CHART #

Pediatric Health History Form – Initial Visit

Child's Name _____ Date of Birth _____ Age _____

Your Name _____ Relationship to Child _____

Child's Past Medical History

Pregnancy/Neonatal Period

Where was your child born? _____

Is the child yours by ☐birth ☐adoption ☐stepchild ☐other

Pregnancy complications _____

Delivery by ☐vaginal ☐c-section

Reason for c-section _____

Complications _____

Was your child premature ☐No ☐Yes, born at _____ weeks

Complications _____

Apgar scores 1 minute _____ 5 minutes _____

Birth weight _____ Length _____

Other problems in the newborn period _____

_____

Infancy/Childhood/Adolescence

Has your child ever been treated for or diagnosed with: (explain)

- ☐ Asthma or reactive airway disease _____
- ☐Wheezing or bronchiolitis _____
- ☐ Seasonal allergies or eczema _____
- ☐ Food allergy _____
- ☐ Recurrent ear infections _____
- ☐ Pneumonia _____
- ☐ Urinary tract infections _____
- ☐ Genetic syndrome _____
- ☐ Seizures _____
- ☐ Anemia _____
- ☐ Broken bone _____
- ☐ Mental retardation or learning disability _____
- ☐ Depression/anxiety _____

Other chronic medical conditions _____

_____

_____

Has your child ever been hospitalized ☐No ☐ Yes (explain)

_____

_____

Previous surgeries and dates _____

_____

Please list any specialist your child is currently seeing and reason:

_____

_____

Medications

ALLERGIES to medicine/vaccines (list and describe reaction)

_____

_____

_____

Current medications and dose: _____

_____

_____

Vitamins _____

Herbal supplements _____

Over-the-counter meds _____

Development/Nutrition

At what age did your child:

Walk alone _____ Sit alone _____

Toilet train(day) _____ Say words _____

Was your child breastfed ☐ No ☐Yes, how long? _____ 1st period (females) _____

Has your child had any unusual feeding/dietary problems? Explain.

_____

Current milk intake: Type _____ Amount _____oz/d

Social History

Who lives in the household with the child? ☐ Mom ☐ Dad

☐ Siblings (# _____) ☐ Grandparents ☐ Other _____

Child's parents are ☐ married ☐ unmarried ☐ divorced ☐ other

Childcare ☐ parents ☐ relatives ☐ daycare ☐ babysitter/nanny

Days per week in childcare (not with parents) _____

Do any household members smoke ☐ Yes ☐ No

How many hours per day does your child spend:

Watching TV _____Computer _____Video games _____

Child's school name _____ Grade _____

Any concerns about school performance? ☐ No ☐ Yes, explain

_____

Any concerns about peer or teacher relationships? ☐ No ☐ Yes

_____

Sports/exercise: Type _____

How often? _____ How long _____min

Family History

Do any family members have any of the following conditions:

Condition	Mother	Father	Sibling	Grandparent
Asthma	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Blood disorder	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Heart attack/disease	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Depression/anxiety	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐
_____	☐	☐	☐	☐

Please explain all positives. _____

_____

_____

_____

_____

Review of Systems (*Check all that apply*)

Constitutional
- ☐ Fever, chills ☐ Fatigue
- ☐ Unexplained weight loss/gain
- ☐ Excessive thirst

Ear, Nose, and Throat
- ☐ Loud voice, hearing problem
- ☐ Mouth-breathing, snoring
- ☐ Ear pain
- ☐ Frequent runny nose

Respiratory
- ☐ Cough, short of breath
- ☐ Chest tightness, wheeze

Musculoskeletal
- ☐ Muscle pain, weakness
- ☐ Joint pain, swelling
- ☐ Bone pain

Other (eye,skin,blood)
- ☐ Blurry vision ☐ Squinting
- ☐ "Crossed" eyes ☐ Itchy eyes
- ☐ Rashes ☐ Abnormal moles
- ☐ Abnormal bruising, bleed

Gastrointestinal
- ☐ Nausea, vomiting, diarrhea
- ☐ Constipation, blood in stool
- ☐ Abdominal pain

Cardiovascular
- ☐ Chest pain, palpitaions
- ☐ Tires easily with exertion
- ☐ Fainting

