BUCKLEY ROAD PEDIATRICS

Patient Demographic Information:

Patient's First Name:_____**Last Name:**_____

DOB:_____**Sex assigned at birth:** Male / Female

Cultural Demographics:

Race: ○African American ○Asian ○Pacific Islander ○White ○Other_____

Ethnicity: ○Hispanic ○Non-Hispanic ○Prefer not to specify

Parent Information:

Mother / Father / Guardian:

First Name:_____**Last Name:**_____

Maiden Name:_____**DOB:**__/__/_____

Address:_____

City:_____**State:**_____**Zip:**_____

Primary Phone: (____)____-_____ Home / Cell / Work

Secondary Phone: (____)____-_____ Home / Cell / Work

Employer: _____

Mother / Father:

First Name:_____**Last Name:**_____

Maiden Name:_____**DOB:**__/__/_____

Address:_____

City:_____**State:**_____**Zip:**_____

Primary Phone: (____)____-_____ Home / Cell / Work

Secondary Phone: (____)____-_____ Home / Cell / Work

Employer: _____

Who does the Patient primarily live with? (please check one)

○Mother ○Father ○Both ○Guardian

****PLEASE FILL OUT AND SIGN BACK SIDE****

Pharmacy Information:

Primary:
Pharmacy Name:_____
Pharmacy Address:_____
Pharmacy Phone: (___)___-_____

Secondary: (optional)
Pharmacy Name:_____
Pharmacy Address:_____
Pharmacy Phone: (___)___-_____

Insurance Information:

Primary:
Insurance Name:_____**ID#:**_____
Subscriber Name:_____**DOB:**__/__/_____
Employer:_____

Secondary: (optional)
Insurance Name:_____**ID#:**_____
Subscriber Name:_____**DOB:**__/__/_____
Employer:_____

Emergency Contact:

If you wish to have an emergency contact please put someone not listed on page 1.

First Name:_____**Last Name:**_____

Primary Phone: (___)___-_____ Home / Cell / Work

Secondary Phone: (___)___-_____ Home / Cell / Work

Relation:_____

By signing below I hereby authorize the above information is accurate:

_____ _____
Signature of Patient or Legal Guardian Date:

****IF THIS DOCUMENT IS NOT SIGNED IT WILL BE CONSIDERED AN INVALID DOCUMENT AND WILL NOT BE ENTERED INTO THE CHART****

“Talk Soft” Automation Confirmation System

“Talk Soft” is an electronic confirmation system that will contact you about an upcoming appointment. Please note that “talk Soft” is not a guarantee of confirmation due to rescheduling or canceling of appointments. If you are unsure of an upcoming appointment please call the office. It is the patient’s responsibility regarding appointments.

- ☐ I would like to sign up for “Talk Soft”
- ☐ I would like to **Decline** “Talk Soft”

Patient’s Name:_____**DOB:**_____

Please list the following:

Primary Phone:(____)_____-_____

Secondary Phone:(____)_____-_____

Email:_____

Please write in numerical order of how you would like to receive reminders from 1-3.

___Primary Phone Call:

___Primary Phone Text:

___Secondary Phone Call:

___Mailed Letter:

___Portal / Email:

Patient’s Signature:_____Date:_____

-OR-

Parent/Guardian Signature:_____Date:_____

Buckley Road Pediatrics, PLLC

SUMMARY OF PRIVACY PRACTICES

Dear Parents:

The treatment of your child(ren) is important to us. Please take a minute to read your rights regarding the privacy of their medical information and of our practice's policy and procedure relating to their medical information. Our practice has a formal privacy notice that is followed by all personnel associated with the practice. This is a summary of the notice, which you may review. The privacy notice details the allowable uses and disclosures of your child(ren)'s medical information that are:

Treatment; to provide your child(ren)'s care within our practice or with others involved in their care outside of the practice.

Payment; to provide our guarantor, your health insurance company or other responsible third part with information to allow for payment.

Healthcare options; for our practice operations

The privacy notice also explains your rights:

Right to inspect and copy; You have the right to inspect and receive a copy of your child(ren)'s medical information by a written request. There are limited occasions where a request will not be accommodated.

Right to request amendment; You have the right to ask the physician to amend your child(ren)'s medical information by written request. The physician is not obligated to allow an amendment.

Right to an accounting of disclosures; You have the right to an accounting of any disclosures of your child(ren)'s medical information not relating to the treatment, payment, healthcare operation or a prior release or an authorization.

Right to request restrictions; You have a right to restrict the use of your child(ren)'s medical information with a written request.

