Family Data Sheet- AGC Pediatrics, LLC

Date ____/____/_____

Mother's Name_____
Mother's Address_____
_____ Zip _____
Mother's Employer_____
Work # _____ Cell # _____
Email _____

(Please complete if applicable)
Stepfather's Name _____
Stepfather's Address_____
_____Zip _____
Stepfather's Employer_____
Work # _____ Cell # _____
Email _____

Father's Name_____
Father's Address_____
_____ Zip _____
Father's Employer_____
Work # _____ Cell # _____
Email _____

(Please complete if applicable)
Stepmother's Name _____
Stepmother's Address_____
_____Zip _____
Stepmother's Employer_____
Work # _____ Cell # _____
Email _____

Child Name	DOB	Primary Language	Race*	Ethnicity*	Live With: (Circle All That Apply)			
					Both Parents	Mother	Father	Guardian:(Provide legal paperwork)
					Both Parents	Mother	Father	Guardian:(Provide legal paperwork)
					Both Parents	Mother	Father	Guardian:(Provide legal paperwork)
					Both Parents	Mother	Father	Guardian:(Provide legal paperwork)
					Both Parents	Mother	Father	Guardian:(Provide legal paperwork)
					Both Parents	Mother	Father	Guardian:(Provide legal paperwork)
					Both Parents	Mother	Father	Guardian:(Provide legal paperwork)

*Race: White, Black/AM, American Indian, Alaska Native, Asian, Native Hawaiian or other spec. islander, Other

* Ethnicity: Spanish/Hispanic Y or N

If guardian: Name _____ Relationship _____

Address _____ City/State/Zip _____ Phone _____

If parents are divorced/not married who has legal responsibility for the health insurance coverage for the child(ren)? (Please provide appropriate legal paperwork)

Name _____ Relationship _____

Address _____ City/State/Zip _____ Phone _____

Primary Insurance Information: Subscriber Name: _____

DOB: _____ Phone: _____ Insurance Co: _____

Member ID: _____ Group #: _____

Secondary Insurance _____ Subscriber Name: _____

Member ID: _____ Group #: _____

This section can only be complete by a parent or legal guardian

Financial/Privacy Policies (HIPAA)

_____(Initial) I authorize AGC Pediatrics, LLC to treat the above named child.

_____ (Initial) I authorize release of medical and billing information to the insurance company so that payment for charges can be processed.

_____ (Initial) I authorize and direct the insurance company to pay the portion of charges due to AGC Pediatrics.

_____ (Initial) I acknowledge that a copy of the AGC Pediatrics Financial Policy and Privacy Policies have been made available.

_____ (Initial) I authorize AGC Pediatrics to leave a voice mail message containing protected healthcare information at the following numbers:

(Home) _____ (Cell) _____

Signature _____ Date _____/_____/_____

Acknowledgement of Receipt of Notice of Privacy Practice
(HIPAA Requirement)

By signing below, I hereby acknowledge that I was provided a copy of the Notice of Privacy Practices for AGC Pediatrics, LLC.

Parent/Legal Guardian Signature: _____ Date: _____

Medical History From - AGC Pediatrics, LLC

Patient Name: _____ DOB: ____ /____ /_____

Form completed by: _____

Pregnancy History

Mother's age at Birth_____ Baby's due date _____ Birth weight _____ Birth length _____

Was delivery vaginal or c-section (please circle one) Was delivery early / on time / late (please circle one)

Circle any the following complications or usage during pregnancy:

Infection Diabetes High Blood Pressure Hospitalized

Early Labor Smoking Alcohol/ Drugs Medications

Did the baby have any of the following problems during or after delivery (circle all that apply):

Infection Jaundice Seizures Breathing Problems Feeding Other (please explain) _____

General History

Do you consider your child to be in good health? Yes No DK
Explain _____

Does your child have any serious illnesses or medical conditions? Yes No DK
Explain _____

Has your child had any surgery or been hospitalized? Yes No DK
Explain _____

Is your child allergic to any medications? Yes No DK
Explain _____

Past Medical History

Does your child have, or has your child had:

