**Smithfield Pediatrics**
**7 Smith Ave**
**Suite 103**
**Greenville, RI 02828**
**(Phone) 401-231-3138 (fax) 401-231-4757**

*PATIENT NAM E:*_____

DATE OF BIRTH:_____SOC SEC #_____

MAILNG ADDRESS_____

_____

Best Contact Number _____

STREET ADDRESS (IF DIFFERENT FROM MAILING ADDRESS):

_____

_____

_____

***MOTHER'S NAME:***_____

DATE OF BIRTH:_____SOC SEC #_____

CELL PHONE NUMBER:_____

PLACE OF EMPLOYMENT:_____

***FATHER'S NAME:***_____

DATE OF BIRTH:_____SOC SEC #_____

CELL PHONE NUMBER:_____

PLACE OF EMPLOYMENT:_____

***FOSTER PARENT (S)/ LEGAL GUARDIAN (S):***

NAME(S):_____

DATE(S) OF BIRTH:_____

CELL PHONE NUMBER(S):_____

PLACE OF EMPLOYMENT:_____

PATIENT NAME: _____

DATE OF BIRTH: _____

*PRIMARY INSURANCE*: _____
POLICY NUMBER: _____
GROUP NUMBER: _____
NAME OF POLICY HOLDER: _____
RELATIONSHIP TO PATIENT: _____
POLICY HOLDER PLACE OF EMPLOYMENT: _____

_____

*SECONDARY INSURANCE:* _____
POLICY NUMBER: _____
GROUP NUMBER: _____
NAME OF POLICY HOLDER: _____
RELATIONSHIP TO PATIENT: _____
POLICY HOLDER PLACE OF EMPLOYMENT: _____

_____

EMAIL ADDRESS FOR THE PARENT/LEGAL GUARDIAN (WILL BE USED TO ACTIVATE YOUR CHILD'S PATIENT PORTAL ACCOUNT)

_____ @ _____

PRESCRIPTIONS ARE SENT ELECTRONICALLY TO YOUR PHARMACY. PLEASE SPECIFY WHICH PHARMACY YOU WOULD LIKE THEM SENT TO.

PHARMACY NAME_____

ADDRESS_____

_____

Date: _____

**NEW PATIENT QUESTIONAIRE**

Patient Name: _____ Date of Birth: _____

Mother's Name: _____ Age: _____

Father's Name: _____ Age: _____

**PREGNANCY AND BIRTH:**

1. Mother's age at birth? _____
2. Did mother have any illness during pregnancy? Yes_____ No _____

If yes, what type?_____

3. Did she take any medications other than vitamins or iron? Yes ___ No___

If yes, which ones?_____

4. Was the baby on time? Yes_____ No _____
5. What was the birth weight? Lbs._____ oz._____
6. Did the baby have any trouble starting to breathe? Yes_____ No_____
   Please explain_____
7. Did the baby have trouble while in the hospital? (Jaundice, infections, other?)

Yes _____No _____ what kind? _____

**FAMILY HISTORY:**

1. Are the child's parents both in good health? Yes _____No_____
2. Is there any family history of the following diseases?

Anemia _____ Asthma _____Allergies _____Diabetes_____

High blood pressure _____ Heart trouble _____Cancer _____ TB_____

Mental illness _____ Drug problems_____Alcohol problems_____

Inherited illness _____ Venereal disease _____ AIDS _____

Others _____

3. List age, sex, and general health of brothers and sisters_____

_____

_____

4. Have any of your children died? Yes _____ No____

If yes, what was the cause? _____

_____

**SAFETY/ENVIRONMENT:**

1. Do you live in a private house_____, apartment___, mobile home_____ other? _____
2. Do you know the hottest temperature of the water in your pipes? Yes_____ No_____
3. Is there a working smoke alarm on each floor in the house? Yes _____ No_____
4. Does your child always use a car seat/seat belt when riding in a car? Yes _____ No_____
5. Are there any smokers in the household? Yes _____ No_____
6. Are there any problems with the condition of your home? (peeling paint, insects, rats, or mice) Yes _____ No_____
7. Can you provide us with a record of your child's immunizations? Yes _____No_____

New Patient Questionnaire

Page 2- For one year old and up

**PAST MEDICAL HISTORY:**

1. Where has your child gone for check-ups until now? _____
2. Date of last physical exam? _____
3. Date of last Dental checkup? _____
4. Has your child had allergic reactions to any medications, foods, insect bites? Yes____ No____ Which ones? _____
5. Has your child has allergic reactions to any immunizations? Yes __ No __
   Which ones? _____
6. Any hospitalizations, other than birth? Yes ____ No ____
   For what? _____
7. Any serious injuries? Yes____ No____ If so,what kind? _____
8. Are any medications taken regularly? Yes ____ No ____ Please name them and write the dose. _____
9. Any Past surgeries? Yes ____ No ____ If so, for what? _____

