JEFFERSON
Pediatrics & Family Medicine

New Patient Registration Packet

This packet must be completed before your initial appointment.

For your convenience, the form is available on our website, or you can pick up a paper copy at any time before your first visit. If the form is not filled out prior to your appointment, it may need to be rescheduled based on our providers' discretion and their schedule for that day. Please understand that rescheduling may be necessary due to other patients.

If you intend to fill out the form in our office,
please arrive 30 to 60 minutes early.

For Pediatric Patients:
Please besure to complete the parent/guardian information and the authorization of visit form (page 2). When filling out medical history, medications, allergies, ect. please provide their name next to their information.

Other patients may ignore the pediatric forms and sections.

Benefits of Submitting New Patient Paperwork Early:

At Jefferson Pediatrics & Family Medicine, we understand how valuable your time is. To ensure that appointments run on schedule and efficiently, we kindly ask that patients arrive with their paperwork completed. We are currently developing a HIPAA-compliant online submission method through our EMR system. In the meantime, please fill out this document completely and bring it with you to your appointment.

If you finish your new patient paperwork before your appointment, you are welcome to drop it off at any time. Submitting your forms early allows our staff to prepare your patient files, enabling our providers to review your specific medical needs ahead of your visit.

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Patient Intake Form

Patient Information

☐Parents of multiple children please check this box and fill out the form on page 2.

Last Name:_____ First:_____MI:_____

Date of Birth:_____/_____/_____ Gender: ___Male __Female SSN:_____

Street Address:_____City:_____State:____Zip Code:_____

Home Phone#:_____ Cell#:_____Email:_____

Marital Status: ☐ Single ☐ Married ☐ Legally Separated ☐ Widowed ☐ N/A

Spouse or Partner's Name:_____

Emergency Contact and phone#:_____ Relationship to Patient:_____

Patient Employer or School:_____

Previous Primary Physician:_____ Last Visit:_____

Preferred Pharmacy:_____

How did you hear about us:_____

Insurance Information

Primary Insurance Name:_____

Policy Holder Name:_____ DOB:____/____/_____

Policy Number:_____ Group Number:_____

*If employer providers insurance, please list employer here:*_____

Phone number:_____

- Children under 18 years old will only be seen with written consent from a parent, and they must be accompanied by an adult.
- By signing, I authorize Jefferson Pediatrics, P.C. to review my medical coverage and release all information necessary for processing claims related to services provided to my child.
- I grant permission for Jefferson Pediatrics & Family Medicine to share records with other medical providers to enhance my care.
- I have chosen not to receive a copy of the Notice of Privacy Practices.
- The undersigned agrees that all services must be paid for at the time they are rendered. If collection efforts are required, the undersigned will cover all associated costs, including attorney fees and court expenses.

Signature: _____ **Date:**___/___/_____

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Pediatric Patient's Only

Pediatric Patient Information

*Parents of multiple children please fill out a line for each one.

Child's Full Name Date of Birth Sex SSN Race Ethnicity

_____

_____

_____

_____

_____

_____

Parent/Guardiān Information

Parent/ Guardian information:

Full Name:_____ Date of Birth:_____/_____/_____ SSN:_____

Relationship to Patient:_____ Email:_____

Street Address:_____ City:_____ State:____ Zip Code:_____

Phone#:_____ Cell#:_____ Employer:_____

Work#:_____ Emergency Contact and number:_____

Parent/ Guardian information:

Full Name:_____ Date of Birth:_____/_____/_____ SSN:_____

Relationship to Patient:_____ Email:_____

Street Address:_____ City:_____ State:____ Zip Code:_____

Phone#:_____ Cell#:_____ Employer:_____

Work#:_____ Emergency Contact and number:_____

Authorization Of Visit

I certify that I am the Legal Gaurdian of _____

_____.

child or children's names/DOB

I am giving permission for the following list of people to have the above-named child/children seen, treated, and receive medical information at Jefferson Pediatrics & Family Medicine.

Name:_____ Relationship to Patient:_____ Phone#:_____

Name:_____ Relationship to Patient:_____ Phone#:_____

Parent/Guardian Name: _____ Date:___/___/_____

Parent/ Guardian Signature:_____ Phone#:_____

Parent/Guardian Name: _____ Date:___/___/_____

Parent/ Guardian Signature:_____ Phone#:_____

Current Medications & Supplements

*Parents filling this form for multiply children, please add their names next to their medications or supplements.

