WELCOME TO NEW ENGLAND PEDIATRICS: YOUR MEDICAL HOME

YOUR NEW PATIENT PACKET CONTAINS:

- New England Pediatrics—Your Medical Home
- Patient Information (Demographics/Emergency Contact/Insurance
- Guarantor Agreement
- Pediatric Health History (One per child)
- Acknowledge Receipt of Privacy Practices
- Consent to Treat a Minor (Caregiver other than parent)
- State of Connecticut Vaccine Program (Additional patient information)

These forms can also be found/downloaded/completed on our website: www.nepeds.com

Submit completed forms by email to info@nepeds.com, or by mail to either address below prior to your first visit. Our doctors and staff look forward to meeting you and caring for your family.

NEW ENGLAND PEDIATRICS: YOUR MEDICAL HOME

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WELCOME TO YOUR MEDICAL HOME

New England Pediatrics

PCMH—or Patient Centered Medical Home—is a type of medical practice where you, the patient (and family) is at the very center of your health care team, with an accent on the word "TEAM".

Your **team** of health care providers-doctors, nurses, support staff and trusted family members

- **Commits to learn** about you, your family, and preferences—to tailor your care to your life and needs
- **Communicate effectively,** allow you to ask questions, make sure you understand the answers, and encourage you to give feedback about your experience
- **Support learning** how to best care for yourself, to set your personal goals, provide local resources to assist you, and **COORDINATE** your care with specialists when needed

YOU THE PATIENT (AND FAMILY)

- **Know** that you are **a full partner in your care,** get to know your team, talk to them, learn about your condition, follow the plan that you and your team set forth
- **Select** a specific physician if you would like to and bring your questions to every visit
- **Tell** your team if you have sought interim care elsewhere, to coordinate your health information—new tests, medicines, procedures, injuries, ER visits
- **Be proactive** to ensure and maintain your optimal health over the long term; address illness efficiently and thoroughly; learn to access our Patient Portal

YOUR MEDICAL HOME: NEW ENGLAND PEDIATRICS

- Is **available to help you 24/7/365** if needed, by phone or same-day appointments
- Gives relevant information to medical specialists, school personnel, occupational, physical or speech therapists, and to behavioral health resources
- Tracks your test results, referrals, consult reports, ongoing therapies
- Keeps you at the center of the healthcare team, respect you as a full partner in decision-making, explains your treatment options, and provide community resources to support your needs and well-being

WELCOME TO NEW ENGLAND PEDIATRICS: YOUR MEDICAL HOME
YOUR TEAM IS HERE FOR YOU

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PATIENT INFORMATION Date ___/___/___

☐ New Patient ☐ Update ☐ STAMFORD ☐ NEW CANAAN

New England Pediatrics

PREFERRED PHARMACY _____

CHILDREN

LAST	FIRST	CELL PHONE	SEX	DATE OF BIRTH M	D	Y
LAST	FIRST	CELL PHONE	SEX	M	D	Y
LAST	FIRST	CELL PHONE	SEX	M	D	Y
LAST	FIRST	CELL PHONE	SEX	M	D	Y

PARENT 1 ☐ Male ☐ Female GUARANTOR ☐ YES ☐ NO

LAST	FIRST		DATE OF BIRTH M	D	Y
HOME ADDRESS	CITY	STATE	ZIP		
HOME PHONE (PRIMARY ☐)	CELL PHONE (PRIMARY ☐)	EMAIL			
COMPANY NAME		POSITION			
BUSINESS ADDRESS-STREET	CITY	STATE	ZIP		
BUSINESS PHONE	BUSINESS FAX				

PARENT 2 ☐ Male ☐ Female GUARANTOR ☐ YES ☐ NO

LAST	FIRST		DATE OF BIRTH M	D	Y
HOME ADDRESS	CITY	STATE	ZIP		
HOME PHONE (PRIMARY ☐)	CELL PHONE (PRIMARY ☐)	EMAIL			
COMPANY NAME		POSITION			
BUSINESS ADDRESS-STREET	CITY	STATE	ZIP		
BUSINESS PHONE	BUSINESS FAX				

