PEDIATRIC PATIENT INFORMATION

PATIENT INFORMATION

Name:____
Address:______________________________________
City, State, Zip:_________________________________
Home Phone:___________________________________
Work Phone:___________________________________
Cell Phone:____________________________________
Email:____
Social Security Number:___________________________
Date of Birth_____________________________________
Sex: ☐M ☐F
Student Status: ☐Part-time ☐Full-time
Child resides with: ☐Mother & Father ☐Mother ☐Father ☐Other

In cases of divorce or separation, it is our policy that the parent who accompanies the child into the office for treatment is responsible for payment of service.

Is Patient Address same as Billing Address? ☐Yes ☐No
If No, write actual billing address/recipient here:

____
____
____

PRIMARY CARE PHYSICIAN

☐Dr. Cochran ☐Dr. Goldman ☐Dr. Pirozzi

EMPLOYMENT INFORMATION

Mother's Employer

Employer:______________________________________
Address:_______________________________________
City, State, Zip:_________________________________
Occupation:____________________________________

Father's Employer

Employer:______________________________________
Address:_______________________________________
City, State, Zip:_________________________________
Occupation:____________________________________

FAMILY INFORMATION

Mother/Guardian Name:____________________________
Date of Birth:____________________________________
Father/Guardian Name:_____________________________
Date of Birth:____________________________________
Sibling #1 Name:________________________________
Date of Birth:____________________________________
Sibling #2 Name:________________________________
Date of Birth:____________________________________
Sibling #3 Name:________________________________
Date of Birth:____________________________________

EMERGENCY CONTACT INFORMATION

Name:____
Home Phone:___________________________________
Work Phone:___________________________________
Cell Phone:____________________________________
Relationship to patient:__________________________

INSURANCE INFORMATION

PRIMARY INSURANCE

Company Name:_______________________________
ID/Policy #:___________________________________
Group #:_____________________________________
Cardholder Name:______________________________
Relationship:__________________________________
Social Security Number:________________________
Date of Birth:_________________________________
Employer:_____________________________________

Send Claims to:

Address:______________________________________
City, State, Zip:_______________________________

SECONDARY INSURANCE

Company Name:_______________________________
ID/Policy #:___________________________________
Group #:_____________________________________
Cardholder Name:______________________________
Relationship:__________________________________
Social Security Number:________________________
Date of Birth:_________________________________
Employer:_____________________________________

Send Claims to:

Address:______________________________________
City, State, Zip:_______________________________

REFERRAL INFORMATION

How were you referred to Ghent Family Practice?
☐Website ☐Friend
☐Another Physician ☐Existing Patient

Assignment of Benefits: I hereby assign all medical and/or surgical benefits to which I am entitled including major medical, Medicare, private insurance, and any other health plans to Ghent Family Practice. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be valid as the original. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of any and all information necessary to secure the payment.

PAYMENT IS EXPECTED AT TIME OF SERVICE

Signed:_______________________________________
Date:____

Ghent Family Practice, Inc.
3535 Granger Road
Akron, OH 44333
www.ghentfamilypractice.com
Phone: 330-666-3400 Fax: 330-665-5133

Updated By:_________________________ Date:_______________

GHENT FAMILY PRACTICE, INC.

COMPREHENSIVE CARE DATA BASE—AGE 0-15

Name:	Date of Birth:	Age:
Address: City: Zip:		Phone:
Mother:________________________ Phone: ________________________ Cell Phone: _____________________	Father:________________________ Phone:________________________ Cell Phone:_____________________	Custodial Parent/Guardian: ________________________________

CHILD'S BIRTH HISTORY

DURING PREGNANCY DID THE MOTHER:

HAVE HIGH BLOOD PRESSURE?	HAVE ANY OTHER INFECTIONS?	HAVE ANY PROBLEMS WITH LABOR OR DELIVERY?
HAVE DIABETES OR SUGAR IN HER URINE?	TAKE ANY MEDICATIONS, DRUGS, OR ALCOHOL?	HOW MUCH DID THE BABY WEIGH AT BIRTH? ________LBS. __________OZ.

WAS THE BABY PREMATURE? YES ☐ NO ☐ # WEEKS EARLY_______	AT THE TIME OF THE BIRTH OF THIS BABY, WHAT WAS THE AGE OF THE MOTHER?_____ WHAT WAS THE AGE OF THE FATHER?______
APGAR SCORE (IF KNOWN)_________________	
DID THE CHILD HAVE ANY PROBLEMS AFTER BIRTH? YES ☐ NO ☐ WAS HEPATITIS B VACCINE GIVEN AT BIRTH? DATE:________________	IF YES, WHAT KIND?___________________ ______________________________________

CHILD'S MEDICAL HISTORY

HAS YOUR CHILD EVER STAYED OVERNIGHT IN A HOSPITAL?

