SMITHFIELD PEDIATRICS

41 Sanderson Rd. Suite 202
Smithfield, R.I. 02917
(phone) 401-231-3138 (fax) 401-231-4757

PATIENT NAME :_____

DATE OF BIRTH:_____ SOC SEC #_____

MAILING 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 _____

Name of patient _____ Date: _____

NEW PATIENT QUESTIONAIRE

✱ 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 check-up? _____
4. Has your child had allergic reactions to any medications, foods, insect bites? Yes_____ No _____ Which ones? _____
5. Has your child had 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 _____ 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 severe colic or any unusual feeding problem during the first three months? Yes _____ No _____ If yes, please explain _____
3. Do any foods disagree with him/her? Yes _____ No _____ Which ones? _____
4. For the first 6 months, was he/she breast fed? Yes _____ No _____
5. Does he/she take vitamins? _____

REVIEW OF SYSTEMS:

1. Has your child had frequent ear infections? Yes _____ No _____
2. Any eye problems? Yes _____ No _____
3. Has he/she had any problems with teeth? Yes _____ No _____
4. Does he/she have frequent colds or sore throats? 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: _____

_____

DEVELOPMENT/BEHAVIOR:

1. At what age did your child sit alone? _____
2. At what age did 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? _____

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

41 Sanderson Road, Suite 202
Smithfield, RI 02917-2603

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

PATIENT NAME:_____
DATE OF BIRTH:_____

IN THE EVENT THAT I, THE PARENT/ LEGAL GUARDIAN, OF THE ABOVE NAMED PATIENT AM UNABLE TO TAKE PATIENT TO AN APPOINTMENT I AUTHORIZE THE FOLLOWING PERSON/PEOPLE TO ACCOMPANY MY CHILD TO THE VISIT.

1._____RELATION TO PT_____
2._____RELATION TO PT_____
3._____RELATION TO PT_____
4._____RELATION TO PT_____
5._____RELATION TO PT_____

PLEASE MAKE SURE THESE PEOPLE HAVE A COPY OF PATIENTS CURRENT INSURANCE CARD WITH THEM ALONG WITH APPLICABLE COPAY AND ALL PERTINENT INFORMATION REGARDING THE REASON FOR THE APPOINTMENT. PLEASE ALSO PROVIDE THEM WITH A PHONE NUMBER YOU CAN BE REACHED AT IF THE DOCTOR HAS ANY QUESTIONS.
THIS LIST IS ABLE TO BE ADJUSTED AT ANY TIME. PLEASE SEE THE RECEPTIONIST IF CHANGES ARE NECESSARY.

SIGNATURE OF PERSON COMPLETING FORM:
_____

PRINTED NAME:_____
TODAYS DATE:_____

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HIPPA

Receipt of Notice of Privacy Practices

Written Acknowledgement Form

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

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.: _____

SMITHFIELD PEDIATRICS

ALTERNATIVE METHOD OF COMMUNICATION CONSENT

Effective Date: August 1, 2013

Patient Name: _____ DOB: _____

1. May we leave a message on your home phone? Yes____ NO____

   Phone number ____ - ____ - _____

   a. Brief Message b. Extended Message (Please Circle One)

2. May we leave a message on your cell phone? Yes____ NO ____

   Cell number ____ - ____ - _____

   a. Brief Message b. Extended Message (Please Circle One)

Are there any alternative phone numbers or addresses (other than those on file) that you would like to receive communications? _____

_____

_____

Signature of Parent/Legal Guardian: _____

Print Name : _____ Date :_____

_____

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Newborns only

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 Kathleen Deblasio, Office Manager.

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, 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
Dinusha Dietrich MD
Smithfield Pediatrics

I understand and accept the above statements.

Parent Signature _____
Date _____

Name/DOB of Children

_____
_____
_____
_____
_____
_____
_____

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ETHNICITY

____HISPANIC OR LATINO
____NOT HISPANIC OR LATINO
____PREFER NOT TO ANSWER

RACE

____WHITE
____HISPANIC
____BLACK/AFRICAN AMERICAN
____ASIAN
____NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
____MULTI-RACIAL (CHECK ALL THAT APPLY)
____OTHER_____
____PREFER NOT TO ANSWER

PRIMARY LANGUAGE SPOKEN IN HOME

____ENGLISH
____SPANISH
____PORTUGUESE
____RUSSIAN
____OTHER_____

HOW DID YOU HEAR ABOUT US?

____REFERRAL FROM RELATIVE OR FRIEND
____ADVERTISEMENT
____INTERNET
____OUR WEBSITE