Wee Care Pediatrics

Patient Registration Form

Today's date: _____

Patient Information

Patient's Name: _____ ☐Male ☐Female DOB: ____/____/____
First Middle Last

Social Security Number: _____ Preferred Language: _____

Address: _____ City: _____ State: _____ Zip: _____

Race:
☐American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander
☐ Asian ☐ Caucasian
☐ Black or African American ☐ Decline to Answer

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Decline to Answer

Family Information

Mother/Guardian:

Name: _____ DOB: ____/____/____ SSN: _____
First Middle Last Maiden

Address: _____ City: _____ State: _____ Zip: _____

Phone # Home _____ Cell: _____ Email: _____

Employer: _____ Occupation: _____ Work Phone: _____

Father/Guardian:

Name: _____ DOB: ____/____/____ SSN: _____
First Middle Last

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home _____ Cell: _____ Email: _____

Employer: _____ Occupation: _____ Work Phone: _____

Siblings' Names:

_____ DOB: ____/____/____ _____ DOB: ____/____/____

_____ DOB: ____/____/____ _____ DOB: ____/____/____

_____ DOB: ____/____/____ _____ DOB: ____/____/____

_____ DOB: ____/____/____ _____ DOB: ____/____/____

_____ DOB: ____/____/____ _____ DOB: ____/____/____

Emergency Contact

Name: _____ Relationship to Patient: _____

Phone: Home: _____ Cell: _____

How did you hear about our office?

☐ Website ☐ Mailer/Flyer
☐ Billboard ☐ Poster
☐ Magazine ☐ Church

Who may we thank for your referral?

☐ Friend, Name: _____
☐ Another Doctor's Office: _____
☐ Internet, Site: _____

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Insurance Information

Primary Insurance:

Insured's Name:_____ DOB:____/____/____ SSN:_____

Insurance Company:_____ Phone:_____

Policy #:_____ Group Name:_____ Group #_____

Claim's Address:_____City:_____State:_____Zip:_____

Secondary Insurance:

Insured's Name:_____ DOB:____/____/____ SSN:_____

Insurance Company:_____ Phone:_____

Policy #:_____ Group Name:_____ Group #_____

Claim's Address:_____City:_____State:_____Zip:_____

Financial Stipulations/Assignment of Benefits

I authorize Wee Care Pediatrics to provide medical care for my child as necessary. I understand that I am financially responsible for any amount not covered by my insurance plan, and copay's or deductibles are due at time of service. I authorize Wee Care Pediatrics to release insurance information for the purpose of evaluating and administrating claims for benefit reimbursement. I understand it is my responsibility to update any changes on my health insurance or contact information. Failure to do so may result in financial responsibility. All information provided will be protected in accordance with HIPAA guidelines.

Parent/Guardian Printed Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

I have received a copy of the "Notice of Privacy Practices."

Signature: _____ Date: _____

Request for Confidential Communication of Your Protected Health Information

With whom may we discuss your child's healthcare?

_____ Relationship to child:_____

_____ Relationship to child:_____

_____ Relationship to child:_____

Consent to Treat

I hereby authorize Wee Care Pediatrics to provide medical care, treat and diagnose my child listed above.

Parent/Guardian Signature_____ Date_____

The following people are authorized to bring my child in for medical care in my absence.

_____ (Must have picture ID at EVERY visit)

_____ (Must have picture ID at EVERY visit)

_____ (Must have picture ID at EVERY visit)

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If more space needed for answers below, please write on back of paper and check here ☐

Pregnancy History

Birth History	☐Full term ☐preterm ____wks	Drank Alcohol?	☐No ☐Yes
Delivered	☐Vaginal ☐C-section	Smoked Cigarettes?	☐No ☐Yes
Medications? Drugs?	☐No ☐Yes	Birth Weight	lbs oz

Any complications/problems during pregnancy? _____

Newborn History

At birth, did your child have any of the following?

Trouble Breathing	☐No	☐Yes	Given any medications	☐No	☐Yes
Needed Oxygen/Turned Blue	☐No	☐Yes	Seizure, fits, convulsions	☐No	☐Yes
Jaundice (Turned Yellow)	☐No	☐Yes	Jittery	☐No	☐Yes
Birth Defect	☐No	☐Yes	Feeding problems/vomiting	☐No	☐Yes
Hospitalized more than 7 days	☐No	☐Yes	Infection	☐No	☐Yes
Twin or Multiple babies	☐No	☐Yes	In NICU	☐No	☐Yes

Any other newborn conditions/problems?_____

Medical History

Does patient have any allergies to food or medicines? _____
Current Medications? _____
Immunizations ☐Up to Date ☐Behind
Past Illnesses? _____
Previous Admissions/Surgeries? _____