**FEEDING & NUTRITION:**

1. Is your child's appetite usually good? Yes ____ No ____
2. Was there sever colic or any unusual feeding problem during the first three months? Yes ____ No ____ If yes, Please explain _____
3. Do any food disagree with him /her? Yes ____ No ____ which ones?
   _____
4. For the first 6 months, was he/she breastfed? Yes ____ No ____
5. Does he/she take vitamins? Yes_____ No____

**REVIEW OF SYMPTOMS:**

1. Has your child had frequent ear infections? Yes ____ No ____
2. Any eye problem? Yes ____ No ____
3. Has he/she had any problems with teeth? Yes ____ No ____
4. Does he/she have frequent colds or sore throat? Yes ____ No ____
5. Is there asthma, pneumonia or recurrent cough? Yes ____ No ____
6. Does he/she have a heart murmur or any heart conditions? Yes ____ No ____ if so, what?
   _____
7. Any problems with urination? Yes ____ No ____
8. Any problems with diarrhea or constipation? Yes ____ No ____ Have you tried any medications? _____
9. Have there been any convulsions or other problems with the nervous system? Yes _____ No ____ If yes, what kind? _____
10. Any eczema, hives or other skin conditions? Yes ____ No ____
11. Has your child ever been anemic? Yes ____ No ____
12. Please List any other medical problems: _____

**DEVELOPMENTAL/BEHAVIOR:**

1. At what age did your child sit alone? _____
2. At what age he/she walk alone? _____
3. Did he/she say any words by age 18 months? Yes ____ No ____
4. Does he/she have any trouble sleeping? Yes ____ No ____
5. How does he/she get along with other children? _____

SMITHFIELD PEDIATRICS

ALTERNATE METHOD OF COMMUNICATION CONSENT

EFFECTIVE AUGUST 1, 2013

PATIENT: _____ DOB:_____/_____/_____

1. May we leave a message on your **HOME** phone? YES _____ NO _____

   **Phone Number** _____-_____-_____

**a.** Brief message b. Detailed message **(Please Circle One)**

2. May we leave a message on your **CELL** phone? YES _____ NO _____

   **Phone Number** _____-_____-_____

**b.** Brief message b. Detailed message **(Please Circle One)**

Are there any alternate phone numbers that you would like to receive communications?

_____

_____

Signature of Parent/Legal Guardian: _____

Print Name: _____ Date: _____

# SMITHFIELD PEDIATRICS

Stephanie Penchuk, M.D., F.A.A.P.
Dinusha Dietrich, M.D., F.A.A.P.

7 Smith Avenue, Suite 103
Greenville, RI 02828

Phone: (401) 231-3138
Fax: (401) 231-4757

## HIPPA

Receipt of Notice of Privacy Practices

Written Acknowledgement Form

I, _____ have received a copy of Smithfield Pediatrics' Notice
(Parent's Na me)

of Privacy Practices.

_____ _____

Signature of Parent Date

Name (s) of **Child (ren):**

_____ D.O.B.: _____

_____ D.O.B.: _____

_____ D.O.B.: _____

_____ D.O.B.: _____

_____ D.O.B.: _____

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Dinusha Dietrich, M.D., F.A.A.P.

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**Patient Name:** _____ **DOB:** _____

In the event that I, the PARENT/LEGAL GUARDIAN of the above named patient, am unable to take the patient to an appointment hereby authorize the following people/person to accompany my child to the visit.

| NAME | RELATIONSHIP TO PATIENT |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

PLEASE MAKE SURE THEY BRING:

A COPY OF THE PATIENTS **CURRENT** INSURANCE CARD.

APPLICABLE CO-PAY DUE AT VISIT

ALL PERTINENT INFORMATION REGARDING THE REASON FOR APPOINTMENT

A PHONE NUMBER WHERE YOU CAN **BE IMMEDIATELY** REACHED IN CASE THE DOCTOR HAS QUESTIONS.

•• This list can be changed at any given time if you choose
•• ALL Legal Issues will need Original Documentation present for patients chart.