INSURANCE

PRIMARY INSURANCE NAME	POLICY NUMBER	GROUP NUMBER *if any*
SUSCRIBER NAME	RELATION TO PATIENT	
SECONDARY INSURANCE NAME	POLICY NUMBER	GROUP NUMBER *if any*
SUSCRIBER NAME	RELATION TO PATIENT	

IN CASE OF EMERGENCY — Contact (if unable to reach parent):

LAST NAME	FIRST NAME	PHONE	RELATIONSHIP

Who may we thank for your referral? INTERNET ☐ _____ ADVERTISEMENT ☐ _____ PHYSICIAN REFERRAL ☐ _____

PATIENT REFERRAL ☐ _____ OTHER ☐ _____ WELCOME WAGON ☐

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Guarantor Financial Agreement and Authorization for Treatment

PRACTICE POLICIES

- New England Pediatrics accepts cash, check or credit card as a form of payment.
- You will receive a monthly statement if you have a balance due. Patient balances more than 30 days overdue are subject to an 18% annual interest charge.
- If we must refer your account to a collection agency or law firm to collect an unpaid balance, you will have to pay the costs of collection as well as the unpaid balance in order to remain a patient of our practice.
- If your account is placed in collection for failure to pay an outstanding balance, we reserve the right to discontinue our services. If we take this action, we will send you a medical records release for your signature so that you may transfer care and records to a new physician.
- You are responsible for any bank charges associated with checks not honored by our bank.
- If there is an outstanding patient balance for more than 60 days, we cannot schedule well child care.
- Well visits not cancelled 24 hours before the scheduled time are subject to a $50 charge. Sick visits not cancelled at least 2 hours prior to the scheduled time are subject to a $25 charge.
- New England Pediatrics reserves the right to charge a reasonable and customary fee for the completion of forms and applications and the preparation of medical records for transfer. Payment is due upon receipt of the document(s).
- I understand New England Pediatrics (NEP) may obtain my prescription history and preferred medications from a centralized database to assist in my care and I authorize NEP to do so.

IF YOU HAVE PRIVATE INSURANCE OR ARE UNINSURED

- Professional services rendered are charged to the patient. Payment is expected when services are rendered.
- We will not bill your insurance company. New England Pediatrics will provide you with an “Attending Doctor Statement” or “Encounter Form” at each visit so that you may file a claim with your insurance company.

IF YOU HAVE A MANAGED CARE PLAN IN WHICH WE PARTICIPATE

- If you have a managed care plan in which we participate, you are responsible to provide us with current and accurate information at each visit.
- You are responsible for fees incurred if we do not have your current insurance information at the time of service.
- Co-pays must be paid at the time of service. Failure to do so will result in an additional $10 charge.
- Your child’s name should appear on your insurance card (plan dependent).
- If a doctor’s name is required on the card as your Primary Care Provider (PCP), it must be the name of a New England Pediatrics doctor, otherwise full payment may be due at the time of the visit.
- You may be responsible for fees if routine services provided are not covered by your insurance plan, or if your insurance company denies payment for covered services.

I, _____ *print name of responsible party*

authorize New England Pediatrics to treat my child/children. I have read and agree to the financial terms outlined herein.

SIGNATURE OF RESPONSIBLE PARTY DATE

RELATIONSHIP TO PATIENT

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New England Pediatrics

PEDIATRIC HEALTH HISTORY FORM (one per child)

Patient Name _____ DOB: ____/____/____

Parent/Guardian Name _____ Date: ____/____/____ Relationship: _____

Present Health Concerns: _____

MEDICATIONS: Please list all prescription and non-prescription medications, vitamins, home remedies, birth control, herbs etc.

Medication Name	Dose	Frequency

ALLERGIES: List all reactions to medicines, foods and other agents.

Allergy	Reaction or Side Effect

* If the patient is taking 3 or more medications please bring them with you to each appointment.

PERSONAL MEDICAL HISTORY: Please indicate (circle) whether the patient has had any of the following medical problems.

