Lake Forest Pediatric Associates

New Patient Questionnaire

Today's Date _____

Name of Child _____ Date of Birth_____

Household

Please list all those living in the child's home

Name	Relationship to Child	Birth Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If mother and father are not living together or if child does not live with parents, what is the child's custody status?

Birth history

Were there any complications during the pregnancy? No ❑ Yes ❑ Please give details:

Did mother take drugs or prescribed medications? No ❑ Yes ❑

Did mother smoke? No ❑ Yes ❑

Was the baby full term ❑ or premature ❑ how early?

Where was the baby born?

What was the birth weight?

Were there any complications of labor or delivery? No ❑ Yes ❑

Were there any newborn problems after birth? No ❑ Yes ❑ Please give details:

Name of Child _____ Date of Birth_____

Your Child's Health

Has your child ever been seen by a subspecialist? No ❑ Yes ❑

Do you consider your child to be in good health? No ❑ Yes ❑

Has your child ever been hospitalized overnight? No ❑ Yes ❑

Has your child ever had surgery? No ❑ Yes ❑

Has your child had any chronic or serious illnesses? No ❑ Yes ❑

Has your child had any major injuries? No ❑ Yes ❑

Is your child **allergic** to any medications? No ❑ Yes ❑

Is your child **allergic** to anything else? No ❑ Yes ❑

Is your child currently taking any medication? No ❑ Yes ❑

Are your child's immunizations [shots] current? No ❑ Yes ❑

Development

Has your child had any problems or delays in development? No ❑ Yes ❑

Does your child receive any therapy or any special services at school? No ❑ Yes ❑

Does your child have any behavioral or discipline problems? No ❑ Yes ❑

Has your child failed or repeated a grade in school? No ❑ Yes ❑

Past Medical History (Skip this section if your child is a newborn)

Does your child have or has he/she ever had:

Frequent ear infections No ❑ Yes ❑

Problems with ears or hearing No ❑ Yes ❑

Nasal allergies No ❑ Yes ❑

Problems with eyes or vision No ❑ Yes ❑

Asthma, bronchitis, or bronchiolitis No ❑ Yes ❑

Pneumonia No ❑ Yes ❑

Chickenpox or shingles No ❑ Yes ❑

Heart problem or murmur No ❑ Yes ❑

Anemia or bleeding problem No ❑ Yes ❑

Blood transfusion No ❑ Yes ❑

Frequent abdominal pain No ❑ Yes ❑

Name of Child _____ Date of Birth_____

Frequent constipation	No ❑ Yes ❑
Bladder or kidney infection or bedwetting	No ❑ Yes ❑
[for girls] has she started her menstrual periods?	No ❑ Yes ❑
[for girls] any problems with her periods?	No ❑ Yes ❑
Skin problems – eczema, acne	No ❑ Yes ❑
Frequent headaches	No ❑ Yes ❑
Seizures, convulsions, or epilepsy	No ❑ Yes ❑
Diabetes	No ❑ Yes ❑
Thyroid or other endocrine problems	No ❑ Yes ❑
Use of alcohol or drugs	No ❑ Yes ❑
Learning or attention problems	No ❑ Yes ❑
Any other significant problem	No ❑ Yes ❑

Your child's environment

Does anyone in the household smoke?	No ❑ Yes ❑
Does someone else care for your child during the day or after school?	No ❑ Yes ❑
Is your home childproofed?	No ❑ Yes ❑
Are there firearms in your home?	No ❑ Yes ❑
If yes, are they locked up?	No ❑ Yes ❑
Are there working smoke and carbon monoxide detectors at home?	No ❑ Yes ❑
Does your family always use seat belts / car seats?	No ❑ Yes ❑
Is anyone in your family getting hit or abused?	No ❑ Yes ❑
Has your child been exposed to anyone with tuberculosis?	No ❑ Yes ❑
Does your drinking water come from a well?	No ❑ Yes ❑
Are there any pets in the home?	No ❑ Yes ❑

Family Medical History

Has any blood relative on either side of the family had:		who?
Heart disease, or heart attack before age 50	No ❑ Yes ❑	
High blood pressure	No ❑ Yes ❑	
Elevated cholesterol or triglycerides	No ❑ Yes ❑	

Name of Child _____ Date of Birth_____

Diabetes or sugar problems	No ❑ Yes ❑
Cancer	No ❑ Yes ❑
Thyroid disease	No ❑ Yes ❑
Kidney disease	No ❑ Yes ❑
Asthma	No ❑ Yes ❑
Emphysema	No ❑ Yes ❑
Cystic fibrosis	No ❑ Yes ❑
Tuberculosis	No ❑ Yes ❑
Hepatitis	No ❑ Yes ❑
Cirrhosis	No ❑ Yes ❑
Ulcerative colitis	No ❑ Yes ❑
Crohn's disease	No ❑ Yes ❑
Bleeding or clotting disorder	No ❑ Yes ❑
Immune deficiency disorder	No ❑ Yes ❑
HIV or AIDS	No ❑ Yes ❑
Arthritis	No ❑ Yes ❑
Seizures or convulsions	No ❑ Yes ❑
Stroke	No ❑ Yes ❑
Neurologic disorder	No ❑ Yes ❑
Psychiatric disorder	No ❑ Yes ❑
Attention or learning disorder	No ❑ Yes ❑
Birth defects	No ❑ Yes ❑