Right to confidential communication; You have the right to request that we communicate with you regarding medical matters in a certain way to help keep them confidential.

Right to a paper copy of the privacy note; You have the right to a paper copy of the full privacy notice. If you would like a copy, please ask a staff member for a copy.

Right to complain; You have a right to complain if you feel there is a problem with how our practice handles issues of privacy and confidentiality. If this should be your concern, please submit this request in writing. If you have questions regarding our practice's use and disclosures of your child(ren)'s medical information or your rights as a parent do not hesitate to ask a member of our staff for more explanation. Our goal is to make your child(ren)'s visits as pleasant as possible.

<u>Acknowledgment</u>

I acknowledge that I have received and reviewed a copy of this notice.

Patient, Parent, or Legal Guardian:

Print_____ Sign_____ Date_____

Patient Name:_____ DOB_____

Authorization to share medical information:

Patient Name:_________________________________ Date of Birth:___/___/______

Legal Guardian:____

Legal Guardian:____

- The above patient is receiving care at Buckley Road Pediatrics, PLLC. This authorization is valid at Buckley Road Pediatrics 5116 W Taft Rd Liverpool, NY 13088 until revoked or modified at any time by myself/legal guardian in writing and won't affect any release prior to modification or revocation of this authorization.
- I hereby authorize Buckley Road Pediatrics to share information regarding my/my child's medical care with the individual(s) that are over the age of 18 and to the degree that I have specified below.
- I understand that this authorization may be revoked in writing at any time and that this revocation will be honored with the exception of any previous requests processed.

I authorize the following individual:__________________________________to:
(name and relation)

____Discuss medical treatment/Bring to appointments ____Discuss billing/collection issues
____Pick up any copies of medical records ____Schedule/Modify appointments
Phone#:_______________ **[ ]** Leave call back number only **[ ]** Leave full detailed message

I authorize the following individual:__________________________________to:
(name and relation)

____Discuss medical treatment/Bring to appointments ____Discuss billing/collection issues
____Pick up any copies of medical records ____Schedule/Modify appointments
Phone#:_______________ **[ ]** Leave call back number only **[ ]** Leave full detailed message

I authorize the following individual:__________________________________to:
(name and relation)

____Discuss medical treatment/Bring to appointments ____Discuss billing/collection issues
____Pick up any copies of medical records ____Schedule/Modify appointments
Phone#:_______________ **[ ]** Leave call back number only **[ ]** Leave full detailed message

I authorize the following individual:__________________________________to:
(name and relation)

____Discuss medical treatment/Bring to appointments ____Discuss billing/collection issues
____Pick up any copies of medical records ____Schedule/Modify appointments
Phone#:_______________ **[ ]** Leave call back number only **[ ]** Leave full detailed message

By signing below I hereby authorize to share the above information

____ ______________
Signature of Patient or Legal Guardian Date:

Patient Responsibility / Terms & Conditions

Patients Name:_____DOB:_____

Please be advised that it is solely the patient's responsibility to remember appointments and to show up on time or call prior to the scheduled appointment to cancel so that the time slot can be used for other patients. Our courtesy call reminder calls are simply a courtesy and are not guaranteed. If you do not receive the reminder call, message or other form of reminder, it is still the patient's responsibility to keep the appointment and show up on time. We do understand that emergencies happen, but please be respectful and cancel or reschedule any appointments in advance to the scheduled time.

I understand that it is my responsibility to schedule, remember, and keep my child's appointment and it is also my responsibility to cancel or reschedule my child's appointment if I am unable to keep the appointment before the scheduled appointment date and time.

Print Name:_`_____

*Signature:*_____Date:_____

I authorize payment of medical benefits to undersigned physicians for services.

*Signature:*_____

I authorize release of any medical information necessary to process insurance claims. Also, I request payment of governmental benefits to myself or the party whom accepts assignment below

*Signature:*_____

If insurance does not cover the visit, I will be financially responsible for the bill.

*Signature:*_____

Initial History Questionnaire

Name

ID NUMBER

FORM COMPLETED BY

DATE COMPLETED

BIRTH DATE

AGE

☐ M ☐ F

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names, ages, and where they live. _____

What is the child's living situation if not with both biological parents?

☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody

☐ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

Birth History ☐ Don't know birth history

Birth weight _____ Was the baby born at term? _____ OR _____ weeks

Were there any prenatal or neonatal complications?

☐ Yes ☐ No Explain _____

Was a NICU stay required? ☐ Yes ☐ No Explain _____

During pregnancy, did mother

Use tobacco ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No

Use drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins

What _____ When _____

Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, why?

