Pediatric Associates of Plymouth, Inc.

3031 Walton Road, C101
Plymouth Meeting, PA 19462

50 West Third Ave., Suite 400
Collegeville, PA 19426

Date: _____

Family Last Name _____

Mother's Full Name _____

Father's Full Name _____

Address _____

_____

_____

Home Phone # _____

Name & Address of Person Responsible for Bill

(*if different than above*)

_____

_____

_____

Emergency Contact Name & Phone #

_____

Blue Book Given? Y N Referred By _____

Children's Full Names, Dates of Birth & SS#'s

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Primary Insurance Co. _____

Policy Holder _____

ID # _____

Group # _____

Effective Date: _____

Secondary Insurance Co. _____

Policy Holder _____

ID # _____

Group # _____

Effective Date: _____

Father's Social Security # _____

Date of Birth _____

Place of Employment _____

Work Phone # _____

Cell Phone # _____

Mother's Social Security # _____

Date of Birth _____

Place of Employment _____

Work Phone # _____

Cell Phone # _____

Financial Responsibility: *I authorize Pediatric Associates of Plymouth to release any medical information to my insurance companies to determine benefits and payable benefits for related services. I understand that I am financially responsible for any balance not covered by my Insurance Companies. I understand I am responsible for all co-pays due at the time of the visit. My signature indicates that I have read the above and agree to the terms and conditions.*

Signature: _____ Date: _____

Medical History

Child's Name _____ **Birthdate**_____ **Gender:** Male ___ Female___

Pregnancy

What number pregnancy was this baby? _____ Was the pregnancy normal? Y N If no, explain _____
Did the mother have any illness during the pregnancy? Y N If Yes, explain _____
Was the baby born on time? Y N If not, was it early or late? _____ By how many weeks? _____
In what hospital was the baby born? _____ Who delivered the baby? _____
Was the delivery vaginal or cesarean? (circle one) Were there complications? Y N If yes, explain _____
What was the baby's birth weight? _____ Length? _____ Discharge weight? _____
Child's Blood Type _____ Mother's Blood Type _____ Father's Blood Type _____

Post Natal Course

Did the baby come home with the mother, on time? Y N If not, when? _____
Did the baby have any problems in the nursery? Y N If yes, what? _____
If the baby breast fed? Y N If formula is used, which one? _____

Infections/Illnesses

Circle any of the following that your child has had:

Chicken Pox Seizures Mononucleosis Ear Infections Anemia Strep Throat Urinary Tract Infections
Other _____

Please comment on the following, if they apply to your child:
Hospitalizations _____
Operations _____
Allergies _____
Current Medications _____

Family History If any family members listed below are deceased, please indicate so with a "D", and age at which they passed away.

Child's mother's age _____ Child's father's age _____
Maternal grandmother _____ Maternal grandfather _____ Paternal grandmother _____ Paternal grandfather _____
Ages, sex, and health status of child's siblings:

Are this child's parents Single Married Divorced Separated? (circle one)
Circle any of the following diseases which any member of either side of the family has had:

Tuberculosis Cancer Diabetes Seizures Heart Disease High Blood Pressure
Mental Illness Anemia Asthma Allergies Color-Blindness Migraine Headaches
Inherited Diseases: (specify) _____

Family Habits

Smoking? Y N Alcohol Use? Y N Drug Use? Y N Guns in the house? Y N Pets? Y N

Do you have any special concerns about your child?

Is there anything else that you want us to know about your child?

Informant _____ **Relationship to Child** _____ **Date** _____

PEDIATRIC ASSOCIATES OF PLYMOUTH, INC.

PEDIATRIC AND ADOLESCENT MEDICINE

Jane Mooney Longacre, M.D., F.A.A.P.
Mary Anne Gazdick, M.D., F.A.A.P.
Alexander R. Salomon, M.D., F.A.A.P.
John B. Evans, M.D., F.A.A.P.
Alicia Boellner-Kahn, M.D., F.A.A.P.
Song S. Chin, M.D., F.A.A.P.

HOURS BY APPOINTMENT ONLY

Walton Campus
3031 Walton Road
Building C, Suite 101
Plymouth Meeting, PA 19462
Phone 610-825-3500 / Fax 610-825-8502

50 West Third Avenue, Suite 400
Collegeville, PA 19426
Phone 610-489-2229 / Fax 610-489-4788

Authorization to Treat Minor Patient in Absence of Parent/Guardian

I, _____, the parent and legal guardian of _____,
(name of parent)
_____,
_____,
_____, } List names

hereby authorize _____ _____
(name of person bringing child to the office) (name of person bringing child to the office)

_____ _____
(name of person bringing child to the office) (name of person bringing child to the office)

to accompany my above-named child to office visits with Pediatric Associates of Plymouth, Inc.

and consent to the examination and/or treatment of my child during the office visits. This authorization includes necessary bloodwork as well as the administration of any recommended immunizations.

This authorization:

- ❑ is effective only on _____.
- ❑ is effective from _____ to _____.
- ❑ is effective until revoked by me in writing.

I reserve the right to revoke this authorization at any time by writing to the above named physician.

_____ _____
(Signature of Witness) (Signature of Parent/Guardian)

_____ _____
(Date) (Date)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND
CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Read before signing the Acknowledgement and Consent

This acknowledgement of notice and consent authorizes Pediatric Associates of Plymouth, Inc to use and disclose health information about you for treatment, payment, and health care operations purposes.

Notice of Privacy Practices. Pediatric Associates of Plymouth, Inc. has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgement and consent.

Amendments. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

How to contact our Privacy Officer:

Mail:	Address to : Pediatric Associates of Plymouth, Inc., Attention: Privacy Officer,
{Address}	3031 Walton Road C101, Plymouth Meeting, Pa. 19426
Telephone:	(610)825-3500
Facsimile:	(610)825-8502

Acknowledgement and Consent

Print or type all information except the signature.

I have received the Notice of Privacy Practices for Pediatric Associates of Plymouth, Inc. Pediatric Associates of Plymouth, Inc. is authorized to use and disclose health information about _____ (patient name) for treatment, payment, and healthcare operations purposes consistent with its Notice of Privacy Practices.

_____ _____

Signature of patient's personal representative Date
(Signature of patient if over 18 years old)

Personal representative information:

_____

Name of personal representative

_____

Relationship to Patient