

**LaGrange Pediatrics, LTD
4727 Willow Springs Road
LaGrange, Illinois 60525**

INITIAL HISTORY QUESTIONNAIRE

Child's Name _____ Birthdate: _____
 Father's Name _____ Mother's Name _____
 Address _____ Home # _____
 Employer (Father) _____ Work # _____
 Employer (Mother) _____ Work # _____
 Cell Phone (Father) _____ Cell Phone (Mother) _____

HOUSEHOLD (Please list all those living in child's home)

Name	Relationship to Child	Age	Health Problems	
_____	_____	_____	_____	Are there siblings or half siblings or step siblings not listed? If so, please list their names and ages and where they live. _____
_____	_____	_____	_____	_____
_____	_____	_____	_____	Have any of your children died? _____
_____	_____	_____	_____	If mother and father are not living together or if child does not live with parents, what is the child's custody status? _____
_____	_____	_____	_____	If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home? _____
_____	_____	_____	_____	_____

BIRTH HISTORY

Birth weight _____ Apgar Scores _____ Was the delivery Vaginal or Cesarean? If cesarean, why _____
 Was the baby born At term? Early? Late? If early, how many weeks' gestation? _____
 Did your baby have any problems right after birth? Yes No Explain _____
 Did mother have any illness or problems with her pregnancy? Yes No Explain _____
 Was initial feeding Breast? Bottle? Did your baby go home with mother from hospital? Yes No
 Explain _____
 During pregnancy, did mother smoke? Yes No Drink alcohol? Yes No Use drugs or medication? Yes No
 What _____ When _____

GENERAL

Are you concerned about your child's health? Yes No Explain _____
 Does your child have any serious illness or medical condition? Yes No Explain _____
 Has your child had serious injuries or accidents? Yes No Explain _____
 Has your child had any surgery? Yes No Explain _____
 Has your child ever been hospitalized? Yes No Explain _____
 Is your child allergic to any medicines or drugs? Yes No Explain _____
 In times of stress, do you have support available? Yes No Explain _____

DEVELOPMENT

Are you concerned about your child's physical development? Yes No Explain _____
 Are you concerned about your child's mental or emotional development? Yes No Explain _____
 Are you concerned about your child's attention span? Yes No Explain _____
 Is your child in school? Yes No Explain _____
 Are you concerned about his/her behavior in school? Yes No Explain _____
 Has he/she failed or repeated a grade in school? Yes No Explain _____
 Are you concerned about how he/she is doing in academic subjects? Yes No Explain _____
 Is he/she in special or resource classes? Yes No Explain _____
 Does he/she have problems getting along well with other children? Yes No Explain _____

INITIAL HISTORY QUESTIONNAIRE

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FAMILY HISTORY

Have any family members had the following? (including parents, grandparents, aunts, uncles and cousins)

Deafness	Yes	No	Who _____	Comments _____
Nasal allergies or food allergies	Yes	No	Who _____	Comments _____
Asthma	Yes	No	Who _____	Comments _____
Tuberculosis	Yes	No	Who _____	Comments _____
Heart disease (before 50 yrs old)	Yes	No	Who _____	Comments _____
High blood pressure (before 50 yrs old)	Yes	No	Who _____	Comments _____
High cholesterol	Yes	No	Who _____	Comments _____
Anemia	Yes	No	Who _____	Comments _____
Bleeding disorder	Yes	No	Who _____	Comments _____
Liver disease	Yes	No	Who _____	Comments _____
Kidney disease	Yes	No	Who _____	Comments _____
Diabetes (before 50 yrs old)	Yes	No	Who _____	Comments _____
Bed-wetting (after 10 yrs old)	Yes	No	Who _____	Comments _____
Epilepsy or convulsions	Yes	No	Who _____	Comments _____
Alcohol abuse	Yes	No	Who _____	Comments _____
Drug abuse	Yes	No	Who _____	Comments _____
Mental illness	Yes	No	Who _____	Comments _____
Mental retardation	Yes	No	Who _____	Comments _____
Immune problems, HIV or AIDS	Yes	No	Who _____	Comments _____
Cancer	Yes	No	Who _____	Comments _____
Additional family history				

PAST HISTORY

Does your child have, or has he/she ever had?

