

Church Hill Pediatrics and Adolescent Medicine

Demographic Form

Today's Date _____

PATIENT'S INFORMATION

Child's Name: _____ DOB: _____ M / F Cell: (16yr & ^) _____
Child's Name: _____ DOB: _____ M / F Cell: (16yr & ^) _____
Child's Name: _____ DOB: _____ M / F Cell: (16yr & ^) _____
Child's Name: _____ DOB: _____ M / F Cell: (16yr & ^) _____

Race: _____
____ American Indian or Alaska Native
____ Asian
____ Black or African American

____ Native Hawaiian or Other Pacific
Islanders
____ White
____ Patient Declined to Specify

Ethnicity: _____
____ Hispanic or Latino
____ Not Hispanic or Latino
____ Patient Declined to Specify

PARENT'S INFORMATION

Parent/Guardian #1

Name: _____ DOB: _____ Relationship _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: Primary#: _____ Type: _____ Alternate#: _____ Type: _____
Email: _____

Parent/Guardian #2

Name: _____ DOB: _____ Relationship _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: Primary#: _____ Type: _____ Alternate#: _____ Type: _____
Email: _____

PARENTS / LEGAL GUARDIANS (please circle): **Married** **Living Together** **Single** **Widowed** **Separated** **Divorced**

If Divorced or Separated, who is the Custodial Parent? _____

PLEASE NOTE: LEGAL DOCUMENTATION WILL BE REQUIRED FOR ANY CUSTODY ARRANGEMENTS.

I grant the following PERSON permission to take messages AND/OR seek medical attention for my child. (If unable to reach parent or guardian)

Name: _____ Phone#: _____
Relationship to patient: _____

APPOINTMENT REMINDERS VIA TEXT/EMAIL/PHONE MESSAGES: I authorize the doctor and or staff to leave messages regarding my child (S) personal health information such as test results, medication, and or referral information or recommendations. UNLESS YOU SPECIFICALLY REQUEST (NO) THEN CIRCLE **OPT OUT ******

PRIVACY NOTICE ACKNOWLEDGEMENT: HIPPA

I HEREBY ACKNOWLEDGE THAT I RECEIVED A ****COPY**(UPON REQUEST) NOTICE OF PRIVACY PRACTICES**. I understand that if I have questions or complaints regarding my privacy rights that I may contact the Privacy Officer. I further understand that the practice will offer me updates to this notice should it be modified.

Signature: _____ **Date:** _____

INSURANCE

Primary Insurance **Billing Address & Responsible Party for Billing Issues:** ☐Parent/Guardian #1 ☐Parent/Guardian #2

Plan Name: _____ ID #: _____ Effective Date: _____

Subscriber: _____ Subscriber DOB: _____

Relationship to Patient: _____

Secondary Insurance Information (if applicable)

Plan Name: _____ ID #: _____ Effective Date: _____

Subscriber: _____ Subscriber DOB: _____

Relationship to Patient: _____

Church Hill Pediatrics and Adolescent Medicine will submit medical claims to the insurance company based on the information I have provided. I understand that I am responsible for updating insurance information each time services are rendered. If this insurance information is not correct, I understand that I will be responsible for any charges. I further understand that Church Hill Pediatrics and Adolescent Medicine has privacy policies and financial policies in place. I have been offered the opportunity to read and receive a copy of Church Hill Pediatrics and Adolescent Medicine's Notice of Privacy Practices and Financial Policy.

Signature: _____ **Relationship to Patient:** _____ **Date:** _____

RELEASE OF INFORMATION

I authorize the release of any information concerning my Child'(s) healthcare and treatment provided for the purpose of administering claims for insurance benefits. I also authorize payment of benefits directly to Church Hill Pediatrics and Adolescent Medicine and I understand I will be responsible for any charges not covered by my insurance company.

Signature: _____ **Date:** _____

Medical History Questionnaire

Demographics

Child's name _____ DOB _____ Adopted/Foster care? ☐ Y ☐ N

Parents' names _____ Parents married? ☐ Y ☐ N

Parents' occupation _____

Siblings' names and ages _____

Others living in the home _____

Pets in home _____ Any guns in home? ☐ Y ☐ N Smokers in household? ☐ Y ☐ N

Daycare or school? ☐ Y ☐ N School name _____ IEP/504 Plan ☐ Y ☐ N

Birth History (Birth to 4 only)

Place of birth _____ Birth weight _____

Problems during pregnancy _____

Premature ☐ Y ☐ N How many weeks? _____

Birth method ☐ vaginal ☐ c-section

Problems after birth _____

Family Health History (which family member)

Asthma/allergy _____

Developmental delay _____

High cholesterol (before 50) _____

Sudden death (before 50) _____

Mental health _____

ADHD _____

Cancer _____ Type _____

Other _____

Medications/Allergies/Immunizations

Medications/dosage _____

Vitamins/supplements _____

Immunizations up-to-date? ☐ Y ☐ N

Personal Health History (please indicated if your child has history of any of the following)

Skin

- ☐ Eczema
- ☐ Psoriasis

Ear, Eye, Nose, Throat

- ☐ Trouble seeing (glasses/contacts)
- ☐ Lazy eye (strabismus)
- ☐ Hearing loss
- ☐ Frequent ear infections
- ☐ Frequent throat infections

Respiratory

- ☐ Asthma
- ☐ Pneumonia

Gastrointestinal

- ☐ Reflux
- ☐ Frequent constipation

Allergy/Immune System

- ☐ Seasonal/Environmental allergy
- ☐ Food allergy
- ☐ Medication allergy
- ☐ Anaphylaxis

Cardiac

- ☐ Murmur
- ☐ Heart disease

Genitourinary

- ☐ Urinary tract infection
- ☐ Kidney disease

Neurologic

- ☐ Seizures or epilepsy
- ☐ Concussion/head injury

Developmental/Behavioral

- ☐ Autism
- ☐ Growth delay
- ☐ Speech delay
- ☐ Motor delay
- ☐ Special services

Other illness

Hospitalizations

Surgery

Church Hill Pediatrics and Adolescent Medicine, LLC

*32 Church Hill Road
Newtown, CT 06470
Tel. (203) 426-5437
Fax (203) 426-2100*

Financial Responsibility Form

Please read this Financial Responsibility Form and sign at the bottom to acknowledge that you understand your accountability.