_____ _____

Parent/Guardian Signature Parent/Guardian Name (PRINTED)

Date: _____

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Dear Parent,

Congratulations on the birth of your child. During this time of new joys and happiness, please remember to contact your insurance company and notify them of the birth of your child including name and date of birth, so they can be added to your health insurance.
If your insurance requires that a Primary Care Physician be listed, please be sure to list Dr. Penchuk or Dr. Dietrich as of the date of your child's birth.

**It is YOUR financial responsibility to notify your insurance company with this Information WITHIN 30 DAYS of birth. Beyond 30 days you could be at risk of not having your insurance company retroactive the effective date to cover your child's initial visits. In this case you will be responsible for ALL HEALTHCARE COSTS of related services for your child by Smithfield Pediatrics.**

If you have any questions, please contact our Office Manager, Kathleen Deblasio

Sincerely,

Dr. Stephanie Penchuk/Dr. Dinusha Dietrich

**I have read and understand the above. I agree that it is my responsibility to notify my insurance company of my child's birth and failing to do so will result in uninsured services that I will be financial responsible for.**

Parent Signature: _____ Date: _____

Print Name: _____

Child's Name: _____ DOB: _____

# *SMITHFIELD PEDIATRICS*
## ***Patient Financial Agreement***

Our primary goal at Smithfield Pediatrics is to provide your child with quality health care. In order for our staff to be able to focus on health care, we have developed the following policies regarding payment for services.

**PARENT/LEGAL GUARDIAN RESPONSIBILITIES**

1. It is your responsibility to provide us with accurate insurance information for each insurance plan for each member of your family at all visits.
2. If your insurance company requires you to choose a primary care physician (PCP), it is your responsibility, PRIOR TO YOUR VISIT, to make sure that your child's doctor at Smithfield Pediatrics is listed as the PCP.
3. Our billing office, Comprehensive Practice Management, is available to provide you with assistance, but cannot resolve disputes between you and your insurance company.
4. If your insurance requires a referral to see a specialist, it is YOUR responsibility to contact our office as soon as possible to create a referral. Some specialist referrals are lengthy and require some time to complete. Same day referral requests may not be able to be processed. Your knowledge of your insurance plan regulations and benefits as well as adequate planning will help avoid delays and denied claims.
5. It is your responsibility to keep scheduled appointments. We expect 24 hour notice for all cancellations. We reserve the right to charge $25.00 cancellation fee for appointments not cancelled 24 hours in advance. Missed appointments will result in additional charges, not billable to your insurance company, or, dismissal from our practice.

**COPAYS/DEDUCTIBLES**

1 If your insurance plan requires a copayment, it must be paid at the time of service. We accept cash, check, and Master Card/Visa credit or debit card, Discover, American Express or money orders.

2 If another family member is financially responsible for payment, you will still be expected to pay the copay at the time of visit. We expect the parent accompanying the child to pay applicable charges regardless of any child support agreements. We will gladly furnish you with necessary statements for reimbursement.

3 If your child comes to an office visit without a parent, you are still responsible for the copayment at the time of the visit.

4 It is your responsibility to understand deductibles that may apply to your insurance plan. Our billing office will send you a statement of the amount that your insurance company has determined you owe as a result of any deductible.

**PATIENT BILLS**

If you do not have insurance coverage, you will be expected to pay in full at the time of visit.

1 Our billing office, Comprehensive Practice Management, will send out billing statements for any outstanding balances. If the balance is still unpaid after 3 statements, we will send 2 final letters then your account will be sent to a collection agency. Our collection agency may report delinquent accounts to credit bureaus.

2 If your account has been sent to collections, you will be responsible for the collection and attorney fees, in addition to the original charges.

3 Balances less than $10.00 will be collected at your visit, they will not generate a bill.

**INSURANCE INFORMATION**

1. It is your responsibility to provide the accurate insurance information for your child. If your child is covered by more than 1 insurance, you must provide all information for all the insurances and must know which one is primary, secondary, etc. If an insurance claim is rejected as a result of incorrect information you provided, you will be responsible for payment.

2. Medical insurance does not always cover the entire cost of your child's medical care. In some cases, we do not learn that a service is not covered until after we submit a bill. You are responsible for payment if your insurance company refuses to pay for a service.

3. Smithfield Pediatrics will submit claims to your insurance company on your behalf. You *give* us permission to *provide* your insurer(s) with any information necessary *for* payment. You give us permission to ask your insurer to pay us directly for care we provide.

We appreciate the opportunity to participate in your child's health care.

Sincerely,

Stephanie Penchuk MD
Dinesh Dietrich MD
Jennifer Barton PA-C

**Smithfield Pediatrics**

Name/DOB of Children

_____

I understand and accept the above statements. _____

_____

Parent Signature_____

Date_____