

East End Pediatrics, P.C.
Patient Registration - 2019

Child's Last Name: _____ First Name : _____ MI: _____

Mother's maiden name: _____

Sex _____ Date of birth _____

Patient: Cell phone: _____ Patient's email: _____

Siblings: Name: _____ DOB: _____ Cell #: _____

Name: _____ DOB: _____ Cell #: _____

Name: _____ DOB: _____ Cell #: _____

Race (check one):

American Indian or Alaskan Native

Asian

Black

Hawaiian Native or Pacific Islander

White

I prefer not to answer

Ethnicity (check one):

Unknown

Hispanic or Latino

Not Hispanic or Latino

I prefer not to answer

Permanent Billing /Mailing Address:

_____ (Street or PO Box)

_____ (City)

_____ (State & Zip)

Is patient a year-round or seasonal Hamptons resident? (Circle one) Year-round Seasonal Visiting

Alternate address of patient/family (non-billing address):

School _____

Phone numbers/addresses/email:

Parent 1: Name _____ Relationship to child _____

Date of birth _____ Occupation: _____ Employer: _____

Mailing Address: _____

(If different from above) (Street address) _____ (City) _____ (State & Zip) _____

Home Phone: _____ Work phone _____ Cell: _____

Parent's email: _____

Lives with patient full time (circle one)? Yes No

In the event of separation or divorce, please explain any important living arrangement details :

Parent 2: Name _____ Relationship to child _____

Date of birth _____ Occupation: _____ Employer: _____

Home Phone: _____ Work phone: _____ Cell: _____

Mailing Address: _____

(If different from above) (Street or PO Box) _____ (City) _____ (State & Zip) _____

Parent's email: _____

Lives with patient full time(circle one)? Yes No

In the event of separation or divorce, please explain any important living arrangement details:

Emergency Contact, other than parents (name, phone number and relationship to family):

1: _____ 2: _____

Name and phone number of any specialist your child sees on a regular basis:

Preferred personal physician (Please check one): *ONLY FILL OUT FOR YEAR ROUND PATIENTS*

Dr. Gail Schonfeld

Dr. David Lado

Dr. Antony Perry

Dr. Jennifer Favre

Primary MD, if other than East End Pediatrics:

Name: _____

Address: _____

Phone and fax: _____

Insurance:

Primary Insurance: _____

Policy Holder's Last Name: _____ First Name & Middle Initial: _____

Policy Holder's Birth Date: _____

Group # _____ ID# _____

Secondary Insurance: _____

Policy Holder's Last Name: _____ First Name & Middle Initial: _____

Policy Holder's Birth Date: _____

Group # _____ ID # _____

Billing statements sent to (If different from above):

Name _____

Relationship to patient _____

Resides with patient ___ yes ___ no

Address: _____

Phone: _____ Cell: _____

Privacy Constraints (Check One):

___ No restrictions. Okay to leave message/send mail.

___ Restrictions – Person to person with patient/guardian only.

___ Restrictions (specify): _____

In what language are you most comfortable communicating? _____

Which parent do you want to receive the notifications from our office: _____

We will email or text reminders to schedule appointments, reminders of scheduled appointments, and general notices from the practice. If you **DO NOT** use email or text, how would you prefer to be contacted regarding those issues? (check only one):

Call cell phone Call home phone Call work phone

How do you prefer to be contacted about medical issues and billing issues?

Home phone Cell phone Work phone

To grant authorization for someone other than parents to bring child for care:

I hereby authorize _____ to bring my child to East End Pediatrics, P.C. for medical care. Relationship to my child:	X	
Authorization to pay benefits to physician: I hereby authorize payment directly to the physician the surgical and/or medical benefits, if any, otherwise payable to me for services rendered, realizing that I am responsible for paying any co-payments, deductibles and other fees not covered by my insurance carrier. Notice: There will be a charge of \$20 for any checks not honored by the bank, and a \$20 per month charge on all accounts over 30 days past due. If your account is referred to a collection service, you will be responsible for the legal fees.	X	
Out of network services: We cannot assume responsibility for bills incurred for your child's medical care including lab tests and visits to specialists. If we refer your child for services, we will try, to the best of our ability, to refer to specialists and diagnostic services that are in network with your insurance, however, the final responsibility (including financial responsibility) is yours to determine network participation.	X	
Authorization to release information: I hereby authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims.	X	
Authorization to release information: I hereby authorize East End Pediatrics, P.C. to send immunization, medication records and/or routine physical forms to my child's school or other physicians.	X	
Non Payment Fee: I agree to pay a non payment fee of \$5 in the event that I do not pay on the date of service.	X	
No Show Fee: I understand that a \$25 fee will be charged for appointments (\$35 for well visits) missed without 24 hours notice to East End Pediatrics.	X	
Fund Raising: I understand it is my right to opt out of any fundraising efforts associated with East End Pediatrics. By signing, I am making my wishes known that I do not want to participate in any fundraising efforts.	X	
General consent to treatment including obtaining information from other treating physicians as needed and obtaining information about medications prescribed elsewhere.	X	