INSURANCE COVERAGE

It is your responsibility to be aware of your insurance coverage, including but not limited to policy provisions, exclusion and limitations, and authorizations requirements. This information can be obtained by contacting your insurance carrier. If your coverage is not in effect at the time of the visit, the financial responsibility for that visit will be yours.

- **If you have had any changes in your insurance coverage, you must notify us.**
- **Presentation of your insurance card is required at every visit for each child. Regardless of change or prior visits.**

CO-PAYMENTS, CO-INSURANCES, AND DEDUCTIBLES

Co-payments, co-insurances, and deductibles are your responsibility. As defined by your insurance company and must be collected at the time of each visit or service. In the absence of information regarding your deductible balance (to which we have limited-if any-access) you will be required to pay your deductible for the entire visit or a portion thereof.

Effective **November 1st, 2024**, Patients with deductible/co-insurance plans, will be required to pay **\$75** at the time of the visit.

NO INSURANCE CARD/SELF PAY

Patients without valid insurance information are considered self-pay patients and are required to pay at the time service is rendered. Please be prepared to make this payment with the front desk personnel prior to your visit. You will be responsible for any claims that cannot be filed due to inaccurate insurance coverage documentation.

- **Should you have insurance but are unable to present (a copy of your card) at the time of your visit, you will be asked for a credit card, to be kept on file and authorized for a cash payment or charge**

You may also email a copy of your insurance card, front and back within 24 hours of your visit to:
mail@churchhillpeds.com

By Signing and dating this form, I understand that I am financially responsible for my health insurance deductible, co-insurance or non-covered services. Co-payments and deductibles are due at the time of service. In the event my health plan determines a service to be "not covered", I will be responsible and agree to pay for the costs of service provided. If I am uninsured, I agree to pay for the services rendered to me at the time of service.

Signature of Patient, Authorized Representative or Responsible Party

Date

Print Name of Patient, Authorized Representative or Responsible Party

Date

We accept cash, check, and credit card
Please make checks payable to Church Hill Pediatrics and Adolescent Medicine

Authorization Form: Card on File

Information to be completed by cardholder:

The undersigned agrees and authorized Church Hill Pediatrics and Adolescent Medicine to save the credit card indicated below on file. This may be used in the event that insurance information is missing, invalid, or self pay.

Patient's Name: _____

Name as it Appears ☐ on the credit ☐ card: ☐ ☐

Type of Credit Card: MasterCard Visa Amex Discover

Card number: _____

CVC2# _____ Expiration Date _____ Zip Code _____

I, _____ authorize the above Church Hill Pediatrics and Adolescent Medicine to store the above credit card information as the "Card on File". I understand this authorization will remain in effect until the expiration of the credit card or upon your written request to revoke this authorization. Patient may also revoke this form by submitting a written request to Church Hill Pediatrics and Adolescent Medicine.

Cardholder's Signature

Date

Print Name of Cardholder



CHURCH HILL PEDIATRICS
& ADOLESCENT MEDICINE

*32 Church Hill Road, Suite 200
Newtown, CT 06470*

Phone (203) 426-5437

Fax (203) 426-2100

www.churchhillpeds.com

mail@churchhillpeds.com

VACCINE POLICY

We firmly believe, based on all available literature, evidence, and current studies, that vaccines are a safe and effective way to prevent serious illness and save lives. Therefore, it is our policy that **all eligible patients in our practice receive all of the recommended vaccines according to the schedule published by the American Academy of Pediatrics.**

Vaccine Schedule:

2 MONTH: Vaxelis (DTaP-IPV-Hib-Hep B), Vaxneuvance (PCV15), Rotavirus

4 MONTH: Vaxelis (DTaP-IPV-Hib-Hep B), Vaxneuvance (PCV15), Rotavirus

6 MONTH: Vaxelis (DTaP-IPV-Hib-Hep B), Vaxneuvance (PCV15), Rotavirus

12 MONTH: Vaqta (Hep A) *dose 2 given 6 months later*, MMR, Varicella

15 MONTH: Pentacel (DTaP-IPV-Hib), Prevnar20 (PCV20)

18 MONTH: Vaqta (Hep A)

4 YEAR: Quadracel (DTaP-IPV), MMRV

11 YEAR: Boostrix (Tdap), Menquadfi (MenACWY)

16 YEAR: Menquadfi (Men ACWY), Bexsero (Men B) *dose 2 given 6 months later*

17-18 YEAR: Boostrix (Tdap)

The recommended vaccines and their schedule are the results of many years of scientific study and data gathering on millions of children by thousands of scientists and physicians. Delaying vaccines to give one or two at a time over multiple visits goes against expert recommendations can put your child at risk for serious illness and goes against our medical advice as providers at Church Hill Pediatrics & Adolescent Medicine. Therefore, **we do follow the AAP-recommended schedule for routine vaccinations.**

Please be advised that **if you ultimately refuse to vaccinate against one or any of the required immunizations, we will request that you find another healthcare provider to assume care of your child(ren).**

By signing below, you acknowledge that you have read the above vaccine policy and agree to adhere to the vaccine schedule.

Name(s) of child(ren): _____

Parent name: _____

Parent signature: _____

Date: _____