Shelby Pediatrics, LLC

Karen S. Smith, MD

430 Fourth Ave., Suite 1
Sidney, OH 45365
937-419-TOTS (8687)

Patient Information

Patient Name_____ Preferred Name_____

Date of Birth _____/_____/_____ Sex M F SSN_____-_____-_____

Address_____

City_____ State_____ ZIP_____

Home Phone (_____) _____ Cell Phone (_____) _____ Preferred: Home ☐ Cell ☐

Email _____ May we text with reminders: Yes ☐ No ☐

Language_____ Race_____ Ethnicity_____

After Visit Patient Care Summary: Portal ☐ Paper ☐

How did you hear about us? _____

Parent/Guardian Information

Mother's Name_____ Date of Birth ____/____/____

SSN _____-_____-_____ Relationship: Mother Foster Legal Guardian Step Other

Marital Status: S M D W Employer_____ Occupation_____

Below Information is Same as Child ☐

Address_____ City_____ State_____ ZIP_____

Phone (____) _____ or (____) _____

Father's Name_____ Date of Birth ____/____/____

SSN _____-_____-_____ Relationship: Father Foster Legal Guardian Step Other

Marital Status: S M D W Employer_____ Occupation_____

Below Information is Same as Child ☐

Address_____ City_____ State_____ ZIP_____

Phone (____) _____ or (____) _____

With you every step of the way!

Emergency Contact

Name_____ Address/City/Zip_____

Phone (_____) _____ or (_____) _____

Relationship to Patient _____

Sibling Information

First Name_____ Last Name_____ Birthdate ____/____/____

First Name_____ Last Name_____ Birthdate ____/____/____

First Name_____ Last Name_____ Birthdate ____/____/____

First Name_____ Last Name_____ Birthdate ____/____/____

Insurance Information

Primary:

Cardholder's Full Name: First_____ Last _____

Date of Birth ____/____/____ SSN_____-_____-_____ Employer_____

Address (if different than patients) _____

City_____ State _____ Zip_____Phone (____) _____

Ins. Company_____ ID#_____

Group#_____ Effective Date of Insurance _____/_____/_____

Secondary:

Cardholder's Full Name: First_____ Last _____

Date of Birth ____/____/____ SSN_____-_____-_____ Employer_____

Address (if different than patients) _____

City_____ State _____ Zip_____ Phone (____) _____

Ins. Company_____ ID#_____

Group#_____ Effective Date of Insurance _____/_____/_____

With you every step of the way!

I (We) authorize the following people to **bring my child in for, and consent to, treatment, or receive medical advice over the phone if they are taking care of my child in my absence.**

Name: _____ Date of Birth ____/____/____

Relationship: _____ Phone (____) _____

Name: _____ Date of Birth ____/____/____

Relationship: _____ Phone (____) _____

Name: _____ Date of Birth ____/____/____

Relationship: _____ Phone (____) _____

☐ My Child is 16 years of age or older, and has my permission to seek medical care without a parent or guardian present. I understand that the details of the visit will remain private or confidential between patient and provider, unless patient is at risk for harm.

_____ Parent/Guardian Initials

Privacy Policy

I have received a copy of the Welcome Letter, Financial Policy, HIPAA, and Portal information. I hereby authorize Shelby Pediatrics, LLC to furnish information to insurance carriers concerning illness and/or treatment. I understand that I am responsible for any amount not covered by insurance, including copay and deductibles.

Signature: _____ Date: _____

Print Name: _____ Relationship: _____

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Financial Responsibility

1) According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.

2) Co-payments are due at the time of service.

3) Self-pay patients are expected to pay for 50% at the time of service. If you wish to pay in full at the time of service, there with be a 30% discount.

4) If we do not participate in your insurance plan, you will be responsible for all charges for services rendered.

5) Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Balance is due 10 days after receiving the bill.

6) Any balance outstanding longer than 90 days will be forwarded to a collection agency.

7) For scheduled appointments, prior balances must be paid prior to the visit.

8) We accept cash, checks, Visa, MasterCard, American Express, and Discover.

(9) A $30 fee will be charged for any checks returned for insufficient funds.

Signature: _____ Date: _____

(Parent/Guardian signature)

Print Name: _____ Relationship: _____

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Welcome,

Thank you for choosing Shelby Pediatrics, LLC for your child's care. We appreciate the trust you have placed in us and look forward to developing a long and healthy relationship with you and your child(ren). Our goal is to provide exceptional care in a comfortable, welcoming, and fun environment for children.

Please review the following office policies.