If parents are divorced or separated please fill out this section:

Who has custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? ___ yes ___ no

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

For children 18 and over:

Misc Info/Patient Status:

___ Full Time Student

___ Part Time Student/ Not Employed

If full time student and over 18:

School name _____

Address: _____

Permission to submit vaccine information to registry (for patient' 18 years of age or older) ___ yes ___ no

EAST END PEDIATRICS, P.C.
200 Pantigo Place, Suite E
East Hampton, NY 11937

PATIENT MEDICAL HISTORY

Name: _____ Birth weight _____ Full Term ___ Premature ___
 Hospital of Birth: _____
 Medical problems at birth: _____

Does your child have a history of:	<u>YES</u>	<u>NO</u>
Serious injury or accident?	_____	_____
Surgery or hospitalization	_____	_____
Having had the chicken pox? (At age _____)	_____	_____
Frequent ear or sinus infections	_____	_____
Vision and/or hearing problems	_____	_____
Asthma, bronchitis, bronchiolitis, pneumonia, cystic fibrosis, or other lung problems	_____	_____
Heart murmur or heart disease	_____	_____
Anemia, bleeding disorder, or other blood disorder	_____	_____
Learning, behavioral or mental health problems such as:	_____	_____
Developmental delays, learning disorder, attention deficit disorder, autism, anxiety disorder, depression, or mental retardation	_____	_____
Blood transfusion	_____	_____
Gastrointestinal disorders such as frequent abdominal pain, liver disease, chronic constipation requiring a doctor visit, or encopresis	_____	_____
Bladder or kidney infections, bedwetting after age 7 years, or other kidney problems	_____	_____
Chronic or recurrent skin problems such as eczema or acne	_____	_____
Frequent headaches	_____	_____
Convulsions or other neurologic problems such as cerebral palsy or muscular dystrophy	_____	_____
Diabetes	_____	_____
Thyroid or other endocrine problems	_____	_____
Genetic or chromosome disorder	_____	_____
Cancer/Leukemia	_____	_____
Drug or alcohol dependency	_____	_____
Immune disorder	_____	_____
Any other significant problems	_____	_____
List any medications taken daily, such as vitamins and/or herbal supplements _____	_____	_____
	_____	_____
	_____	_____

Is your child currently under the care of a specialist? _____
 Specialist Name: _____
 Address: _____
 Phone Number: _____ - _____ - _____ Fax Number: _____ - _____ - _____

Does your child smoke cigarettes or use tobacco products? _____

Does your child have any allergies?
 If so, to what? _____

Has your child had any adverse reactions to immunizations? _____

If you answered yes to any of the above, please provide details here including dates: _____

Form completed by: _____ Relationship to child: _____ Date: _____

EAST END PEDIATRICS, P.C.
200 Pantigo Place, Suite E
East Hampton, NY 11937-5921

FAMILY SOCIAL HISTORY

Child's Name: _____ Sex: Male / Female DOB: _____

Please circle appropriate answers

Father/Parent 1/Guardian 1: Occupation: _____ Full-time / Part-time

Mother/Parent 2/Guardian 2: Occupation: _____ Full-time / Part-time

Do both parents work outside the home? Yes / No

Parents are: married / separated / divorced / single / widowed / same-sex

If separated or divorced, who has legal custody? Father / Mother / Shared / Other _____

Is the custody status in process? Yes / No - Visitation status of non-custodial parent _____

Is either parent re-married? Yes / No (Father / Mother)

Was your child adopted? Yes / No If yes, from what country? _____ At what age? _____

Was your child born by assisted fertility methods? Yes / No If yes, which method? _____

Other family members in the home: _____

(siblings, step-siblings, grandparents, other) _____

Others in the home (Nannies, housekeepers) _____

Are there siblings or step-siblings living with other parent or relative? Yes / No

Childcare: Out-of-home Daycare / In-home daycare By whom? _____

Household: Rent / Own / Year-round (Full-time / Part-time) Seasonal
Apartment / House / Single-family dwelling / Multi-family dwelling

Types of pets in the home: _____

Do any family members smoke? Yes / No

In what country was the father born? _____ How long living in the U.S.? _____

What is the father's race/ethnicity?