Medication	Dose/Frequency	Reason/Diagnosis

Allergies (Drug, Food, Environment)

*Parents filling this form for multiply children, please add their names next to their allergey

Allergen	First Observed/ Diagnose	Reaction

Other Care Providers

Please provide the names of any care providers you (or your child, if completing this for them) currently visit, excluding JPFM, along with their specialties or reasons for visit. i.e Specialists, Optometrist, Therapist, ect.

Immediate Concerns

Please list any medical issues you are concerned about that you would like to discuss at your first appointment:

Patient Medical History

*Parents filling this form for multiply children, please add their names next to their medications or supplements.

Diagnosis **Date** **Symptoms** **Treatment**

Family Medical History

Family Memeber	Important Medical Diagnosis	Alive or Deceased?	Age / Cause of Death
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Surgeries or Hopitalizations

*Parents filling this form for multiply children, please add their names next to their information.

Procedure Date Reason

Financial Policy

Thank you for choosing us as your Health Care Provider. We are committed to all our patients' care and treatment. Please understand that payment of your bill is considered part of this treatment. The following is a statement of our Financial Policy, which we require every patient or parent/legal guardian to read prior to receiving any treatment.

All patients must complete the new patient registration packet in its entirety, especially the Insurance information form. If you do not have all of your insurance information, you will be asked to contact your insurance company prior to any treatment or vital signs recorded.

IF YOU DO NOT HAVE INSURANCE, PAYMENTS ARE DUE AT THE TIME OF SERVICE.
WE ACCEPT CASH, CHECKS, AND VISA/MASTERCARD.
A PAYMENT PLAN CAN BE CONSIDERED UPON HISTORY OF CREDIT INFORMATION.

Regarding Insurance
We may accept assignment of insurance benefits. However, your insurance requires that co-payments are to be paid at time of service (we will not bill statements for co-payments). You are fully responsible whether your insurance company pays or not for services rendered. Your insurance policy is a binding contract between you and your insurance company. We are not a party to that contract. If your insurance has not paid your account in full within 60 days, the balance will automatically be transferred to you, this includes non-covered services. You should fully understand all insurance deductibles and other clauses.

Usual Customary Rates
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance arbitrary determination of usual and customary rates.

Minor Patients
The adult accompanying the child (parent and/or legal guardian) is responsible for full payment. Please inform any of the staff members if you have any questions or concerns regarding this financial statement.

☐ I have read the Financial Policy, I understand and agree to this FINANCIAL POLICY.

_____ **Date:**___/___/_____
Signature of Patient, Parent/Guardian, or Responsible Party

HIPAA Privacy Receipt Acknowledgement

Jefferson Pediatrics & Family Medicine's Notice of Privacy Practices has been offered to me. I understand I have the right to review the Notice of Privacy Practices prior to signing this document and by signing this document, acknowledge only that I have been offered the Notice of Privacy Practices or have declined the offer.

Jefferson Pediatrics & Family Medicine reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

☐ **Accepted Notice** ☐ **Declined Notice**

_____ _____
Signature of Patient Signature of Parent/Guardian/ or Personal Representative

_____ _____
Patient's Date of Birth Description of Authority

_____ _____
Date Date

☐ **I authorize the following person(s) minimal access to my protected health information (PHI)(does not include copies of medical records) :**

Name:_____ DOB:_____ Phone#:_____
Name:_____ DOB:_____ Phone#:_____
Name:_____ DOB:_____ Phone#:_____
Name:_____ DOB:_____ Phone#:_____

Patient's signature: _____

For authorization to release limited PHI to the above listed individuals.

☐ **I further authorize Jefferson Pediatrics & Family Medicine to communicate with me electronically through e-mail at the following e-mail address:**

_____

I understand that this e-mail communication is not secured by encryption therefore is not considered a secured or private communication and sensitive medical information will not be shared through it unless specifically requested by the patient. Jefferson Pediatrics & Family Medicine will not be held responsible for further disclosure of your information sent via unencrypted e-mail.

Patient's signature: _____

For authorization of e-mail communications.