Main Office
3124 Blue Ridge Road, Suite 102
Raleigh, NC 27612
Office Number: (919) 782-0021

Brier Creek Office
10208 Cerny Street, Suite 104
Raleigh, NC 27617
Office Number: (919) 226-0662

Patient's Last Name: _____ **First Name:** _____ **Middle Initial:** _____

DOB: _____/_____/_____ **Gender: Male**____ **Female**____ **Patient Phone (***If 16 yrs. or older***):**_____

MOTHER/LEGAL GUARDIAN

Name: _____

DOB: _____/_____/_____

Address: _____

_____

City **State** **Zip**

Home Phone: (_____)_____-_____

Work Phone: (_____)_____- _____

Cell Phone: (_____)_____- _____

Email: _____

Marital Status: (check one)

Single____Married_____Divorced_____Widowed _____

FATHER/LEGAL GUARDIAN

Name: _____

DOB:_____/_____/_____

Address: _____

_____

City **State** **Zip**

Home Phone: (_____)_____-_____

Work Phone: (_____)_____- _____

Cell Phone: (_____)_____- _____

Email: _____

Marital Status: (check one)

Single____Married_____Divorced_____Widowed _____

Who is the primary caregiver? Both_____ **Father**_____**Mother**_____

Other (Please explain): _____

If applicable, who has primary custody? Both_____**Father**_____**Mother**_____**Other**_____

**(Please provide legal documentation for any alternative custody arrangements.)*

EMERGENCY CONTACT (Other Than Parent)

Name: _____ **Relationship:** _____

Home Phone: (_____) _____- _____**Cell Phone:** (_____)_____- _____

INSURANCE INFORMATION

Primary Insurance Company Name: _____

Insured's ID Number: _____ **Group Plan Number:** _____

Insured (Policy Holder) First and Last Name: _____

ADDITIONAL INFORMATION

Race: (check one) American Indian/Alaskan Native_____ Asian_____ Black/African American_____

Native Hawaiian_____ Other Pacific Islander_____ White_____ More than 1 Race_____ Declines to Respond_____

Ethnicity: (check one) Hispanic or Latino_____ Not Hispanic or Latino_____ Declines to Respond_____

Preferred Language: _____

Pharmacy Name: _____ **Pharmacy Address:** _____

Pharmacy Phone Number: _____

I hereby certify that the information above is true and accurate.

X: _____ **Date**_____

SIGNED (Patient, or parent if under 18 years of age.)

BlueRidge Pediatrics

Main Office - Raleigh Location
3124 Blue Ridge Road, Suite 102
Raleigh, North Carolina 27612
Office Number: (919) 782-0021

NEW **Brier Creek Location**
10208 Cerny Street, Suite 104
Raleigh, North Carolina 27617
Office Number: (919) 226-0662

Initial History Questionnaire

Child's Full Name:_____
Preferred Name:_____
Form Completed by:_____relationship_____

Today's date:_____
DOB:_____
[ ] Male [ ] Female
Chart#:_____

SOCIAL HISTORY Please list those living in the child's home:

Name	Relationship	Birth date	Job or School	Health Problems

Biological Parents: [ ] Married [ ] Divorced [ ] Single [ ] Separated [ ]Remarried
If both parents are not living together, who has custody?

	No	Yes	Comments
Are there any siblings not listed above?			
Does your child go to daycare?			where:
Does your child go to school?			where:
Does anyone in your family smoke (even outside)?			who
Does your family have any pets?			type:
Do you have smoke alarms in your house?			
Does your family routinely use seatbelts/carseats?			

BIRTH HISTORY of your child

Born: on time - late – premature(how early? gestational age_____weeks) **At what hospital?**

Birth weight: lbs ozs	No	Yes	Comments on "Yes"
Did mom have any problems with pregnancy?			type:
Was your baby born by Cesarean section?			why:
Did your baby have any problems after birth?			type:
Did baby stay in the hospital after mom went home?			why:

PAST MEDICAL HISTORY	No	Yes	Comments on "Yes"
Has your child had any surgery?			when : why:
Has your child ever been hospitalized?			when : why:
Does you child have any chronic or serious medical conditions?			type:
Has your child had any serious accidents or injuries?			type:
Does your child have any developmental problems?			type:
Is your child allergic to any medications?			meds: type reaction:
Did your child miss or skip any vaccines?			which ones:
Does your child take any medications on a regular basis?			med & dose:
Any over the counter medications on a regular basis?			med & dose:

Where did you hear about our practice?