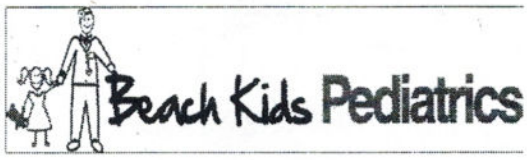
Genitourinary
- ☐ Frequent or painful urination
- ☐ Bedwetting, frequent accidents
- ☐ Vaginal or penile discharge

Neurologic
- ☐ Headaches ☐ Seizures
- ☐ Clumsiness ☐ Milestone delay

Psychiatric/emotional
- ☐ Anxiety/stress ☐Depression
- ☐ Sleep problem ☐ Anger concern
- ☐ Concerns with attention, impulsivity

Reviewed by _____ ***date*** _____

Created 12/2006



Patient Registration Information Form:

How did you hear about us: _____

Patient Name: _____

SSN: _____ DOB: _____ Gender: M / F

Address: _____ City: _____ State:___Zip: 234___

Home Phone #: _____ Mobile #: _____

Emergency Contact: Name: _____ Phone#: _____

Previous or Primary Care Dr: _____ _____

Which best describes your child's immunization history ☐ **Current** ☐ **Partial** ☐ **Do Not Vaccinate**

Do you have your child's immunization record or copy of? ☐ **Yes** ☐ **No**

Mother/Guardian DOB: _____

Name: _____

Address: _____

City:_____State:____Zip:_____ ___

Phone #: _____

Email:_____

SSN:_____

Employer: _____

Occupation:_____

Father/Guardian DOB:_____

Name: _____

Address:_____

City:_____State:____Zip:_____

Phone #:_____

Email:_____

SSN: _____

Employer:_____

Occupation:_____

Other Family Members	**Birthdate**	**Gender**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PHARMACY NAME- PHONE# - STREET NAME:

Insurance Information 1:

Company Name: _____

Name of Policy Holder: _____

Policy #: _____

Group #: _____

Telephone Number for Insurance Company: _____

Insurance Information 2:

Company Name: _____

Name of Policy Holder: _____

Policy #: _____

Group #: _____

Telephone Number for Insurance Company: _____

PLEASE PROVIDE NAME, PHONE # AND RELATIONSHIP OF THOSE (OVER THE AGE OF 18) THAT CAN SEEK MEDICAL TREATMENT FOR THE ABOVE NAMED PATIENT ON YOUR BEHALF.

NAME	PHONE#	RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I verify that the information is accurate:

_____ _____

Signature Date

Relationship to patient (Please circle one) - mother - father - grandparent - stepparent - legal guardian - other

If you answered **NO** to having your child's immunization record. Please fill out the Records Request Form attached so we can obtain the immunizatin record. If you child is school age please provide the name of the school your child is enrolled as another source for obtaining your child's immunization record. We appreciate your help in providing the best care to your child.

School _____

Patient Financial Responsibility Disclosure and Acknowledgment

Your signature on the line below forms a legally binding agreement between Beach Kids Pediatrics, PLLC and the undersigned patient (the "Patient") who is receiving medical services, or the responsible party for minor patients (those patients under 18 years of age). The Responsible Party is the individual who is financially responsible for payment of medical bills associated with the medical services provided by Beach Kids Pediatrics, PLLC, and is the individual indicated on the form below as the Responsible Party in the space provided. **All charges for services rendered are due and payable at the time of service.**

Beach Kids Pediatrics, PLLC has contracts with numerous third party insurance companies and Beach Kids Pediatrics, PLLC will bill such third party insurance companies for services rendered to you by Beach Kids Pediatrics, PLLC as a service to you. The Responsible Party is responsible for payment for services rendered in the event that your insurance declines to make payment for any services rendered for any reason whatsoever. The Responsible Party shall also be responsible for making any and all required co-pays and deductibles. The Responsible Party shall also be responsible for paying any additional amount owing after claim submission to the Patient's insurance and will be billed for any such deficit after Beach Kids Pediatrics, PLLC receives an explanation of benefits (EOB) from the Patient's insurance company.