- **Late Policy**: If your child is 15 minutes late or more
  - *Wellness appointment*: You may be asked to reschedule.
  - *Sick visit*: We will try and work them in but there may be a wait as we see the patients first who have arrived on time.
- **No Show:** In the event that your child does not show up for an appointment, we will send a no-show letter to your home informing you of this event and ask you to call our office to reschedule your child's appointment. After the 3rd missed appointment in a one-year time span, we may dismiss your family from the practice.
- **Cancellations:** If you need to cancel your child's appointment, please make sure you give us a 24-hour notice. This is so we can fill that empty spot for another child that needs to be seen. If you fail to inform us 24 hours in advance, you may be charged a no show.
- **Patient Dismissal:** Dr. Smith may release you from our practice for disruptive behavior, non-compliance with medical advice, or if your family has more than 3 no shows.

We look forward to working together to achieve our child's optimal health. If you have any questions, please do not hesitate to ask.

Please sign below, indicating that you understand these policies.

Signature: _____ Date: _____

(Parent/Guardian signature)

Print Name: _____ Relationship: _____

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Medical Release Form

Patient Name: _____ Birthdate: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Person filling out form (print name): _____ Relationship: _____

I Hereby Authorize:	**To Release to:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Purpose for Request (Check all that applies)

Change of Physician Insurance Continuity of Care HIV Personal Other: _____

Information to Release:

All Clinical Records Progress Note Lab Reports Immunizations Other: _____

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- I release Shelby Pediatrics, LLC from all legal responsibility or liability that may arise from authorized release of information.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, we must have permission by parent/guardian.
- Shelby Pediatrics, LLC will not transfer this information without permission, unless the law authorizes or compels us to do so.
- This authorization will include the release of information concerning HIV testing or treatment of AIDS, Aids related conditions, drugs, or alcohol abuse, drug related conditions, alcoholism, and/or psychiatric or psychological conditions.

Signature of Patient or Guardian: _____ Date: _____

Print name of Patient or Guardian: _____

With you every step of the way!

Child's Name: _____ Date of Birth: _____

Social History

Is the child yours by _____birth_____adoption_____stepchild_____other_____

Number of persons who lives in the household_____number of siblings_____

Alcohol intake _____

Animal Exposure _____

Bike Helmets_____

Blind or serious difficulty seeing_____

Bully/Being bullied? _____

Caffeine intake_____

Changes in family/social situation? _____

Tobacco use_____Do any household members use tobacco_____

Childcare_____

Deaf or serious difficulty hearing_____

Exercise? How much? _____

School Name? Grade? _____

Seat Belt/care seat_____

Siblings_____

Smoke alarm/CO detectors in home_____

Surgical History

Please list all surgeries_____

_____

_____

Medications

List all current medications. Include prescribed and over-the-counter drugs, such as vitamins and inhalers.

_____

_____

_____

With you every step of the way!

Child's Name: _____ Date of Birth: _____

Medical History

Please circle all that apply

ADD/ADHD
Allergies
If yes to what_____
Anemia
Anxiety Disorder
Asthma
Bedwetting
Bladder or kidney problems
Blood Diseases
Cancer
Chicken Pox
Chronic Ear Infections
Congenital Anomalies
Constipation
Depression
Autism Spectrum Disorder
Developmental or Behavioral Disorder
Diabetes
Difficulty Swallowing
Ear or Hearing Problems
Head Injury/Concussion
Heart Problems
Hospital Admission Other Than Birth
Mental Illness
Muscle, Joint or Bone Problems
Seizures/epilepsy
Skin Problems
Thyroid Problems
Vision or Eye Problems
Other_____

Family History

Check all disease that apply.

☐ Allergy	Family Member_____
☐ Anemia	Family Member_____
☐ Anxiety Disorder	Family Member_____
☐ Asthma	Family Member_____
☐ Blood Disorder	Family Member_____
☐ Depressive disorder	Family Member_____
☐ Developmental	Family Member_____
☐ Diabetes	Family Member_____
☐ Liver Disease	Family Member_____
☐ Disorder of Thyroid gland	Family Member_____
☐ Heart Disease	Family Member_____
☐ High Cholesterol	Family Member_____
☐ Hypertensive disorder	Family Member_____
☐ Immunodeficiency disorder	Family Member_____
☐ Kidney disease	Family Member_____
☐ Malignant neoplastic disease	Family Member_____
☐ Mental disorder	Family Member_____
☐ Migraine	Family Member_____
☐ Seizures	Family Member_____
☐ Substance abuse	Family Member_____
☐ Tuberculosis	Family Member_____
☐ Other, please list _____	Family Member_____

With you every step of the way!