

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

WELCOME TO YOUR MEDICAL HOME



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

PATIENT INFORMATION Date ____/____/____

New Patient Update STAMFORD NEW CANAAN



PREFERRED PHARMACY _____

CHILDREN

DATE OF BIRTH

LAST	FIRST	CELL PHONE	SEX	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

DATE OF BIRTH

LAST	FIRST	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

DATE OF BIRTH

LAST	FIRST	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 <i>if any</i>
SUSCRIBER NAME	RELATION TO PATIENT	
SECONDARY INSURANCE NAME	POLICY NUMBER	GROUP NUMBER <i>if any</i>
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 _____

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

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 | Heart Disease/Murmur | Vision Problems |
| Anemia/ Bleeding Problem | Ear Infections | Environmental Allergy |
| Pneumonia | Convulsions/Epilepsy | Bladder/Kidney Infections |
| Diarrhea | Constipation | Skin Problems |
| Hearing Problems | Headache | Developmental Delay |
| Diabetes | Other _____ | Other _____ |
| 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: _____ Pevnar: _____ 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 | Measles | Mumps | Meningitis |
| Covid 19 | RSV | Rubella | Tuberculosis (TB) |

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 themselves, feeding themselves, 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: _____



Acknowledgment of Receipt of Notice of Privacy Practices

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 _____