WHAT YEAR?	WHY?
1.	
2.	
3.	

CHILD'S HEIGHT:	CHILD'S WEIGHT:
WHAT MEDICINE DOES YOUR CHILD TAKE?	
WHAT MEDICINE IS YOUR CHILD ALLERGIC TO?	
IF FEMALE, WHAT WAS AGE AT ONSET OF MENSES?	

HAS YOUR CHILD HAD PROBLEMS WITH:

Mark only if YES

☐Ears/Hearing ☐Ear Infections
☐Eyes ☐Heart
☐Fractured Bones ☐Stomach or Bowels
☐Urinating

FAMILY HISTORY

Mark only if YES	**MOTHER**	**FATHER**	**MOTHER'S FAMILY**	**FATHER'S FAMILY**	**SIBLING**
Allergies	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Blood Disorder (including Sickle Cell)	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Elevated Cholesterol	☐	☐	☐	☐	☐
Heart Attack (<50 years of age)	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐
Mental Retardation	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐
Smoker in house	☐	☐	☐	☐	☐

IF YOU WISH TO MAKE ANY COMMENTS REGARDING THE "YES" ITEMS, USE THE BACK OF THIS FORM

Ghent Family Practice
Billing and Insurance Policies

Ghent Family Practice, Inc. welcomes you as a patient. We will make every effort to work with you and your insurer to maximize your healthcare benefits. Please notify us immediately of any changes in your insurance coverage. To avoid any problems and to expedite the services you may require, please be aware of the following:

1. Payment in full is expected at the time of the office visit **unless** you have an insurance plan with which we are contracted, then **your copay is due at the time of the visit. If you do not pay your copay at the time of the visit, it is subject to a $5.00 service charge.** Review your insurance contract closely. You may be responsible for multiple copay/co-insurance payments dependant upon services rendered.

2. The parent or child accompanying a minor child is responsible for payment of the child's care, unless other arrangements have been made with our office **prior** to the visit.

3. If you are billed for charges your insurance company should pay and didn't, please contact your insurance company to find out the status of the claim. We cannot intercede for you except to supply reasonable medical documentation.

4. Some insurance plans do not cover screening or preventative procedures or health assessment physicals. If you desire to proceed with these exams, you will be responsible for the costs. We will, of course, provide you with an estimate of that cost. If this practice provides services not covered by your insurance plan, you will be billed directly for those services.

5. We contract with many insurance plans including HMO's and PPO's. They often have restrictions on what is covered. They may require authorization for referrals to specialists and emergency room visits, as well as specifying where testing is done. We cannot know all the restrictions that may apply to your policy. We therefore suggest you take responsibility to understand your insurance plan. We have found that they will not pay if you do not follow their rules to the letter.

6. Notify us immediately of any changes to your insurance coverage. This ensures that your claims are paid in a timely manner. Since a copy of your insurance card is kept in your chart and referred to as necessary, please make sure we have a copy of the newest card.

7. Notify our Referral Department ***at least one week in advance*** of any appointments you have to see specialists or receive testing. This allows us time to complete a referral for you should one be required. If we are not notified you may end up financially responsible for those services. Calling us the day of your appointment could result in a denial from our physician to complete a referral. This office is prohibited from issuing ***retroactive*** referrals. We are not permitted by your insurance company to write a referral for a specialist visit after that visit has occurred.

8. If you are having financial difficulties, a budget payment plan can be arranged with our Billing Department. Please call to set this up as soon as you know you have a problem, thus avoiding unnecessary collection procedures. Ignoring billing statements leads us to believe that you don't appreciate our service, or don't intend to pay.

9. If you have any concerns or complaints about the healthcare benefits provided by your insurance company, we encourage you to contact your employer's Human Resources Department.

10. If you are experiencing any difficulties with your insurance benefits, you have access to the Consumer Services Division of the Ohio Department of Insurance. You can contact Consumer Services with complaints or concerns at 1-800-686-1526.

Managed Care has added much more overhead expense to our practice due to ever increasing constraints on payment, paperwork and getting medical care authorized. For these reasons we have instituted the above policies.

I have read, understand and agree with the above policies regarding billing and insurance for Ghent Family Practice, Inc.

______________________________ ________________

Patient Signature **Date**