East End Pediatrics, P.C.
Patient Registration - 2017

Child's Last Name:______________________________ First Name : _______________MI: ___
Mother's maiden name: ____________________________________
Sex _____ Date of birth _____________
Siblings: Name: _______________________ Cell #: ________________ Email: ____________________
Name: _______________________ Cell #: _________________ Email:____________________
Name: _______________________ Cell #: _________________ Email: _____________________

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:
1. Preferred phone number: ____________________________________
2. Alternate phone: ___________________________
3. Patient: Cell phone: ______________________ Patient's email: ___________________________________

4. 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 :

____

5. 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):

Dr. Gail Schonfeld

Dr. David Lado

Dr. Antony Perry

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**

Where do you prefer billing statements to be sent?
☐ **Patient portal (requires registration on the portal)** ☐ **Mailing address**

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	

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	

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 11937-5921

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: ______________ ______________ ______________ ______________

	YES	NO	Family member's relationship to patient & specify condition if multiple are listed	*Specify Maternal or Paternal* Circle: M= Maternal/P= Paternal
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: ________

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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

PATIENT MEDICAL HISTORY

Name: ______________________________ **Birth weight**______ **Full Term**__ **Premature**__
Hospital of Birth: ______________________________
Medical problems at birth: ______________________________

Does your child have a history of:	**YES**	**NO**
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, PC
200 Pantigo Place, Suite E
East Hampton, NY 11937 -5921
Phone: 631-324-8030 Fax: 631-324-8032

AUTHORIZATION FOR TRANSFER OF RECORDS

To: ____

Address: ____

Phone #: ____________________ Fax #: ____________________

I hereby authorize ____
to transfer all medical information pertaining to:

______________________________ Date of Birth: ____________________
Print Name of Child

To: East End Pediatrics, PC
Address: 200 Pantigo Place Ste E
East Hampton, NY 11937 -5921

These records may include HIV test results.

____
Print Name of Parent or Legal Guardian

____
Signature of Parent or Legal Guardian

Address: ______________________________

Date of Request: ____________ ______________________________

CONFIDENTIAL COMMUNICATION

THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM CONFIDENTIAL RECORDS WHICH ARE PROTECTED BY STATE LAW. STATE LAW PROHIBITS YOU FROM MAKING FURTHER DISCLOSURES OF THIS INFORMATION WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS, OR AS OTHERWISE PERMITTED BY LAW. ANY UNAUTHORIZED FURTHER DISCLOSURE IN VIOLATION OF STATE LAW MAY RESULT IN A FINE OR JAIL SENTENCE OR BOTH. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT AUTHORIZATION FOR FURTHER DISCLOSURE. IF YOU HAVE RECEIVED THIS COMMUNICATION IN ERROR, PLEASE NOTIFY THE SENDER IMMEDIATELY BY TELEPHONE AND RETURN THE ORIGINAL COMMUNICATION TO US AT THE ABOVE ADDRESS BY THE U.S. POSTAL SERVICE. THANK YOU.

CREDIT CARD ON FILE CONSENT FORM

We now use a service, Instamed, which gives us the ability to swipe your credit card, debit card or health savings account card and accept a payment in the office at the time of service or at a later date. The credit card number is securely stored on a remote server with Instamed and is not visible to us.

We will notify you of your balance due after receiving the explanation from your insurance company. You will have 48 hours to discuss any questions or concerns, and if we do not hear from you within that time, we will charge your credit card, debit card, or health savings account (HSA) card. Our billing department will send you a receipt of any charges that are made to your card.

Please indicate below how you would like to be notified:

Phone #:________________________

OR

Email#:________________________

By signing below, you are agreeing to keep a credit card on file for future payments.

____

Your child's name (please print)

____

Your name (please print) and signature   Today's date

Please circle the type of card below:

MASTERCARD   VISA   AMEX