Ethnicity: Hispanic or Latino / Not Hispanic or Latino / Unknown or Decline to Answer

Race: American Indian or Alaskan Native / Asian / Black / Hawaiian Native or Pacific Islander / White

In what country was the mother born? _____ How long living in the U.S.? _____

What is the mother's race/ethnicity?

Ethnicity: Hispanic or Latino / Not Hispanic or Latino / Unknown or Decline to Answer

Race: American Indian or Alaskan Native / Asian / Black / Hawaiian Native or Pacific Islander / White

In what country was the child born? _____ How long living in the U.S.? _____

What is the child's race/ethnicity?

Ethnicity: Hispanic or Latino / Not Hispanic or Latino / Unknown or Decline to Answer

Race: American Indian or Alaskan Native / Asian / Black / Hawaiian Native or Pacific Islander / White

Person completing this form _____ Relationship to patient _____ Date _____

EAST END PEDIATRICS, P.C.
200 Pantigo Place, Suite E
East Hampton, NY 11937-5921

FAMILY MEDICAL HISTORY (The Patient's Parents, Grandparents, Brothers, Sisters, First Cousins, Aunts & Uncles)

Child's Name: _____ Date of Birth: _____
 Mother's name: _____ Father's Name: _____

If siblings have **both** biological parents in common please list below. If not, please request another form for that child.

Name of each sibling: _____
 DOB of each sibling: _____

	<u>YES</u>	<u>NO</u>	<u>Family member's relationship to patient & specify condition if multiple are listed</u>	<u>*Specify Maternal or Paternal*</u> M or P
Asthma	_____	_____	_____	M or P
Nasal allergies	_____	_____	_____	M or P
Heart disease such as coronary artery disease (before age 50), congenital heart disease, mitral valve prolapse, arrhythmia	_____	_____	_____	M or P
Rheumatic fever/rheumatic heart disease	_____	_____	_____	M or P
High blood pressure	_____	_____	_____	M or P
Elevated cholesterol	_____	_____	_____	M or P
Anemia, bleeding or blood disorders including: sickle cell disease or trait, thalassemia, hemochromatosis	_____	_____	_____	M or P
Tuberculosis	_____	_____	_____	M or P
Immune problems such as HIV, chemotherapy, radiation therapy, organ transplant	_____	_____	_____	M or P
Liver disease	_____	_____	_____	M or P
Kidney disease	_____	_____	_____	M or P
Diabetes before age 50 years	_____	_____	_____	M or P
Epilepsy, convulsions or other neurologic disorder	_____	_____	_____	M or P
Mental Retardation	_____	_____	_____	M or P
Autism	_____	_____	_____	M or P
Vision or hearing problems	_____	_____	_____	M or P
Alcohol or drug abuse	_____	_____	_____	M or P
Mental Illness	_____	_____	_____	M or P
Birth defects	_____	_____	_____	M or P
Early cancer	_____	_____	_____	M or P
Cystic fibrosis	_____	_____	_____	M or P
Hip Dysplasia	_____	_____	_____	M or P
Autoimmune disorder such as lupus or rheumatoid arthritis	_____	_____	_____	M or P
Migraine headaches	_____	_____	_____	M or P
SIDS or other childhood deaths	_____	_____	_____	M or P
Thyroid disease	_____	_____	_____	M or P
Intestinal ulcers, colitis, gastroesophageal reflux	_____	_____	_____	M or P

Other: _____
 Form completed by: _____ Relationship to child: _____ Date: _____

East End Pediatrics, P.C.

200 Pantigo Place, Suite E, East Hampton, NY 11937

www.eastendpediatricspc.com

Phone: 631-324-8030 Fax: 631-324-8032

Gail A. Schonfeld, M.D., F.A.A.P.

David Lado, M.D.

Antony W. Perry, M.D., F.A.A.P.

Office Hours:

Monday-Friday 8:30 a.m.-6:00 p.m.

Saturday: 8:30 a.m.-4:00 p.m.

Sunday: Urgent Only

Hours expanded during July and August

Office visit by appointment only

Philosophy: We at East End Pediatrics strongly believe in the importance of prevention, continuity of care and evidence-based medicine. Routine check ups, immunizations, and development and mental health surveillance are essential to that care. To maintain continuity we strongly discourage the use of the emergency room and urgent care centers, and we offer same-day emergency and urgent care appointments 365 days a year with continuous on-call availability for treatment, advice and guidance. We care for children from birth to age 23 years.