Social History

Birth Parents: ☐Married ☐Divorced ☐ Mother Deceased ☐ Father deceased ☐ Single ☐ Separated
Patient currently lives with: ☐Birth mother ☐Birth Father ☐Step mother ☐Step father ☐Foster parents
Does anyone in the household smoke? ☐No ☐Yes
Does patient attend day care or other setting with multiple children? ☐No ☐Yes
Does patient attend school? ☐No ☐Yes, Name of School _____
Where does patient live? ☐Within city limits ☐Outside city limits ☐Rural setting
Is the house more than 30 years old? ☐No ☐Yes If yes, any peeling paint? ☐No ☐Yes
Water Supply? ☐City ☐Well water
If the patient has been to foreign country in last 6 months, which country? _____

Family History

Please indicate family members with any of the following conditions by checking YES or NO. In the "Family Member" column, please note which family member had the condition. For example: MGM=maternal grandmother, MGF=maternal grandfather, PGM=paternal grandmother, PGF=paternal grandfather, A=aunt, U=uncle, M=mother, F=father, S=sibling.

Condition	No	Yes	Family Member	Condition	No	Yes	Family Member
Sudden Infant Death				Kidney Problems			
Birth Defect				Liver Disease			
Cancer (before 55 y/o)				Bed wetting (after 10 y/o)			
Thyroid				Obesity			
Diabetes (before 55 y/o)				Epilepsy/convulsions			
Allergies				Alcohol/Drug Abuse			
Asthma				Mental Illness/depression			
Heart Disease (< 55 y/o)				Developmental Disability			
High Blood Pressure				Immune problems, HIV			
Bleeding disorders				Childhood hearing loss			

Additional family history? _____

Wee Care Pediatrics

No Show Policy

Patient Name: _____ DOB: ____/____/____

A $25 NO SHOW fee will be billed to those who fail to cancel an appointment. The fee is not covered by your insurance and will apply if you fail to notify us of a cancellation at least twenty-four hours in advance of your appointment time. You are responsible for canceling your child's appointment if you cannot attend. We never schedule an appointment without your consent. We will send a courtesy reminder by voice, text or email 4 days and 1 day prior to your appointment. This service allows you to respond to confirm or reschedule/cancel your appointment. Upon the 4th NO SHOW, you may be dismissed from the practice. I understand that it is my responsibility to arrive for my appointment on time and that I may not be seen if I am late.

NO SHOWS:

1) ☐ Date: _____ 2) ☐ Date: _____ 3) ☐ Date: _____

3 Strike Policy

Wee Care Pediatrics does not tolerate the mistreatment of staff or property. Parents who are disruptive or verbally abusive towards staff, other patients or other parents will receive a strike. Destruction of any Wee Care Property will also lead to a strike. If you have 3 strikes, you will be dismissed from our practice. Extreme instances may result in immediate dismissal. We kindly ask that you follow the golden rule: Do unto others as you would have them do unto you.

STRIKES:

1) ☐ Date: _____ 2) ☐ Date: _____ 3) ☐ Date: _____

Signature: _____ Date: _____

Print Name: _____

Wee Care Pediatrics

Payment Policy and Procedures

Hester Suh, MD

Thank you for choosing Wee Care Pediatrics for your child's medical care. The following is an explanation of our payment procedures and office policies. Please read carefully and sign below.

1. Payment is due at the time of service. We accept cash, Visa, MasterCard, Discover and American Express. We do not accept personal checks. Patients utilizing our cash pay program must pay before each visit. Please make sure to get a receipt when providing payment.
2. The parent or guardian who brings the child for their visit is responsible for payment at the time of service. We do not intervene between divorced/separated parents or in the matter of custody issues. Reimbursement will need to be between parents or guardians.
3. Appointments must be cancelled at least 24 hours prior to the scheduled appointment time to avoid a $25.00 No Show Fee. We never make appointments without your consent. We give a courtesy text, email or call 1 day and 4 days prior to your appointment. It is your responsibility to keep your contact information current and to cancel any appointments made. You may opt out of these communications at any time.
4. Account balances must be paid prior to any future visits. If a balance is due, a payment must be collected or payment arrangements made before being seen. Emergent cases will be considered on a case-by-case basis.
5. Account balances that exceed 90 days past due are sent to an outside collection agency. You will be responsible for all collection and legal fees that accrue by the outside agency. Payment must be made before any future appointments are made.
6. We will gladly bill your primary and or secondary insurance for you. It is your responsibility to keep your Coordination of Benefits (COB) current with your insurance providers. Failure to do so may result in a lack of payment from your carriers. We are not responsible for non-payment from your insurance plan due to missing COB's and any balances will become subscriber responsibility due in full. Failure to disclose Commercial Insurance as Primary when you have Louisiana Medicaid constituted Medicaid Fraud and Abuse.
7. In order to bill your insurance company, we must have an up to date insurance card. If we are unable to verify your insurance coverage at the time of service, you will be considered as a cash pay patient.
8. Most importantly, Wee Care Pediatrics wants the best care possible for your child and we understand you may have certain financial difficulties. Please feel free to discuss any financial matters with our billing department.

I have read the above policy and agree to abide by the terms of this agreement

Signature: _____/_____ Date: _____
Parent or Legal Guardian Print Name Signature

Patient Name: _____ Date of Birth: _____