The Responsible Party shall:

- Provide, and update to maintain current, the Responsible Party's current address and phone number for both the Responsible Party and the Patient.
- Present all current insurance cards prior to each of the Patient's office visits.
- Verify at each office visit that the information, including address, phone number, and insurance information is accurate and current by signing Beach Kids Pediatrics, PLLC's data sheet.
- Pay any required co-pay at the time of each office visit.
- Pay any additional amount owing within thirty (30) days of receiving a statement from Beach Kids Pediatrics, PLLC; it being understood that Beach Kids Pediatrics, PLLC will bill the Responsible Party for any amounts not paid by the insurance company as set forth on the EOB received from the Patient's insurance company.

Returned Checks – If payment is made by check and the check is returned unpaid for insufficient funds, or unpaid for any other reason, the Responsible Party shall be financially responsible to Beach Kids Pediatrics, PLLC for the original face amount of the returned check plus a service charge equal to $35.00 (the "Service Charge"). Beach Kids Pediatrics, PLLC will notify Responsible Party by mail in the event that a check is returned and shall in such notice provide fifteen (15) days from the date of the notice for repayment by the Responsible Party of the face amount of the check plus the Service Charge. If payment of the face amount of the check plus the Service Charge is not received by Beach Kids Pediatrics, PLLC within the applicable 15 day time period, then Beach Kids Pediatrics, PLLC may turn the account over to Beach Kids Pediatrics, PLLC's collection agency for collection of the same. The Responsible Party shall be responsible for all costs of collection in addition to the face amount of the check and Service Charge.

Non-Payment – In the event that Beach Kids Pediatrics, PLLC should initiate collection proceedings or other legal action to collect an overdue account, the Patient and Responsible Party each acknowledge and understand that Beach Kids Pediatrics, PLLC has the right to and shall disclose to its outside collections agency all relevant personal and account information necessary to collect payment for services rendered, including any applicable service charges and applicable costs of collections. The Patient and the Responsible Party each understand and acknowledge that they are responsible for all costs of collection, including without limitation attorneys' fees and costs, and that interest shall accrue on all unpaid balances at the rate of 18% per annum until repaid in full.

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services, or as the Responsible Party, as applicable. Your signature below verifies that you have read the above disclosures, understand your responsibilities, and agree to the terms set forth herein.

Patient Name (Print): _____

Patient Signature: _____ Date: _____

Responsible Party Name (Print): _____

Responsible Party Signature: _____ Date: _____

Financial & Office Policies

FINANCIAL POLICY

Initial____ **INSURANCE:** I understand it is my responsibility to confirm with my insurance company that the physician is currently under contract with my plan or be willing to be seen at "out of network" benefits. Any questions about medical, well baby/preventive care, labs/x-rays and immunization coverage should be directed to my insurance carrier prior to my visits. I agree to be responsible for all copays, deductibles and non-covered services determined by my insurance plan.

Initial____ **CHECK IN:** I agree to pay copays and past due balances at the time of check-in. If I do not have a copay or have not come prepared to pay past due balances, my child's appointment may rescheduled for a later time. I agree to bring a current insurance card with me at each visit. I will be asked to verify insurance and demographic information so records remain current.

Initial____ **SELF PAY:** If I do not have proof of insurance coverage or if insurance is no longer effective at the time services are rendered, I understand that payment is due at the time of service.

Initial____ **PAYMENTS:** I will promptly pay all amounts that have been determined my responsibility by my insurance carrier upon receipt of my statement. I understand that my health insurance contract is between my insurance company and myself. Any balance remaining after my health insurance pays, denies or deems non-covered under my plan will by my responsibility. If I have not paid my bill or have not arranged for a payment plan, the practice may ask for the assistance of an outside collection agency. I understand and acknowledge that I am responsible for all costs of collection, including without limitation attorneys' fees and costs, and that interest shall accrue on all unpaid balances at the rate of 18% per annum until repaid in full. If my account is turned over to a collection agency, I will be dismissed from the practice. The practice will try to work with me to avoid this.

Initial____ **SERVICE FEES:** I understand my account will be charged $35.00 for NSF/Returned checks. I understand patient balances of 60 days or more (unless previous financial arrangements have been made) may be charged $10.

Initial____ **CREDIT CARD ON FILE:** I agree to maintain my credit or debit card on file to satisfy all co-pays, deductibles, and balances not covered by my insurance company. I understand the card will **only** be used if my child's account has been **delinquent** for more than **60 days.**

OFFICE POLICY

Initial____ **APPOINTMENTS AND LATE ARRIVALS:** We require patients to arrive on time for their appointments. If you arrive more than 20 minutes past your scheduled appointment time, you may either be rescheduled so that other patients are not inconvenienced or if you prefer to wait, you may be seen when the day's schedule permits.

