Decatur Morgan Pediatrics

New Patient Packet

Patient Information

Patient Name:_____Sex: Male/Female
Date of Birth: _____/_____/_____ Social Security Number:_____
Patient Address _____
City_____State_____Zip_____
Phone Number:_____Email:_____
Father's Name:_____Date of Birth___/___/___
Marital Status: __Single__Married__Widowed__Divorced SS#_____
Father's Employer:_____Occupation_____
Father's Phone Number_____(Circle One) Cell Home Work
Is Mother responsible for the Bill if Insurance fails to pay part or all? (Circle One) ___Yes___No
Mother's Name_____Date of Birth___/___/___
Marital Status: __Single__Married__Widowed__Divorced SS#_____
Mother's Employer:_____Occupation_____
Mother's Phone Number:_____(Circle One) Cell Home Work
Is Father responsible for the Bill if Insurance fails to pay part or all? (Circle One) ___Yes____No

Insurance Information

Primary Insurance Co. Name:_____
Subscriber Name:_____Date of Birth_____
Policy/Contract #:_____Group #:_____
Secondary Insurance Co. Name:_____
Subscriber Name:_____Date of Birth_____
Policy/Contract #:_____Group #:_____

Emergency Contact

Name_____Phone#:_____
Relationship to Patient/Parents:_____

Other Children in Family: _____
_____
_____

Signature of Responsible Party:_____
Printed Name:_____

Decatur Morgan Pediatrics

Consent Form
Medication History Acknowledgment

I, _____, understand that my Physician or my child's Physician may need access to my/our medication history and may work in conjunction with my pharmacy and /or insurance carrier in order to provide accurate medical treatment.

Signature of Responsible Party:_____Printed Name_____

Preferred Pharmacy:_____
Pharmacy is located on _____City_____

Medical Treatment and Release of Individual Health information
I give permission to release health information necessary to my child's treatment and the processing of insurance claims to the following:

1. Billing Services
2. Individual Insurance companies
3. Physicians associated with patient care
4. Hosptial lab and procedural departments
5. Agencies associated with patient care
6. Companies providing electronic health record services

Please list any family members , relatives, significant others who may obtain health information or records on your behalf. Also list anyone who may obtain medical treatment and health information on your child's behalf.

Name:_____Relationship_____
Name:_____Relationship_____
Name:_____Relationship_____
Name:_____Relationship_____
Name:_____Relationship_____

Insurance release/ assignment of benefit/payment authorization
Your fee for services is due and payable by cash, check, credit or debit card at the time of treatment. We may not participate in all insurance plans and if your plan is one in which we do not participate, please ask for an office receipt so you can file for reimbursement. Regardless of any insurance, the guarantor is responsible for his/her bill. The guarantor will also be responsible for all charges incurred by collection agencies or past due accounts.

Signature of Responsible Party_____Printed Name_____

Decatur Morgan Pediatrics

Initial History Questionaire

Patient Name:_____ DOB: __/___/___ Age Today: ____Years____Month

Form Completed by:_____Today's Date_____

Household Information:

Please list those living in the child's home:

Name	Relationship to Child	AGE	Health Problems

Any siblings not listed (not living with your?) If so, list their names, ages, where they live

Name	Relationship	Age	Place of Residence

Birth History Information:

*Birth Weight_____Was the baby born at term?_____or ____Weeks Delivery: _____Vaginal_____Cesarean

*If Cesarean birth, why?_____

_____Any prenatal or neonatal complications?_____

*Was a NICU stay required? If so, please explain:_____

_____

*During pregnancy, did mother _____Use Tobacco _____Drink Alcohol _____Use prenatal Vitamins

_____Use drugs or other medications What Medications_____

*Was initial feeding by _____Formula _____Breat Milk How long Breatfed_____

*Did your baby fo home with mother from the hospital? _____Yes _____No Details_____

_____

General

* Do you consider your child to be in good health? ___Yes___No If no explain:_____

_____

* Does your child have any serious illness or medical conditions? ___Yes___No If yes explain:_____

_____

*Has your child had any surgery? __Yes__No Explain_____

*Has your child ever been hospitalized? __Yes__ No Explain_____

*Is your child allergic to any medicaitons? ___Yes___No Explain_____

*Does your family have enough to eat? ___Yes___No Explain_____

Decatur Morgan Pediatrics

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I authorize the use or disclosure of my protected health information (PHI) as described. I understand that the information I authorize a person or entity to receive may be re-disclosed and is no longer protected by federal privacy regulations.

Patient Name:_____DOB_____SS#_____

I hereby authorize Decatur Morgan Pediatrics to ___release to and/or ____obtain from the following information pertaining to my treatment:

Release to or Obtain from:

Name:_____Phone_____Fax_____

Release or Obtain the following Information:

____Progress Notes _____History & Physical _____Lab _____Immunization Records
____Discharge Summary _____Pathology Report _____Referrals _____Imaging Report
____Other_____
____Entire Medical Record

The purpose for this disclosure?_____

Please Fax records to: 256-973-5865 or mail to: Decatur Morgan Pediatrics
1215 7th Street SE
Decatur, Al 35601

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services for alcohol or drug abuse. I understand that authorizing the disclosure is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used on disclosure as provided in CFR164.524. If I have questions about disclosure of my health records, I may contact the Health Information Director at 256-973-6175.

REVOCATION: This authorization to release confidential information may be revoked by me , in writing, at any time, except to the extent that action has already been taken. Said revocation is to be presented to the Medical Records Department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, the information will expire on the following date, event or condition:_____
If I fail to specify an expiration date, event or condition this authorization will expire in 6 months from the date of signing.

It is often necessary to release your health information via fax or other electronic submission when it is needed for continuing care. We confirm receipt of information when it is faxed. I authorize transmission of my health records in situations where this information is needed for continuing care. I understand that as the recipient, I am responsible for the security of these medical records copies and the health information contained therein, whether in paper format or a CD/DVD

Signature of Patient /Representative:_____Date_____

Relationship to Patient?_____

Witness Signature:_____Date_____