_____

_____

Extra Comments:

_____

_____

_____

_____

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Name:_____ DOB: _____

FAMILY HISTORY Any family members (parents, siblings, grandparents, aunts or uncles only) have these?

	No	Yes	Relation/Type Problem		No	Yes	Relation/Type
Active Smoker				High Blood-Pressure			
Allergies				High Cholesterol			
Anemia/Blood				HIV/AIDS			
Asthma				Immune Problems			
Birth Defect				Kidney disease			
Bone/Joint probs				Learning Problems			
Cancer				Liver disease			
Deafness				Lung disease			
Diabetes				Mental Illness			
Drug abuse				Rheumatic Fever			
Eye problems				Seizures			
Genetic Defect				Thyroid disease			
Heart Disease				Tuberculosis			

REVIEW OF SYSTEMS Has your child had any problems with or do you have concerns with any of the following:

	No	Yes	Comments on "Yes"		No	Yes	Comments on "Yes"
Abdominal Pain				Hearing problems			
Allergy				Heart, murmurs			
Anemia				High blood pressure			
Asthma/wheezing				Illicit drug use			
Attention problems				Joint Pain/swelling			
Bedwetting/soiling				Learning problems			
Bladder/kidney probs				Liver problems			
Bleeding problems				Many ear infections			
Broken Bones				Many headaches			
Cancer/Leukemia				Many sore throats			
Cerebral Palsy				Menstrual problems			
Chickenpox				Nasal problems			
Constipation				Pneumonia			
Cystic Fibrosis				Seizures			
Dental problems				Skin problems			
Developmental probs				Sleep problems			
Diabetes				Speeach/Language			
Emotional/Behavioral				Thyroid problems			
Genetic Disorders				Vision or Eyes			

Any Other Concerns/Extra Comments: _____

_____

_____

Thank you for your time filling out this form. Please sign below stating to the best of your knowledge the above information is correct.

_____ _____
Signature of parent/guardian date

I have reviewed the above information with the parent/guardian.

_____ _____
Provider signature date

CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION

I consent to disclosure of the following protected health information about my child to the following family member(s) or person(s) involved in my child's care or payment for my child's care:

List names other than parents. If no one else should receive this information, please write "No one."

_____

_____.

Check all that may apply:

_____ All of my child's medical information
_____ Information necessary to schedule appointments for my child
_____ Lab or test results
_____ Information necessary to provide, call in or pick up prescriptions for my child
_____ Information necessary to help my child's family member(s) take care of my child
_____ Information necessary to allow my child's family member(s) to pick up or arrange for medical equipment to be provided for my child
_____ Information necessary to bill for or submit claims for care provided to my child to government or private insurance payors

My consent will remain in effect as long as my child is a patient of Blue Ridge Pediatrics, LLP unless and until I notify Blue Ridge Pediatrics, LLP in writing of any changes.

_____
Patient's Name

_____ _____
Signature of Patient or Representative Date

_____ _____
Print Name Relationship to Patient

Although allowed under HIPAA, North Carolina law does not permit release of PHI outside of the Hospital unless required by law, pursuant to a court order or patient authorization, or for treatment, payment, or health care operations purposes as defined and limited by HIPAA. There is no exception for family members except for residents of a nursing home. The North Carolina physician-patient privilege statute, N.C.G.S. § 8-53, and HIPAA allow verbal authorization or consent for release, respectively, of information to family members. However, the better practice is to document the patient's consent in order to have clear evidence of the patient's intent. The package does not include a consent or authorization to release PHI to other providers or to insurance companies or others since most providers already have such forms. The contents of this form can be combined with such existing consent forms.