Chickenpox	Yes	No	When _____
Frequent ear infection	Yes	No	Explain _____
Problems with ears or hearing	Yes	No	Explain _____
Nasal allergies or food allergies	Yes	No	Explain _____
Problems with eyes or vision	Yes	No	Explain _____
Asthma, bronchitis, bronchiolitis or pneumonia	Yes	No	Explain _____
Any heart problem or heart murmur	Yes	No	Explain _____
Anemia or bleeding problem	Yes	No	Explain _____
Blood transfusion	Yes	No	Explain _____
Frequent abdominal pain	Yes	No	Explain _____
Constipation requiring doctor visits	Yes	No	Explain _____
Bladder or kidney infection	Yes	No	Explain _____
Bedwetting (after 6 yrs old)	Yes	No	Explain _____
(for girls) Has she started her menstrual periods	Yes	No	Explain _____
(for girls) Are there problems with her periods	Yes	No	Explain _____
Any chronic or recurrent skin problems (acne, eczema, etc.)	Yes	No	Explain _____
Frequent headaches	Yes	No	Explain _____
Convulsions or other neurological problems	Yes	No	Explain _____
Diabetes	Yes	No	Explain _____
Thyroid or other endocrine problem	Yes	No	Explain _____
Any other significant problem	Yes	No	Explain _____
Use of alcohol or drugs	Yes	No	Explain _____

LaGrange Pediatrics, LTD
 4727 Willow Springs Road
 LaGrange, Illinois 60525
 708-588-0088 (fax) 708-588-0588

Date _____ **Primary Doctor** _____ **Referred by** _____

Father's Information

Mother's Information

Full Name _____
 Birth Date ____ - ____ - ____ SS# ____ - ____ - ____
 Address _____
 City,St,Zip _____
 Home Phone _____
 Employer _____
 Employer Address _____
 Work Phone Number _____
 Cell Phone Number _____

Full Name _____
 Birth Date ____ - ____ - ____ SS# ____ - ____ - ____
 Address _____
 City,St,Zip _____
 Home Phone _____
 Employer _____
 Employer Address _____
 Work Phone Number _____
 Cell Phone Number _____

Emergency Contact Name _____ Phone Number _____

FULL NAME OF CHILD	SEX	BIRTHDATE	ALLERGIES
_____	M or F	_____	_____
_____	M or F	_____	_____
_____	M or F	_____	_____
_____	M or F	_____	_____
_____	M or F	_____	_____

PRIMARY INSURANCE INFORMATION:

Cardholder Name _____ ID # _____
 Group # _____ Effective Date _____
 DOB of Cardholder _____ Employer _____
 Insurance Co. Name _____ Address _____

I Hereby Authorize the Release of any medical or other information necessary to process a claim for reimbursement of medial care for my child(ren) provided by LaGrange Pediatrics, LTD. I authorize LaGrange Pediatrics, LTD to submit this claim directly to my insurance company, and I authorize my insurance company to make payments directly to LaGrange Pediatrics. I ALSO UNDERSTAND THAT IF MY INSURANCE DOES NOT RESPOND TO OR REJECTS ANY CLAIM, I AM RESPONSIBLE FOR PAYMENT.

Signature _____ Date _____

Statement of Financial Policies

LaGrange Pediatrics, LTD

Thank you for choosing our practice. We are committed to providing quality health care for your child. Your clear understanding of our financial policy is important. Please speak with someone in the business office if you have any questions.

Payment:

All payment is expected at the time of service unless other specific arrangements have been made with our office. Participating health insurance plans may have a deductible, co-insurance, or co-payment, which is the subscriber's responsibility to pay. These are due at the time of service by the person who accompanies the child to the office at the time of service. The responsibility for payment for services for any dependent children whose parents are divorced rests with the parent who seeks treatment. Any court ordered responsibility judgment must be determined between the individuals involved without the inclusion of our office.

We accept cash, personal in-state checks, Visa or Master Card.

There will be a fee for all returned checks.