Chickenpox	Yes	No	DK	HIV	Yes	No	DK
Problems with ear or hearing	Yes	No	DK	Chemotherapy	Yes	No	DK
Heart problems	Yes	No	DK	Cancer	Yes	No	DK
Blood transfusion	Yes	No	DK	Obesity	Yes	No	DK
Organ Transplant	Yes	No	DK	Diabetes	Yes	No	DK
Abdominal pain (Frequent)	Yes	No	DK	High blood pressure	Yes	No	DK
Frequent ear infections	Yes	No	DK	Dental decay	Yes	No	DK
Allergies (other than Medication)	Yes	No	DK	History of family Violence	Yes	No	DK
Anemia or Bleeding problems	Yes	No	DK	Pregnancy	Yes	No	DK
Malignancy/bone morrow transplant	Yes	No	DK	Tobacco use	Yes	No	DK
Recurrent Urinary Tract Infection	Yes	No	DK				
Congenital cataracts/retinoblastoma	Yes	No	DK	For girls:			
Metabolic / Genetic disorders	Yes	No	DK	Problem with periods	Yes	No	DK
Bed-wetting (after 5 years old)	Yes	No	DK	Has had first period	Yes	No	DK
Thyroid or endocrine problems	Yes	No	DK	Age at first period	Age _____		
Developmental delay	Yes	No	DK				
History of injures/Fractures/Concussions	Yes	No	DK	For boys:			
Use of alcohol or drugs	Yes	No	DK	Testicular/ Scrotum pain	Yes	No	DK
History of family violence	Yes	No	DK	Testicular / Scrotum swelling	Yes	No	DK
Sexually transmitted infections	Yes	No	DK				
Asthma, bronchitis, bronchiolitis, or pneumonia	Yes	No	DK				
Kidney disease or urologic malformations	Yes	No	DK				
Sleep problems (snoring)	Yes	No	DK				
Chronic or recurrent Skin problems	Yes	No	DK				
Frequent headaches	Yes	No	DK				
ADD/ADHD/ mood problems/ depression	Yes	No	DK				

AGC Pediatrics, LLC

Authorization to Leave Personal Health Information by Alternate Means

Patient Name: _____ DOB ____/____/____

Patient Mailing Address: _____

City _____ State _____ Zip _____

Please check all that apply.

We:

( ) May leave a detailed message on your home voicemail.

( ) May leave a detailed message on your work voicemail.

( ) May leave information with your parent: _____ _____
Name Phone Number

( ) May leave information with another family member: _____
Name

_____
Phone Number

( ) May leave a detailed message on your cellular phone.

( ) May send automated text messages for appointment reminders and scheduling.

( ) May leave a detailed message at a different phone number: _____
Name

_____
Phone Number

With my signature below, I acknowledge and understand that this information will be kept in a medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify my healthcare provider should I change one or more of the telephone numbers listed above.

_____ _____
Patient(if 18 or over) Parent or legally authorized individual's signature Date

AGC Pediatrics, LLC

BILLING AND CREDIT POLICY

Patient Name: _____ DOB: _____/_____/_____

Parent Name: _____ (Please print)

It is one of AGC Pediatrics' goals to offer quality service at a reasonable cost. We strive to concentrate on serving our patients and to spend as little time as possible on administrative duties. To achieve this goal we need your cooperation.

Payment for all services not covered by your insurance (including co-payments and partial deductible payments) is expected at the time of your appointment unless other arrangements are made. You will also be responsible for any payment for any services requested and/or approved by you, but not covered by your insurance carrier. In addition, you will be responsible for any services rendered to your child(ren) for services requiring interpretation by an outside agency and billed by them directly (ie. Labs, x-rays, etc.). (It is the responsibility of the patient (parents/guardians) to know what is covered and not covered by their insurance carrier.) For your convenience, payments to AGC Pediatrics can be made by cash, check or credit card and can be paid in person, by mail, or telephone.

By signing below, I/We have selected AGC Pediatrics, LLC as my/our child's pediatric primary care provider and agree to:

- Bring my child myself or send him/her in with someone whom I've listed on the Family Data Sheet.
- Make full payment or co-payment at the time of service as detailed above.
- Keep all appointments, or if one is broken or cancelled with less than 24 hours notice, I/We may be subject to a $30 missed appointment fee.
- Remain in contact with AGC Pediatrics billing staff regarding any payment arrangements different than full payment on date of service.
- Keep the account current through timely payment and communications required.
- All accounts not current are subject to the AGC Pediatrics collection program and could result in a loss of Privileges/relationship with AGC Pediatrics.
- Grant the right to collect all reasonable cost, billing fees, attorney's fees, collection agency fees and disbursements associated with any legal action taken to recover a debt for services rendered.

A billing charge is subject to be added each month to outstanding accounts unless prior arrangements are made. Remember it is the policy of AGC Pediatrics, that both a father and mother are responsible for a minor child's care and bills regardless of any other financial/legal arrangements dictating who will pay. In the event the bank returns a check to us, a service charge of $30 (maximum) in addition to any bank fee will be added to the account.

Financial hardship should never stand in the way of medical care. Since open communication can benefit both parties, any hardship should be discussed with AGC Pediatrics earlier rather than later. This will simplify a difficult situation. Please feel free to speak with the Billing and Accounts Department if you have any questions about our policy.

I HAVE READ AND UNDERSTAND THE TERMS AND CONDITIONS SET FORTH ABOVE AND AGREE TO THE TERMS AND CONDITIONS TEREIN. I FURTHER UNDERSTAND THAT FAILURE TO COMPLY WITH THIS AND ANY OTHER POLICIES OF AGC PEDIATRICS, LLC MAY RESULTS IN TERMINATION OF PROFESSIONAL SERVICES. (A DUPLICATE OF COPY OF THE BILLING AND CREDIT POLICY IS AVAILABLE FOR MY REFERENCE, UPON REQUEST).

_____ _____

Father / Mother / Legal Guardian (Please circle one) SIGNATURE SIGN HERE PLEASE Date

_____ _____

Father / Mother / Legal Guardian (Please circle one) Date