Was initial feeding ☐ Formula ☐ Breast milk How long breastfed? _____

Did your baby go home with mother from the hospital?

☐ Yes ☐ No Explain _____

General DK = don't know

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ DK Explain _____

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ DK Explain _____

Has your child had any surgery? ☐ Yes ☐ No ☐ DK Explain _____

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ DK Explain _____

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ DK Explain _____

Do you feel your family has enough to eat? ☐ Yes ☐ No ☐ DK Explain _____

Biological Family History DK = don't know

Have any family members had the following?

Childhood hearing loss	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Asthma	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tuberculosis	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Heart disease (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
High cholesterol/takes cholesterol medication	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Anemia	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bleeding disorder	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Dental decay	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Cancer (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

(Biological Family History continued on back side.)

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Biological Family History *(Continued from front side.)* DK = don't know

Liver disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Kidney disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Diabetes (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bed-wetting (after 10 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Obesity	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Epilepsy or convulsions	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Alcohol abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Drug abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Mental illness/depression	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Developmental disability	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tobacco use	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

Additional family history _____

Past History DK = don't know

Does your child have, or has your child ever had,

Chickenpox	☐ Yes	☐ No	☐ DK	When _____
Frequent ear infections	☐ Yes	☐ No	☐ DK	Explain _____
Problems with ears or hearing	☐ Yes	☐ No	☐ DK	Explain _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Explain _____
Problems with eyes or vision	☐ Yes	☐ No	☐ DK	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	☐ DK	Explain _____
Any heart problem or heart murmur	☐ Yes	☐ No	☐ DK	Explain _____
Anemia or bleeding problem	☐ Yes	☐ No	☐ DK	Explain _____
Blood transfusion	☐ Yes	☐ No	☐ DK	Explain _____
HIV	☐ Yes	☐ No	☐ DK	Explain _____
Organ transplant	☐ Yes	☐ No	☐ DK	Explain _____
Malignancy/bone marrow transplant	☐ Yes	☐ No	☐ DK	Explain _____
Chemotherapy	☐ Yes	☐ No	☐ DK	Explain _____
Frequent abdominal pain	☐ Yes	☐ No	☐ DK	Explain _____
Constipation requiring doctor visits	☐ Yes	☐ No	☐ DK	Explain _____
Recurrent urinary tract infections and problems	☐ Yes	☐ No	☐ DK	Explain _____
Congenital cataracts/retinoblastoma	☐ Yes	☐ No	☐ DK	Explain _____
Metabolic/Genetic disorders	☐ Yes	☐ No	☐ DK	Explain _____
Cancer	☐ Yes	☐ No	☐ DK	Explain _____
Kidney disease or urologic malformations	☐ Yes	☐ No	☐ DK	Explain _____
Bed-wetting (after 5 years old)	☐ Yes	☐ No	☐ DK	Explain _____
Sleep problems; snoring	☐ Yes	☐ No	☐ DK	Explain _____
Chronic or recurrent skin problems (eg, acne, eczema)	☐ Yes	☐ No	☐ DK	Explain _____
Frequent headaches	☐ Yes	☐ No	☐ DK	Explain _____
Convulsions or other neurologic problems	☐ Yes	☐ No	☐ DK	Explain _____
Obesity	☐ Yes	☐ No	☐ DK	Explain _____
Diabetes	☐ Yes	☐ No	☐ DK	Explain _____
Thyroid or other endocrine problems	☐ Yes	☐ No	☐ DK	Explain _____
High blood pressure	☐ Yes	☐ No	☐ DK	Explain _____
History of serious injuries/fractures/concussions	☐ Yes	☐ No	☐ DK	Explain _____
Use of alcohol or drugs	☐ Yes	☐ No	☐ DK	Explain _____
Tobacco use	☐ Yes	☐ No	☐ DK	Explain _____
ADHD/anxiety/mood problems/depression	☐ Yes	☐ No	☐ DK	Explain _____
Developmental delay	☐ Yes	☐ No	☐ DK	Explain _____
Dental decay	☐ Yes	☐ No	☐ DK	Explain _____
History of family violence	☐ Yes	☐ No	☐ DK	Explain _____
Sexually transmitted infections	☐ Yes	☐ No	☐ DK	Explain _____
Pregnancy	☐ Yes	☐ No	☐ DK	Explain _____
(For girls) Problems with her periods	☐ Yes	☐ No	☐ DK	Explain _____

Has had first period ☐ Yes ☐ No Age of first period _____

Any other significant problem _____

This American Academy of Pediatrics Initial History Questionnaire is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 3rd Edition.

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