STONY BROOK PEDIATRICS PC, FAAP

Dansville Office 22 Red Jacket St Dansville NY 14437 PH (585) 335 5200 Fax (585) 335 8579
Geneseo Office 50 E South St, Suite 400, Geneseo NY 14454 PH (585) 243 9340 Fax (585) 243 9344

PATIENT INFORMATION SHEET

PATIENT INFORMATION TODAY'S DATE ____/____/_____

PATIENT_____
LAST FIRST MI PREFER TO BE CALLED

DATE OF BIRTH _____ SEX_____

MAILING ADDRESS _____

CITY _____ STATE_____ZIP _____

HOME PHONE (_____) _____ CELL PHONE_____

RACE/ETHNICITY SELECT ALL THAT APPLY

- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Black/African American
- ☐ White
- ☐ Native Hawaiian/Pacific Islander
- ☐ Decline
- ☐ Hispanic/Latin/Spanish Origin

PATIENT PRIMARILY LIVES WITH:

- ☐ BOTH PARENTS
- ☐ MOTHER
- ☐ FATHER
- ☐ GUARDIAN
- ☐ GRANDPARENT
- ☐ FOSTER PARENT

PREFERRED LANGUAGE:

IS A TRANSLATOR REQUIRED? YES / NO

PARENT/LEGAL GUARDIAN PREFERRED METHOD OF COMMUNICATION

- ☐ Telephone
- ☐ Mail
- ☐ Web Enable
- ☐ Decline

MAY WE LEAVE A VOICE MAIL MESSAGE REGARDING APPOINTMENTS? YES NO

PREFERRED PHARMACY NAME_____ TOWN_____

PLEASE PROVIDE ANY CURRENT CUSTODY ORDERS (IF APPLICABLE)

MOTHER/LEGAL GUARDIAN'S INFORMATION

MOTHER'S NAME_____
LAST FIRST MI PREFER TO BE CALLED

DATE OF BIRTH _____SOCIAL SEC.#_____SEX_____RACE _____

HOME PHONE_____

ALTERNATE PHONE_____ WORK PHONE (___)_____

EMAIL (to be web enabled)_____

EMPLOYER _____WHAT IS YOUR JOB THERE _____

EMPLOYMENT ADDRESS_____
CITY STATE ZIP

MARITAL STATUS: **SINGLE** **MARRIED** **RE-MARRIED** **DIVORCED** **WIDOWED**

FATHER/LEGAL GUARDIAN'S INFORMATION

FATHER'S NAME _____
LAST FIRST MI PREFER TO BE CALLED

DATE OF BIRTH _____ SOCIAL SEC.# _____ SEX _____ RACE _____

HOME PHONE _____

MAILING ADDRESS IF DIFFERENT THAN ABOVE _____

CITY _____ STATE _____ ZIP _____

ALTERNATE PHONE _____ WORK PHONE (___) _____

EMAIL _____

EMPLOYER _____ WHAT IS YOUR JOB THERE _____

EMPLOYMENT ADDRESS _____
CITY STATE ZIP

MARITAL STATUS: **SINGLE** **MARRIED** **RE-MARRIED** **DIVORCED** **WIDOWED**

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY _____ SUBSCRIBER ID# _____

EFFECTIVE DATE _____

NAME OF POLICY HOLDER _____ POLICY HOLDER'S DATE OF BIRTH _____

SECONDARY INSURANCE COMPANY _____ SUBSCRIBER ID# _____

EFFECTIVE DATE _____

NAME OF POLICY HOLDER _____ POLICY HOLDER'S DATE OF **BIRTH** _____

**** PATIENT'S WITH PRIMARY INSURANCE WITH APPLICABLE COPAYS/DEDUCTIBLES ARE REQUIRED TO PAY THE CONTRACTUAL COPAYMENTS AT THE TIME OF SERVICE****

EMERGENCY CONTACT _____ PHONE# _____

(NAME OF PERSON THAT DOES NOT RESIDE AT YOUR RESIDENCE)

RELATIONSHIP TO PATIENT _____

HOW DID YOU HEAR ABOUT STONY BROOK PEDIATRICS _____

****** CONTINUED ON NEXT PAGE ******

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

PRIVATE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

I, the undersigned, authorize payment of medical benefits directly to Stony Brook Pediatrics for any services rendered by Stony Brook Pediatrics. This irrevocable assignment and transfer will be for the recovery of insurance payments but shall not be an obligation of Stony Brook Pediatrics to pursue any such right of recovery. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.** I also authorize you to release to the insurance company any information concerning healthcare, treatment, or supplies provided. I permit a copy of this authorization to be used in place of the original.

SIGNATURE_____ **DATE** _____

PAYMENT AGREEMENT

It is the policy of Stony Brook Pediatrics and your insurance company that charges for services rendered by our physician(s) and staff including contractual co-pays and deductibles are paid **AT THE TIME OF SERVICE** unless other formal arrangements have been made in advance with our business office.

For your convenience, Stony Brook Pediatrics will file electronic insurance claims; however, it will be your responsibility to provide our office with the necessary information and signed authorization for filing insurance. This information and authorization must be provided to our office at your first visit, accompanied with a copy of your health insurance card(s).

I agree to the above financial agreement for any services provided to me by Stony Brook Pediatrics

SIGNATURE _____ **DATE** _____

PRIVACY POLICY

Copies of the Privacy Policy for Stony Brook Pediatrics are available on request. Please ask our staff for your copy at your initial visit.

I acknowledge that I have access to a copy of the "Notice of Privacy Practices" from Stony Brook Pediatrics PC.