PATIENT BILLING AND FINANCIAL POLICY

As a courtesy, Blue Ridge Pediatrics, LLP will file a claim for all services to your insurance. Therefore, at registration, you will be asked for your current insurance information and will be asked to sign a form verifying the information. It is your responsibility to assure we have your most current insurance information and to notify us of any changes.

It is also your responsibility as the guarantor to verify that Blue Ridge Pediatrics, LLP is a participating provider with your insurance company and to be familiar with your plan benefits (i.e. deductibles, co- payments, in and out of network costs).

To summarize, you will be responsible for a bill for the following reasons:

- The service is not a covered benefit
- Your insurance company requires you to pay deductibles
- Co-payments and/or co-insurance are required by your insurance company
- Missed Appointment/No Show Fees charged for missed appointments

For all patients who must pay their health care bills, we accept cash, check, American Express, MasterCard, Visa and Discover.

Upon receipt of a billing notice showing your balance due, you are expected to make payment in full. Please contact our office if you have any questions or need assistance with understanding your bill.

To ensure timely receipt of your account information, please contact us if there is a change to your billing address.

The parent/guardian or authorized individual that brings the child to an appointment is responsible for payment of the services rendered.

MISSED APPOINTMENT/NO SHOW POLICY

You may be charged a Missed Appointment/No Show Fee of $30.00 for a missed appointment. An appointment is considered a Missed Appointment/No Show if:

- The patient is a no show/no call for a scheduled appointment.
- We do not receive a 24 hour notice for cancellation of all appointments other than a same day sick appointment.
- We do not receive a 1 hour notice for cancellation of same day sick appointments.
- The patient arrives late for an appointment and the appointment has to be rescheduled for another time.
- For any reason, the patient is not seen by the doctor at their original scheduled appointment time.

Patients who miss or no show for a double appointment (bringing two children in at the same time) will be restricted from scheduling double appointments in the future.

ANY and **ALL** accounts that have 2 missed appointments/no shows within the same calendar year will be terminated from the practice.

_____ _____

Patient's Name Signature of Patient or Representative

_____ _____

Print Name/Relationship to Patient Date

PATIENT ACKNOWLEDGMENT AND CONSENT

I have been given a copy of Blue Ridge Pediatrics, LLP's Notice of Privacy Practices effective_____. I consent to the uses and disclosures of my child's health information as outlined in the notice.

_____
Patient's Name

_____ _____
Signature of Patient or Representative Date

_____ _____
Print Name Relationship to Patient

Please describe the Representative's authority to act on behalf of Patient: _____

_____

MEDICAL ACCESS

Medical History Access-Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

By signing this consent form, you are agreeing that Blue Ridge Pediatrics, LLP can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

_____ _____
Signature of Patient or Representative Date

FOR BLUE RIDGE PEDIATRICS' USE ONLY

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain acknowledgment and the reason you could not obtain it:

_____

_____

Blue Ridge Pediatrics, LLP

Patient Communication Information

Patient Name: _____ DOB: _____

In order for us to better communicate with our patients we are asking all patients to fill out this Patient Communication log.

Have you accessed our Patient Portal? **Yes** or **No** (Circle one)

If **No**, Would you like to access our Patient Portal? **Yes** or **No**

If **Yes**, Please print your **Email Address** here: _____

When we activate your email address you will receive an email confirmation from us. This will include the link to our portal, your log in and your password. If you forgot your log in and/or password the Receptionist can reset your password for you today.

Do you want to **reset** your log in and password? **Yes** or **No**

How would you like us to confirm your appointment? You can select one or both.

By Voice Mail? **Yes** or **No**

By Text (SMS) message? **Yes** or **No**

What is your preferred phone#? _____

Is this your **Home, Work or Cell Number**? (Please circle one)

What is your preferred language? **English** or **Spanish** (Please circle one)

Preferred time to call you? **Morning, Afternoon** or **Evening** (Please circle one)

Is there any special information you would like us to add to your child's account in reference to how we should contact you?

_____

_____

_____

Patient or Guardian's Signature: _____ Today's Date: _____

BRP Employee's Initials: _____ Scanned: _____ Entered in ECW: _____