Croton Pediatrics
Boston Children's Health Physicians
Until every child is well®

BCHP REGISTRATION

DATE: _____

PATIENT NAME: _____ **MED REC NUMBER:** _____

PATIENT ADDRESS: _____

DATE OF BIRTH: _____ **AGE:** _____ **GENDER:** _____

RESPONSIBLE PARTY/GUARANTOR:

NAME: _____ RELATIONSHIP: _____ PHONE NUMBERS:
MAILING ADDRESS (if different than above): _____ HOME #: _____
_____ CELL #: _____
WORK #: _____

PARENT/GUARDIAN INFORMATION:

FATHERS NAME: _____ D.O.B.: _____ FATHERS PHONE #: _____

FATHERS ADDRESS (if different than above): _____
FATHERS E-MAIL: _____

MOTHERS NAME: _____ D.O.B.: _____ MOTHERS PHONE # _____

MOTHERS ADDRESS (if different than above): _____
MOTHERS E-MAIL: _____

EMERGENCY CONTACT INFO:

EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____

PHONE #: _____

INSURANCE INFORMATION:

PRIMARY INS NAME: _____ ADDRESS: _____
ID #: _____ GROUP #: _____ EFFECTIVE DATE: _____
CARDHOLDER: _____ CARDHOLDER D.O.B.: _____ SEX: _____
INSURANCE TELEPHONE #: _____

SECONDARY INS NAME: _____ ADDRESS: _____
ID #: _____ GROUP #: _____ EFFECTIVE DATE: _____
CARDHOLDER: _____ CARDHOLDER D.O.B.: _____ SEX: _____
INSURANCE TELEPHONE #: _____

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize BCHP to release information concerning treatment or services to the insurance carrier(s) responsible for myself or my dependent's care. I request the payment of authorized insurance benefits be made either to me or on my behalf to BCHP for these services. I have been advised that if my insurance requires a co-payment it is due at the time of the visit. Otherwise, a $15 surcharge will be added to my bill.

SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____

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PATIENT QUESTIONAIRE

Parent/Patient: Please complete the following Today's Date:

Patient Name _____ **Date of Birth** _____

Please answer the following:

Medications during pregnancy _____

Number of previous pregnancies _____ Number of previous pregnancies resulting in delivery _____

Age of mother at delivery _____

Child's weight at birth _____ lbs. _____ oz. Name of hospital child born at _____

Full Term ___ yes ____ no / premature? _____ weeks

Delivery _____ vaginal _____ cesarean Reason for C-section_____

If pregnancy was complicated, please explain: _____

Any problems in nursery (yellow skin color, difficulty breathing)? ___ yes ____ no

If yes, please explain _____

MEDICAL HISTORY

Please answer the following:

Feeding method as an infant ___breast ____formula until age in months _____

Solids (age in months) _____ Table food _____

Present diet _____Milk intake per day _____

Food sensitivities _____

Stools ____normal ____ abnormal, please explain _____

Vomiting ____ negative ____ positive, please explain _____

Hospitalizations/or Surgeries_____

Illnesses (ex. Asthma, diabetes) _____

Allergies to medications _____ Current Meds _____

EPI-PEN? ___YES___NO

DEVELOPMENTAL & SOCIAL HISTORY

Please answer at what age your child met developmental milestones and describe issues with school & behavior:

Roll over	____ age	Behavioral problems	_____
Sit up	____age	Marks in school	_____
Walk alone	____ age	Problems in school	_____
Talk (2words)	____ age	Diet Problems	_____
Toilet train	____ age	Sleep Problems	_____

ENVIRONMENTAL DEMOGRAPHICS

Type of Residence: ___Single Family ___Multi-family ___Condo ___Townhouse ___Apartment

Type of water source: ___Municipal___Well___Bottled

Any lead concerns? ___YES ___NO

Any smokers living in the home? ___YES ___NO

Does the residence have (CHECK ALL THAT APPLY):

___Smoke Alarms
___Carbon Monoxide Detectors
___Pool

___Pool
___Pets
___Gun

EDUCATION

Name of School: _____ Grade: _____

FAMILY PROBLEMS

Please check off the illnesses which relatives (including aunts, uncles, cousins, & grandparents) have:

Illness	Relative(s) & Details
Heart Disease/High blood pressure	
Stroke	
Allergy/Asthma	
Tuberculosis	
Cancer/Anemia	
Diabetes	
Miscarriage/Birth defects	
Infectious	
Seizures	
Mental illness	
Alcohol/drug abuse	
Other	

REVIEW OF SYSTEMS

Please check yes or no for the following symptoms your child may be experiencing. Please answer all questions

→		Y	N		Y	N		Y	N
	Weight loss			Weight gain			Fever		
Eyes	Redness			Discharge					
ENT	Frequent ear infections			Nose bleeds					
Respiratory	Difficulty breathing			Cough			Wheezing		
Cardiovascular	Murmur								
Gastrointestinal	Vomiting/diarrhea			Difficulty feeding					
Urinary	Bed wetting			Bladder problems					
Skin	Rash								
Musculoskeletal	Joint pain			Joint swelling					
Neurological	Headache								
Psychiatric	Substance abuse			Behavioral problems			Depression		
Allergic/immune	Recurrent infection			Allergy to food					
Hem/lymph	Pale skin			Bruising					
Endocrine	Urinating large amounts			Excessive thirst					

Parent/Patient Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____

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REQUEST FOR LIMITATIONS AND RESTRICTIONS OF PROTECTED HEALTH INFORMATION

Patient please note: **THE PRACTICE IS NOT REQUIRED TO AGREE TO YOUR REQUEST. PLEASE SEE OUR NOTICE OF PRIVACY PRACTICES FOR MORE INFORMATION REGARDING SUCH REQUESTS.**

Patient Name: _____ Date of Birth: _____

Patient Address: _____
Street

_____
Apartment #

_____
City, State, Zip

Type of PHI to be restricted or limited (Please check all that apply)

- ☐ Home Phone #
- ☐ Home Address
- ☐ Occupation
- ☐ Name of Employer
- ☐ Visit Notes
- ☐ Hospital Notes
- ☐ Prescription Information
- ☐ Patient History
- ☐ Office Address
- ☐ Office Phone #
- ☐ Spouse's Name
- ☐ Other: _____

How would you like to use and (or disclosure of) your PHI restricted?

_____

_____

_____ _____
Signature of Patient or Parent/Legal Guardian Date

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CREDIT CARD ON FILE POLICY

We ask that all patients maintain a valid credit card on file with us. **Any patient balances that are present 30 days after you have received a statement will be billed on your credit card**. Please be assured if there are financial circumstances that preclude you from settling your account, we are more than willing to work with you, but you must communicate this with our billing staff so arrangements can be made.

Your credit card information will be stored in an encrypted merchant services account. Pediatrics of Sleepy Hollow (and BCHP) only has access to the last 4 digits of your account number. Nothing is stored on site.

According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances. Patient balances are billed immediately upon receipt of your insurance plan's explanation of benefits. Your remittance is due within 30 days of receipt of your bill. For your convenience, we accept debit cards and credit cards.

Patient Name: _____ Date of Birth: _____

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Patient Name: _____ Date of Birth: _____

(Please Print Name)_____ authorizes Pediatrics of Sleepy Hollow/BCHP to charge my credit/debit card for the following reasons: Office Visits, Deductibles, Coinsurance, Copayments, Non-covered services, Cancellations and No show Fees.

X_____ Date: ____/____/____

Parent/Guardian Signature