The Patient-Centered Medical Home: We were awarded the designation of National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home, Level 3, the highest level attainable. This award was given in recognition of our efforts to integrate and coordinate care between specialists, mental health and dental providers, hospitals, emergency rooms and your child's school. Therefore, we will request that you help us obtain information from all of these sources when appropriate. Children with chronic conditions will need to be seen on a regular basis to manage their conditions optimally. We consider parents and extended family members as our partners in providing care to your child and will help you with medical, behavioral, educational and mental health issues, as well as offering guidance in parenting.

Website information: We strongly encourage utilization of our website and the patient portal. Our website www.eastendpediatricspc.com contains articles of interest, links to many quality sources of medical and parenting information, and other resources for parents. Once registered on the patient portal you can view many of your child's medical records, including vaccine records, growth charts, lab results, medications, allergies, and summaries of your child's visits here and significant problems. You can also send messages to us about non-urgent matters via the secure, privacy-protected portal, update registration information, complete developmental surveys important for your child's check-ups in the privacy of your home that help us in the care of your child or teen, receive educational literature that we feel will be specifically useful to you, and view and pay bills online. New patients can self register with East End Pediatrics prior to the first visit to facilitate the check-in process in the office. Access to a patient's chart is password protected and the log-in procedure will be explained in detail by our staff. Please call our office with any questions about using the website.

Contacting our office: You may call during office hours to speak to a nurse for advice on symptom management at home or whether your child's condition requires an office visit. Many problems cannot be handled safely over the phone and we may ask you to bring your child in so we can evaluate their condition. We cannot prescribe antibiotics over the phone without examining your child. Messages left for the nurse are usually returned within three hours. Please state the urgency of the call when leaving a message so it can be responded to in the most appropriate timeframe. Messages left for the doctor will usually be returned the same day. Non-urgent messages, including requests to schedule a check up, can be sent via the patient portal.

Emergencies: After hours, you have the ability to leave a message for an appointment to be scheduled for the following day and to reach a doctor if your child is having a medical emergency. When you call our office after hours, press 5 to leave a message for the receptionist to call you in the morning and make an appointment. Press 2 to speak with a doctor for a medical emergency. When calling, please slowly and clearly leave your child's name, your name and phone number on the message and our doctor will return your call. Please make sure you have phone service and stay near your phone.

Most emergencies can be taken care of in our office. In the case of fracture, cuts, seizures, high fevers, etc., call the office; do not go to the emergency room unless your child has been severely injured, is unconscious, or is unable to breathe. If this should occur, always call us first, or have someone else call us so that we can try to meet you at the emergency room. Dr. Schonfeld, Dr. Lado and Dr. Perry have privileges at Southampton Hospital.

Routine Appointments Please make check-up appointments as much in advance as possible. We limit check-ups for children over

2 years of age in July and August, so please schedule these visits in the spring. Since check-up appointments and immunizations are often required at the beginning of the school year, it is best to plan ahead. If you have made an appointment for one child, only one child can be seen.

Referrals: When requesting a referral our doctor must be familiar with the medical condition for which the referral is needed in order to approve it and fill out the necessary clinical information. This usually requires a visit to our office. If you are unsure if you are required to obtain a referral prior to visiting a specialist, please call your insurance company and speak with a customer service representative. Please allow at least two business days for us to process the paperwork.

In-Office Lab: We routinely perform a number of tests in our CLIA-approved office lab. If you have any concerns or questions about our procedures, please speak with our office manager. You can also speak directly with CLIA, the regulatory organization, by calling 877-267-2323.

Parental Consent for Care: All adults involved in the care of the child are encouraged to be part of office visits. However, any adult who is not the child's parent must have written permission, from the parent, to bring the child in for medical care.

Late arrivals to appointments: We value your time and attempt, as much as possible, to run on schedule. However, it is our policy to see all emergencies in the office whenever possible and not refer patients to the hospital emergency room. Therefore, we cannot guarantee that we will always run on schedule. We will attempt to notify families when a delay is anticipated and offer the option to reschedule. We request that patients arrive on time to their scheduled appointments so that they do not force us to run behind

schedule and inconvenience other patients. Every attempt will be made to fit a patient into our schedule. However, priority will be given to patients who arrive on time for their appointments.

Prenatal Counseling This is an opportunity for the mother and father to meet with the pediatrician before your child is born and for your questions to be answered. The fee for this service is available upon request.