Initial____ **NO SHOWS:** We expect patients/parents to give us notice (usually 24 hours prior) if *an appointment is unable to be kept*. There is a fee ($50-$100) for no-shows or appointments cancelled without proper notice. *If there are* three (3) consecutive no-shows in 1 year, *a family may be dismissed from the practice.*

Initial____ **MINORS:** Unaccompanied minors *or minors brought in by persons other than the child's parents,* must have a written authorization for medical treatment assigned by the parent or guardian before treatment can be rendered. Parents must be available by telephone in the event that the physician needs to contact them. **The responsibility for copays, deductibles and fees for no-covered services rests with the accompanying adult.**

I have read, understood and agree to the above financial and office policy. I understand that **Non-compliance *with* this policy *may result in transfer of care from our practice, Beach Kids Pediatrics PLLC.***

Responsible Party Name (Print):

_____

Responsible Party Signature: _____ **Date:** _____

Patient Name _____ **DOB:** _____

Patient Name _____ **DOB**_____

Patient Name _____ **DOB:** _____

CREDIT CARD AUTHORIZATION

I authorize Beach Kids Pediatrics PLLC to maintain my credit/debit card on file. I understand the card will **only** be used if my child's account has been **delinquent** for more than **60 days**, and I have not made any effort to make payment arrangements.

Cardholders Signature:_____ Date:_____

Patient's Name:		Patient's DOB:	
Cardholder's Name:		Phone Number:	
Cardholder's Address:			
City:	State:	Zip:	
_____ VISA _____MC _____AEx			
Credit Card Number:		Exp:	CVV:

ACKNOWLEDGMENT OF RECEIPT

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices of Beach Kids Pediatrics PLLC

If you are signing as the personal representative of the patient:

Patient's Name: _____

Parent or Guardian's Name: _____

Parent or Guardian's Signature: _____

Date: _____

If you are the patient and signing yourself:

Patient's Name: _____

Patient's Signature: _____

Date: _____

DOCSNFK-#1763965-v1-

1004 First Colonial Rd
Suite 103
Virginia Beach, VA 23454
(757) 806-8880 PH (757) 806-8887 FAX

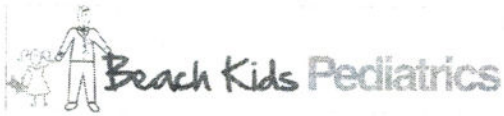
1. Has your child received any immunizations? _____YES _____ NO

2. Is your child up to date with their immunizations? _____ YES _____NO

3. If your child is not up to date, do you want to get them caugh up? _____YES _____NO

4. Do you have any concerns about your child receiving immunizations? _____YES _____ NO

Signature: _____ Date: _____



Bryan McDonald, M.D. F.A.A.P.
Anne "Nan" McDonald, M.D. F.A.A.P
1004 First Colonial Rd.
Suite 103
Virginia Beach, VA 23454
757- 806-8880 Ph 757- 806-8887 Fax

Patient Release of Medical Records Form

Patient's Name: _____

Patient's Date of Birth: _____

I request and give my permission to release my or my child's Medical Records from:

Clinic/Physician: _____

Address: _____

_____

Office Phone: _____

Office Fax: _____

Please release the following records **(PLEASE DO NOT FAX ENTIRE MEDICAL RECORD):**

Please **FAX the following records to (757) 808-8887:**

X Complete Immunization Record (Please **fax** to 757-806-8887)
X Growth Charts (Please **fax** to 757-806-8887)

Please **MAIL the following records to the address noted below:**

___Demographics and Insurance Information
___Problem and Medication Lists
___Labs and Imaging results
___Specialist Consultation Notes
___Other (specify)_____

The Medical Records listed above are to be released to:

Beach Kids Pediatrics
Bryan McDonald, M.D. F.A.A.P.
Anne "Nan" McDonald, M.D. F.A.A.P
1004 First Colonial Rd, Suite 103
Virginia Beach, VA 23454
Phone: 757- 806-8880 Fax: 757- 806-8887

_____ _____

Signature of Patient or Parent/Guardian Date