Height of Father _____ Mother _____

_____ _____ _____

Person completing this form Signature Date

_____ _____ _____

Provider reviewing this form Signature Date

☐ Scan in to Chart

LFPA Account #_____

Lake Forest Pediatric Associates

Notice of Privacy Practices
Acknowledgement & Authorization Form

Patient Name: DOB:

Notice of Privacy Practices (NPP)

The Notice of Privacy Practices (NPP) explains how Lake Forest Pediatric Associates (LFPA) may use and share your protected health information (PHI). It also describes your rights with respect to your PHI.

- LFPA will use and share your PHI to treat you and to bill for the services we provide.
- LFPA will use and share your PHI in the general course of operating our business.
- LFPA will use and share your PHI as required and allowed by law.

Phone Message and Contact Authorization

Do the physicians and staff of Lake Forest Pediatric Associates have your permission to leave messages containing medical and/or financial information on your voice mail? Please CHECK the appropriate answers below:

☐ YES ☐ NO*

**LFPA utilizes an automated system for calling and reminding patients of their appointment date, time, and location. If you check "NO", you will still receive an appointment reminder phone call, which may leave a voice mail message.*

Authorized Individuals

I give authorization to the doctors and staff of Lake Forest Pediatric Associates to discuss my/my child's protected health information (PHI) and financial information with the following people.
The individual(s) named below will also be considered emergency contact(s) unless you specify otherwise.

	NAME	RELATIONSHIP	PHONE
1			
2			
3			

I understand that the NPP is available on the LFPA website (www.lakeforestpediatrics.com) and at my physician's office.
I acknowledge receipt of the LFPA Notice of Privacy Practices (NPP).
I understand that it is my responsibility to inform LFPA of any desired changes to the list of authorized individuals.

Signature of Patient (if 18 years or older), Parent or Guardian Print Name Date

LFPA Account #_____

Lake Forest Pediatric Associates

Financial Policy & Consent For Medical Treatment

Patient Name: DOB:

Account Responsibility

As the patient, or parent/guardian of a child, registered with Lake Forest Pediatrics (LFPA), you are agreeing to accept responsibility for all balances incurred on behalf of the named patient's medical care. Patient balances are due within 14 days of receipt of a statement. If you feel your statement is incorrect, have a concern regarding insurance, or are experiencing financial difficulties please contact our business office ASAP at (847) 295-2260.

The individual (patient or parent/guardian) signing this Financial Policy will be responsible for any charges associated with the patient's account. If a divorce or custody decree requires the other parent to pay all or part of the costs, it is the authorizing parent's responsibility to collect from the other parent. LFPA will not intervene to determine a parent's responsibility for payment.

Co-Pays & Payment at the Time-Of-Service

If required by your insurance plan, you will be expected to pay your co-pay each time your child is seen in our office.
LFPA accepts cash, checks, and all major credit cards.

Additionally, payment will be expected at the time of service when:

- LFPA is not contracted with the patient's insurance plan
- LFPA is not able to verify insurance eligibility
- The patient does not have insurance coverage
- The patient has new insurance coverage, but is unable to provide an insurance card

Professional Services Rendered & Fees

If the patient is seen for a scheduled preventive visit and another condition is treated at the same time, the provider will bill for each service performed in accordance with CPT coding/billing guidelines.

Fees will be charged for the following:

After Hours Phone Calls	$25
Sunday/Holiday	$25
NSF Check	$35
No Show (regular visit)	$35
No Show (extended visit)	$70
Replacement Forms	$10

Past Due & Collection Accounts

Delinquent accounts may be placed with an outside collection agency. If placed with an agency, the account will be assessed a 30% collection fee. **Placement of an account with an agency will result in termination of the patient/provider relationship.**

■I acknowledge that I have read and understand the policies stated above and agree to accept financial responsibility for the services rendered to the patient. I understand that LFPA may file a claim, on my behalf, with my insurance company and that any balance not paid by insurance is my responsibility (contractual write offs excepted). I understand that LFPA can only code and file a claim for medical services with a diagnosis that was encountered and documented in the medical record. Altering a diagnosis code in order to secure insurance payment is inappropriate and fraudulent.

■I authorize the release of any medical information necessary to facilitate the processing of insurance claims.

■I authorize and consent to the providers at Lake Forest Pediatric Associates providing treatment for the patient.

Signature of Patient (if 18 years or older), Parent or Guardian Print Name Date