Divorce: It is our policy to discuss a child's care with both parents. We cannot guarantee the information regarding a child's care will be kept from the non-custodial parent. The parent who brings the child to the office is responsible for the bill, regardless of any arrangement between the parents.

Patient Satisfaction Surveys: We welcome your comments and suggestions. Please ask for the location of our suggestion box and complete the survey, anonymously if you prefer.

Insurance: We participate with Aetna, Affinity (Medicaid, Child Health Plus, Essential, HARP and HIX) Cigna, EmblemHealth including Essential plan (but not: GHI underwritten plans, Emblem Health HMO, Comprehealth, EmblemSelect, HIP Classic or any HIP plans through the Exchange) Empire BC/BS (Including Exchange products, but not their Child Health Plus plan), HealthFirst (including Essential and Leaf Plans), Island Group Administration, Oxford-United Healthcare (not the Metro plan), Tricare, NYS Medicaid, NYSHIP, Medicare, United Health Care (commercial, Compass, Essential and Community Health Plan), US Family Health Plan and 1199.

Child Health Plus Plans we accept:

Affinity
EmblemHealth CHP
HealthFirst
United Healthcare Community Plan

Medicaid Plans we accept:

Affinity
EmblemHealth Medicaid
HealthFirst
New York State Medicaid
United Healthcare Community Plan

Exchange Plans we accept:

Affinity Essential, HARP and HIX
Empire Exchange Plans
Healthfirst Essential and Leaf
EmblemHealth Essential Plan only
United Healthcare Compass and Essential Plans

Please bring your child's insurance card to each visit and show it to the receptionist at check-in. If one of our doctors is not named as your child's Primary Care Provider (PCP) with your insurance company, you must call your company before your child's appointment to change your PCP or you may be financially liable for the cost of the visit.

Additional Fees:

- Copays
- Fees for non-covered services
- Deductibles
- \$5 fee for forms or letters requested, \$10 same day
- Fee of \$5 for nonpayment at the time of service
- Patients whose insurance we cannot verify at the time of service must pay in full
- Fee of \$25 for cancellations/no shows of sick visits, \$35 for check-ups and weekend appointments, without 24 hour notice
- Fees for appointments after posted hours, on weekends and holidays

ABOUT OUR STAFF:

Gail A. Schonfeld, M.D., F.A.A.P. had the good fortune to be recruited by the Town of East Hampton and began her practice here in July, 1982. Dr. Schonfeld was born in Rochester, NY, and was raised in Freeport, Long Island. She is a graduate of Boston University and Boston University School of Medicine, and she did her residency in Pediatrics at North Shore University Hospital in Manhasset, NY. She is Board certified in Pediatrics and is a Fellow of the American Academy of Pediatrics. Dr. Schonfeld is married to Larry Lillie who owns an irrigation business in East Hampton, Lillie Irrigation. They have two sons, Colin and Cory, and three grandchildren, Summer, Savanna, and Charlie Lillie.

David C. Lado, M.D. has been at East End Pediatrics since November 2008. Dr. Lado spent his childhood in North Carolina. He graduated from the University of North Carolina at Chapel Hill, and he earned a Master's Degree in neuroscience at the University of Florida at Gainesville. Dr. Lado received his Medical Degree from SUNY Downstate in Brooklyn, NY where he also completed his pediatric residency. He is of Spanish descent and is fluent in that language. Dr. Lado resides in East Hampton with his family.

Antony W. Perry, M.D., F.A.A.P. joined East End Pediatrics in November 2012. Dr. Perry attended Dartmouth College and received his medical degree from the University of Connecticut School of Medicine. He completed his residency in Pediatrics at North Shore University Hospital in Manhasset, NY and is Board certified in Pediatrics and is a Fellow of the American Academy of Pediatrics. Originally from Sarasota, Florida, Dr. Perry has spent most of his professional career in the Northeast. He is the proud father of two daughters, Morgan and Madison, and resides in East Hampton.

Directions to East End Pediatrics, P.C. (In the East Hampton Healthcare Center)

From the West: Montauk Highway, Route 27 East through the village of East Hampton, bearing right at the windmill. Take the first left turn after Town Hall onto Pantigo Place. Turn right into the parking lot and drive around to the front of the building. We are located in Suite E.

From the East: Route 27 West, through Amagansett. Take the right immediately after Luigi's onto Pantigo Place at the sign for the East Hampton Healthcare Center. Turn right into the parking lot and drive around to the front of the building. We are located in Suite E.