DAYTON PEDIATRICS, P.C. PATIENT INFORMATION

Child's First Name:	Middle Name:	Last Name:	Nickname:

Age:	Birth Date:	Sex:	SSN:	Race:

Other Children's Full Name (if different last names)	Age:

Responsible Party and Primary Care Giver Information

Mother's Name:		**SSN:**
Address:		**Birth Date:**
Home Phone:	**Cell Phone:**	**Work Phone:**
Employer:	**Employer's Address**	
Father's Name:		**SSN:**
Address: (if different)		**Birth Date:**
Home Phone:	**Cell Phone:**	**Work Phone:**
Employer:	**Employer's Address:**	

Insurance Information
(We must have DOB of insured)

Primary Insurance Carrier:		
Insured Person:		**Birth date:**
ID#:	**Group#:**	**Co-payment Amt:**
Secondary Insurance Carrier:		
Insured Person:		**Birth Date:**
ID#:		**Group #:**

Emergency Contact (Someone other than parent)

Name:	**Phone:**
Address:	**Relation:**

Please list any one authorized to bring child to visit other than parents:

Name:	Relation:
Name:	Relation:
Name:	Relation:

DAYTON PEDIATRICS, P.C. PATIENT INFORMATION

PERMISSION FOR TREATMENT: I hereby authorize and consent to the care and treatment of my child, (or me personally if over age 18) including tests, procedures and medical treatments, diagnostic and otherwise, as Dr. James D. Nelson or his designee considers to be necessary or appropriate. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of the treatments or examinations performed.

_____Date:_____
Signature of Parent, Guardian or Patient (if older than 18)

RELEASE OF INFORMATION: Unless otherwise specifically limited below, I hereby authorize Dayton Pediatrics to release to my insurers, to other third party payers, or to such persons as may need access for the purpose set forth herein, any and all medical records and information, including those pertaining to medical history, mental or physical conditions, supplies or services rendered or treatment, for the purpose of review, investigation, evaluation of an application, processing of a claim, medical care review, utilization review, quality assurance review, financial or other audit or other purposes reasonably related to these purposes. This authorization and release of medical information does not authorize the release of the following medical information:
_____
_____

_____Date:_____
Signature of Parent, Guardian or Patient (if older than 18)

AUTHORIZATION FOR SCHOOLS NOTES: I authorize Dayton Pediatrics to send school notes by fax or email for any approved excused absences with or without restrictions.

_____Date:_____
Signature of Parent, Guardian or Patient (if older than 18)

FINANCIAL ARRANGEMENTS: I authorize, direct and assign benefits payable by given insurers to pay directly to Dayton Pediatrics any and all payable amounts up to the amount of my indebtedness with Dayton Pediatrics. I understand my insurance will be filed for amounts due. I understand that I am ultimately responsible for payment of my bill in full regardless of insurance status. I acknowledge that insurance claims are filed as a courtesy to me and any payment issues will be my responsibility. I understand and agree that I will promptly pay for services rendered to me by Dayton Pediatrics. I understand that should I fail to comply with payment agreements/obligations, my account may be referred for collections and I agree to pay all collection cost including reasonable attorneys fees.

I understand that for many reasons, including referral and predetermination requirements among others, insurance and other healthcare payers may not pay part or all of the costs associated with my treatment. In the event this occurs, I understand and agree to make payment in full.

I ALSO UNDERSTAND THAT CO PAYMENTS SET FORTH BY MY INSURANCE ARE DUE AND PAYABLE AT THE TIME OF SERVICE. I AGREE TO PAY THOSE CO PAYMENTS AS REQUIRED.

_____Date:_____

Signature of Parent, Guardian or Patient (if older that 18)

DAYTON PEDIATRICS, P.C. PATIENT INFORMATION

PEDIATRIC MEDICAL HISTORY FORM

Today's Date:_____Prepared By:_____

PATIENT'S NAME:_____

NICKNAME : _____DOB:_____AGE:_____ SEX:_____F___M_____

ADDRESS:_____

HOME PHONE:_____ RELIGION (OPTIONAL)_____

PARENT'S NAME: _____

REFERRED BY:_____

1. List any current medications patient is taking, including over the counter medications?_____

_____

2. Does the patient have allergies to food, grasses, pollen, insect bites or medications:_____

_

_____

3. How would you characterize the patient's health condition at this time? _____Good_____Fair_____Poor_____

4. Are patient's immunizations up to date? _____Yes_____No. Please provide us with the previous shot record.

5. Does the patient's family have a history of: _____Diabetes_____Epilepsy_____Asthma_____Allergies_____

6. Are there other children or adults in the home?_____Yes_____No. If yes, list relationship, sex and age:_____

_____

7. Does the patient have any known neurological or development condition?_____Yes_____No. If yes, please list the condition:_____

8. Please list any accidents or injuries the patient has experienced that effects their current health condition:_____

_____

9. List the patient's past surgeries and give the date:_____

10. Please list any hospital admissions, dates of admissions and the reason for those admissions to hospitals:_____

_____

11. Is patient in school_____Yes_____No. Where:_____Grade:_____