Insurance:

We bill participating insurance companies as a courtesy to you. If you do not have insurance with which we participate, full payment is expected at the time of service.

Your insurance policy is a contract between you and your insurance company. You have certain responsibilities such as presenting your insurance card **at each visit** and paying deductible and co-pay at the time of service. It is your responsibility to inform us of any change in your address, phone number, or insurance information so we can ensure that correct billing, eligibility, and co-payment requirements are accurate. If new insurance information was not given at the time of service, any claim over 60 days old is your responsibility and must be paid directly to us. The responsibility of filing to the insurance company will be yours. You are expected to know what the covered benefits are under your policy, including co-pays and deductibles. Our office cannot always tell you in advance whether or not your charges will be covered by your insurance plan. Because we have no way to know all the individual insurance policies, it is your responsibility to contact your insurance if you are concerned as to whether a charge is covered.

You are responsible for any balance not covered by your insurance plan.

Financial Hardship:

We are not in the business of extending credit to our families. However, we understand that there may be occasions when a family faces financial hardship. Please contact our business office to make special arrangements.

Outstanding Balances:

Any charges remaining unpaid 60 days after the date of service are considered past due. Past due accounts must make arrangements with the billing office prior to scheduling well child appointments.

School, camp, or sport forms will not be provided for patients with past due charges unless arrangements for payments have been made with the billing office.

Accounts over 90 days past due will be considered seriously delinquent. Delinquent accounts are turned over to a collection agency when we have exhausted all other means of collection. Failure to provide payment for services rendered may result in discharge from the practice.

Responsibility for Payment and Assignment of Benefits:

I have read and understand the Financial Policy of LaGrange Pediatrics, Ltd. In consideration of services by LaGrange Pediatrics, Ltd., I agree to pay for all services rendered for the patient. If for any reason a portion of my bill is not paid by insurance, I agree to pay the remaining balance in full.

I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I will also be responsible for the fee charged by the collection agency for costs of collections.

I certify that the insurance information I have given is correct. I, for my child(ren), do assign any available medical benefit payments to LaGrange Pediatrics, Ltd.

PATIENTNAME(S): _____

PATIENTSIGNATURE: _____

Print Name

DATE: _____

**LaGrange Pediatrics, Ltd.
4727 Willow Springs Road
LaGrange, Illinois 60525**

**PATIENT CONSENT FOR USE OF DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

I hereby give my consent for LaGrange Pediatrics, Ltd. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (LaGrange Pediatrics, Ltd.'s Notice of Privacy Practices provides a more complete description of such uses and disclosures).

I have the right to review the Notice of Privacy Practices prior to signing this consent. LaGrange Pediatrics, Ltd. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to LaGrange Pediatrics, Ltd., Privacy Officer, 4727 Willow Springs Road, LaGrange, Illinois 60525.

With this consent, LaGrange Pediatrics, Ltd. may call my home or other alternative locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care including laboratory results among others.

With this consent, LaGrange Pediatrics, Ltd. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, LaGrange Pediatrics, Ltd. may e-mail to my home or other alternative locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have a right to request that LaGrange Pediatrics, Ltd. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to LaGrange Pediatrics, Ltd.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made a disclosure in reliance upon my prior consent. If I do not sign this consent, or later revoke it, LaGrange Pediatrics, Ltd. may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Patient Name(s) (please print)

Date

Print Name(s) of Patient or Legal Guardian

LaGRANGE PEDIATRICS, LTD.
4727 Willow Springs Road
LaGrange, Illinois 60525

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I, _____, have received a copy of
(patient(s) name)

LaGrange Pediatrics, Ltd.'s Notice of Privacy Practices.

Signature of Patient/Guardian

Date

LaGrange Pediatrics, Ltd.
4727 South Willow Springs Road
LaGrange, Illinois 60525
Phone (708) 588-0088 Fax (708) 588-0588

RECORDS RELEASE AUTHORIZATION

I hereby request that my medical records be released to the following office:

Dr. _____

Address _____

Patient Name: _____ Birthdate: _____
(Please Print)

Parent/Guardian _____
(Please Print)

Parent/Guardian Signature _____

Date of Request _____