom & Step Dad ☐ Dad & Step Mom

Parent's marital status: ☐ Married ☐ Unmarried ☐ Separated ☐ Divorced ☐ Widowed

Siblings: Sister Brother ☐ None

Second hand smoke exposure: ☐ Yes ☐ No **Animal exposure:** ☐ Yes ☐ No

Guns present in home: ☐ Yes ☐ No **Smoke/CO detectors in home:** ☐ Yes ☐ No

Child Care: ☐ None ☐ Relative ☐ Private Sitter ☐ Daycare

School Name:

Year in School: ☐ Pre-School ☐ Kindergarten ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

School Performance / GPA: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Extracurricular activities:

Hours of TV time each day: ☐ None ☐ <1h/day ☐ 1h/day ☐ 2h/day ☐ >2h/day

Do you have friends: ☐ Yes ☐ No **Diet:** ☐ Balanced ☐ Picky ☐ Poor

Juice intake: ☐ None ☐ <1cup/day ☐ 1cup/day ☐ 2 cups/day ☐ >2cups/day

Caffeine intake: ☐ None ☐ <1can/day ☐ 1can/day ☐ 2 cans/day ☐ >2cans/day

Drink milk daily: ☐ Yes ☐ No **Seatbelt/car seat used routinely:** ☐ Yes ☐ No

Sunscreen used routinely: ☐ Yes ☐ No

Nightly hours of sleep: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Patient Medical History:

	Yes	No
ADD or ADHD	☐	☐
Allergies	☐	☐
Anemia	☐	☐
Asthma	☐	☐
Birth Defects	☐	☐
Bladder or Kidney Problems	☐	☐
Blood Diseases	☐	☐
Cancer	☐	☐
Constipation	☐	☐
Developmental Delays	☐	☐
Diabetes	☐	☐
Ear or Hearing Problems	☐	☐
Eczema	☐	☐
Heart Problems/Defects	☐	☐
Hospital Admissions Other Than Birth	☐	☐
Learning Disorders	☐	☐
Mental Illness	☐	☐
Migraines	☐	☐
Muscle, Joint, or Bone Problems	☐	☐
Seizures/Epilepsy	☐	☐
Serious Injuries	☐	☐
Skin Problems	☐	☐
Substance Abuse	☐	☐
Thyroid Problems	☐	☐
Vision or Eye Problems	☐	☐

Family History:

Please indicate if any of the family members shown have been diagnosed with any of the conditions listed on the left:

	Mom	Dad	Sister	Brother	Grand-Mother	Grand-Father	Aunt	Uncle
ADD / ADHD	☐	☐	☐	☐	☐	☐	☐	☐
Alcohol / Substance Abuse	☐	☐	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐
Birth Defects	☐	☐	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐	☐	☐
Bowel Disease	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Development Disorder	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Epilepsy/Seizures	☐	☐	☐	☐	☐	☐	☐	☐
Headaches / Migraines	☐	☐	☐	☐	☐	☐	☐	☐
Hearing Impairment / Deafness	☐	☐	☐	☐	☐	☐	☐	☐
Heart Problems	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐
Immune Problems	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐
Liver Problems	☐	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐	☐
SIDS or Sudden Death	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Problems	☐	☐	☐	☐	☐	☐	☐	☐
Visual Problems	☐	☐	☐	☐	☐	☐	☐	☐

Patients age 2 and under must complete the sections below

Prenatal History

Please mark all that apply:

Condition	Yes	No	Notes
Multiple Gestation	☐	☐	_____
Infections	☐	☐	_____
Abnormal Bleeding	☐	☐	_____
Abnormal Ultrasound	☐	☐	_____
Pregnancy Medications	☐	☐	_____
Growth Delay	☐	☐	_____
Group B Strep Positive	☐	☐	_____
Pre-Term Labor	☐	☐	_____
Gestational Diabetes	☐	☐	_____

Birth History

C-Section: ☐ Yes ☐ No

Delivery Complications: ☐ Yes ☐ No

Gestational Week:

NICU Admission: ☐ Yes ☐ No

Anything else we should know?

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_____

_____

_____

_____