- ☐ Asthma/Wheezing
- ☐ Anemia/ Bleeding Problem
- ☐ Pneumonia
- ☐ Diarrhea
- ☐ Hearing Problems
- ☐ Diabetes

Other _____

- ☐ Heart Disease/Murmur
- ☐ Ear Infections
- ☐ Convulsions/Epilepsy
- ☐ Constipation
- ☐ Headache

Other _____

- ☐ Vision Problems
- ☐ Environmental Allergy
- ☐ Bladder/Kidney Infections
- ☐ Skin Problems
- ☐ Developmental Delay

Other _____

HOSPITALIZATIONS/OUTPATIENT PROCEDURES: Please list all prior hospitalizations/serious illnesses and dates.

Reason for hospitalization	Date

IMMUNIZATIONS: Please attach a list or list immunization dates that the patient has received at other health care facilities.

Hepatitis A: _____ DTaP: _____ Polio: _____ Prevnar: _____ MMR: _____

Hepatitis B: _____ Pneumovax: _____ Tdap: _____ Varicella: _____ Menactra: _____

HIB : _____ HPV : _____ MenQuadfi: _____ Other: _____

COMMUNICABLE DISEASES: Has your child ever had any of the following infectious disease(s)?

- ☐ Chickenpox
- ☐ Covid 19
- ☐ Measles
- ☐ RSV
- ☐ Mumps
- ☐ Rubella
- ☐ Meningitis
- ☐ Tuberculosis (TB)

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PREGNANCY & BIRTH:

Is the child yours by: ☐ Birth ☐ Adoption ☐ Stepchild ☐ Other: _____

Method of Delivery: ☐ Vaginal ☐ Caesarean

Hospital of Birth: _____ Country of Birth: _____

Were there any medical problems during pregnancy? ☐ Yes ☐ No

If yes, please explain: _____

☐ Maternal smoking ☐ Alcohol ☐ Drugs ☐ Medications

Were there any problems during labor and delivery? ☐ Yes ☐ No

If yes, please explain: _____

After the baby's birth, were there any problems such as needing oxygen, trouble breathing, jaundice (yellowness), infection etc? ☐ Yes ☐ No

If yes, please explain: _____

Birth weight/length: _____ lbs_____oz

Was your child born prematurely? ☐ Yes ☐ No If yes how early? _____

SLEEP:

Hours per night: _____ How many naps per day: _____

Does your child have any sleep problems? ☐ Yes ☐ No

If yes, please explain: _____

NUTRITION & FEEDING:

Type of feeding as newborn/infancy: ☐ Formula ☐ Breastfed If breastfed, for how long? _____

Has your child had any feeding/dietary problems or restrictions? ☐ Yes ☐ No

If yes, please explain: _____

Milk intake now: ☐ Soy Milk ☐ Rice Milk ☐ Cow's Milk (_____%) ☐ Other, please specify:_____

Ounces per day: _____

Has your child seen a dentist? ☐ Yes ☐ No If yes, date the last visit: _____

What is the water source at the house? ☐ City ☐ Well

Does your child use a bottle? ☐ Yes ☐ No Pacifier? ☐ Yes ☐ No

DEVELOPMENT (May skip this section if child is older than age 12):

At what age did your child: Sit Alone _____ Walk Alone _____ Say Words ____ Toilet Trained (Daytime) ____ Dry at Night ____

Any concerns about growth or progress with rolling over, walking, riding a tricycle, dressing themself, feeding themself, or potty training?
☐ Yes ☐ No

If yes, please explain: _____

Any concerns about language or speech development? ☐ Yes ☐ No

If yes, please explain: _____

In the car, does your child use: ☐ Infant seat ☐ Booster Seat ☐ Seatbelt Only

Does your child wear a helmet while riding a bike? ☐ Yes ☐ No

Do you have concerns about your child's behavior at home or in groups with other children? ☐ Yes ☐ No

If yes, please explain: _____

For Female Patients Only: Age at first menstrual period: _____

SOCIAL HISTORY:

☐ See Sibling Record

Parents are: ☐ Married ☐ Never Married ☐ Separated ☐ Divorced If divorced, for how long? _____