SIGNATURE_____**DATE**_____

Initial History Questionnaire

Patient Name _____ Form Completed by /Relationship to patient _____ Date Completed _____

Household

Please list all adults and children living in the child's home.

Name	Relationship to Child	Birth Date	Notes
			Are there any adults or siblings not listed? If so, please list their names, date of birth, relationship to the child and where they live.

Birth History

Birth weight _____

Was the baby born at term? _____ Early? _____ Late? _____

If early, how many weeks' gestation? _____

Did mother have any illnesses or problems with her pregnancy?

❑ Yes ❑ No Explain _____

During pregnancy, did mother:

Smoke ❑ Yes ❑ No Drink Alcohol ❑ Yes ❑ No

Use drugs or medications ❑ Yes ❑ No

What _____ When _____

Was the delivery ❑ Vaginal ❑Caesarean

If Caesarean, why? _____

Did your baby have any problems right after birth?

❑ Yes ❑ No Explain

_____

Was initial feeding ❑ Breast ❑ Bottle

Did your baby go home with mother from the hospital?

❑ Yes ❑ No Explain

_____

General

Has your child had any broken bones, serious injuries, concussion?	❑ Yes ❑ No	Explain:	
Does your child have any serious illness or medical condition?	❑ Yes ❑ No	Explain:	
Has your child had any Emergency Room visits?	❑ Yes ❑ No	Explain:	
Has your child had any operations or been hospitalized?	❑ Yes ❑ No	Explain:	
Does your child take any medications or supplements?	❑ Yes ❑ No	Explain:	
Is your child allergic to any medicines, foods, bee stings, cats/dogs?	❑ Yes ❑ No	Explain:	

Development

Are you concerned about your child's physical development?	❑ Yes ❑ No	Explain:	
Are you concerned about your child's mental or emotional development?	❑ Yes ❑ No	Explain:	
Are you concerned about your child's attention span?	❑ Yes ❑ No	Explain:	

If your child is in school:

How is his/her behavior in school? _____

Are you concerned about your child's school performance? _____

Has he/she failed or repeated a grade in school? _____

How is he/she doing in academic subjects? _____

Is he/she in a special or resource classes? _____

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Family History

Did/Do you or any of the child's relatives have any of the following? (If YES, please identify relative)	Mother	Father	Siblings	Father's Parents	Mother's Parents
Allergies					
Asthma/Wheezing					
Cardiac (heart) problems					
Fainting					
Sudden Death (before age 60)					
Stroke/Blood Clots					
High cholesterol					
High Blood Pressure					
Diabetes					
Obesity					
Bleeding Tendency					
Cancer (Please specify type)					
Scoliosis					
Dev Hip Dysplasia					
Eczema or Psoriasis					
Arthritis					
Thyroid					
Stomach or Intestinal problems					
Kidney/Renal disease					
Migraines					
Seizures					
Hearing Loss					
Vision problems					
Intellectual Disability					
Developmental delays					
Autism					
Sleep Disorder					
School problem					
Learning disability					
ADHD					
Depression					
Anxiety or OCD					
Bipolar disorder/psychiatric problems					
Alcoholism, drug use/addiction					
Genetic (cystic fibrosis, hemophilia, Marfan syndrome, Leiden V mutation, neurofibromatosis etc.					
Birth Defects					
Reaction to dyes or anesthesia					
Chemical exposure (military or job related)					
Immune problems, HIV or AIDS					

Any additional medical problems that run in the family: _____

_____

_____

Home type: House Apartment Mobile Home

Heating: Forced Air Hot Water/Radiator Wood/Pellet Stove Other

Drinking Water: Village Well Bottled

Flouride in drinking water? Yes No Unsure

Does your child spend time in a home built before 1970 or one recently remodeled ? Yes No

Are there guns in the Home ? Yes No If Yes how are they stored_____

Any Pets? Yes No If Yes please list_____

Any cigarette smokers? Yes No If yes please list_____

Are you experiencing any family or financial problems? Yes/No _____

Child's History

Does your child have, or has he/she ever had:

Chickenpox	❑ Yes	❑ No	When
Frequent ear infections	❑ Yes	❑ No	Explain
Problems with ears or hearing	❑ Yes	❑ No	Explain
Nasal allergies	❑ Yes	❑ No	Explain
Problems with eyes or vision	❑ Yes	❑ No	Explain
Asthma, bronchitis, bronchiolitis, or pneumonia	❑ Yes	❑ No	Explain
Any heart problem or heart murmur	❑ Yes	❑ No	Explain
Anemia or bleeding problem	❑ Yes	❑ No	Explain
Blood transfusion	❑ Yes	❑ No	Explain
Frequent abdominal pain	❑ Yes	❑ No	Explain
Constipation requiring doctor's visits	❑ Yes	❑ No	Explain
Bladder , kidney infection	❑ Yes	❑ No	Explain
Bed-wetting (after 5years old)	❑ Yes	❑ No	Explain
(For girls) Has she started her menstrual periods?	❑ Yes	❑ No	Explain
(For girls) Are there problems with her period?	❑ Yes	❑ No	Explain
Any chronic or recurrent skin problem	❑ Yes	❑ No	Explain
(acne, eczema, etc.)			Explain
Frequent headaches	❑ Yes	❑ No	Explain
Convulsions or other neurological problem	❑ Yes	❑ No	Explain
Diabetes	❑ Yes	❑ No	Explain
Thyroid or other endocrine problem	❑ Yes	❑ No	Explain
Any other significant problem	❑ Yes	❑ No	Explain
Use of alcohol or drugs	❑ Yes	❑ No	Explain