Mother/Parent #1 Occupation: _____ Employer: _____ Not Employed: ☐

Father/Parent #2 Occupation: _____ Employer: _____ Not Employed: ☐

Child's Primary Language: _____ Other language spoken at home: _____

Lived outside of USA? ☐ Yes ☐ No Where: _____ How Long: _____

Do any household members smoke? ☐ Yes ☐ No Is violence in the home of concern? ☐ Yes ☐ No

Are guns present in the home? ☐ Yes ☐ No Under LOCK? ☐ Yes ☐ No

Would you like to speak with the physician regarding your child's:

Alcohol Use ☐ Yes ☐ No Tobacco Use ☐ Yes ☐ No Sexual Activity ☐ Yes ☐ No Mental Health ☐ Yes ☐ No

How many hours per day does your child spend on:

Watching TV _____ On the Computer/iPad/Phone _____ Playing Video Games _____

Any concerns about lead exposure due to having an old home, or because of plumbing, and peeling paint? ☐ Yes ☐ No

Smoke detectors in your home? ☐ Yes ☐ No

Who lives at the home with the patient?

Name	Age	Relationship	Highest Level of Education

SCHOOL HISTORY:

Did/Does your child attend school/preschool? ☐ Yes ☐ No Current grade in school? _____

Which school? _____

Do you have concerns with how your child is doing in school? ☐ Yes ☐ No

Any concerns about relationships with teachers or other students? ☐ Yes ☐ No

If more than 4 years old: does your child have a best friend? ☐ Yes ☐ No

Does your child play any sports? ☐ Yes ☐ No Which sports? _____ Hours per week? _____

Other physical activities: (dance, gymnastics, Tai Kwan Do): _____

Does your child have special needs? (504, IEP, Assistive Technology, Paraprofessional): ☐ Yes ☐ No

If yes, please explain: _____

FAMILY HISTORY:

Indicate with an (X) who in your child's family has had the following conditions. ☐ See Sibling Record

In the first column please indicate living status. L=Living, D=Deceased, U=Unknown.

	Living Status	Asthma	Diabetes	High Blood Pressure	Stroke/Heart Disease	Hearing Loss	Kidney Disease	Cancer (type)	Drug/ Alcohol Abuse	Depression/ Anxiety	Other (Genetic Thyroid)
Mother/Parent 1											
Father/Parent 2											
Siblings											
Maternal Grandmother											
Maternal Grandfather											
Paternal Grandmother											
Paternal Grandfather											
Other											

Acknowledgment of Receipt of Notice of Privacy Practices

New England Pediatrics

We are required by State and Federal laws, including the HIPAA Rules, to safeguard general and health-related information about you. We have created a Notice of Privacy Practices that explains how your protected health information is handled. The Notice of Privacy Practices is provided to patients (and/or authorized representatives) when they first become our patient.

We are asking you to sign this form to show that we offered you a copy of our Notice of Privacy Practices. By signing below, you are only acknowledging that you were offered or received a copy of the Notice of Privacy Practices. You are not making a statement about the content of the Notice of Privacy Practices or about your agreement or disagreement with any portion of it.

This document is to be signed by a person legally responsible for the following patients' medical decisions:

ACKNOWLEDGEMENT

_____ Patient Name

_____ Patient Name

_____ Patient Name

_____ Patient Name

I acknowledge that New England Pediatrics, LLP has offered or provided me with a copy of its Notice of Privacy Practices, which describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact:

PRIVACY CONTACT: Jason Davis, MD 203.972.5232

I also understand that I am entitled to receive updates upon request if New England Pediatrics, LLP amends or changes its Notice of Privacy Practices in a material way.

Printed Name of Patient or Patient(s)'Authorized Representative: _____

Relationship to Patient: _____

Signature of Patient or Patient(s)'Representative: _____

Date: _____

Everything below this line is for OFFICE USE ONLY

This section is to be completed by New England Pediatrics, LLP if unable to obtain written acknowledgement from patient. I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

☐ Patient declined to sign this Written Acknowledgment.

☐ Other (Specify) _____

Name of Employee _____

Title of Employee _____

Date _____

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