PLEASE FILL OUT FORM AND SEND BY EMAIL (staff@sarmientomd.com) OR PRINT AND BRING TO FIRST VISIT

MARTA S. SARMIENTO M.D., INC., FAAP

PATIENT REGISTRATION

(Please Print)

Today's date:			❑ New patient	❑ Change of information	
PATIENT INFORMATION					
Patient's last name: First:		Middle:	Birth weight:	Birth length:	Hospital born at:
Is this patient's legal name? ❑ Yes ❑ No	If not, what is patient's legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:		Social Security no.:		Home phone no.: ( )	
City:	State:	ZIP Code:		Mobile phone no.: ( )	
Chose physician because/Referred to by (please check one box): ❑ Dr.				❑ Insurance Plan	❑ Hospital
❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other:					
Other family members seen here:					

PARENT INFORMATION					
Father's last name: First:		Middle:	Marital status (circle one) Single / Mar / Div / Sep / Wid		
Is this parent's legal name? ❑ Yes ❑ No	If not, what is parent's legal name?	(Former name):	Birth date: / /	Driver's License # :	
Street address (if different):		Social Security no.:		Home phone no.: ( )	
City:	State:	ZIP Code:		Mobile phone no.: ( )	
Occupation:	Employer:			Employer phone no.: ( )	
Mother's last name: First:		Middle:	Marital status (circle one) Single / Mar / Div / Sep / Wid		
Is this parent's legal name? ❑ Yes ❑ No	If not, what is parent's legal name?	(Former name):	Birth date: / /	Driver's License # :	
Street address (if different):		Social Security no.:		Home phone no.: ( )	
City:	State:	ZIP Code:		Mobile phone no.: ( )	
Occupation:	Employer:			Employer phone no.: ( )	
Permission to examine your child in your absence: ❑ Yes ❑ No					
Person who may bring your child:				Relation:	

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

Updated 02/06/2015

Today's Date:	Patient's Name	Birth date:

RESPONSIBLE PARTY (GUARANTOR)

Last name of person responsible for bill:	First:	Birth date: / /	Home phone no.: ( )

Street address (if different):	City:	State:	Zip:	Occupation:

Employer:	Employer address:	Employer phone no.: ( )

Patient's relationship to Guarantor: ❑ Self ❑ Spouse ❑ Child ❑ Other:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist at every visit.)

Is this patient covered by insurance? ❑ Yes ❑ No

Name of primary insurance: ❑ PPO ❑ EPO ❑ POS ❑ Other: _____

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other:

Name of secondary insurance (if applicable): ❑ PPO ❑ EPO ❑ POS ❑ Other: _____

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other:

PLEASE LIST OTHER CHILDREN IN FAMILY

Name:	Date of Birth:	❑ Male	❑ Female
Name:	Date of Birth:	❑ Male	❑ Female
Name:	Date of Birth:	❑ Male	❑ Female
Name:	Date of Birth:	❑ Male	❑ Female

PREFERRED PHARMACY

Name of Pharmacy:	Address:	Phone no.: ( )

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled to: Marta S. Sarmiento, M.D. This assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment. I authorize the use of this signature on all insurance submissions.

_____ _____

Patient/Guardian signature *Date*

FOR OFFICE USE ONLY

Patient Alert Information:

MARTA S. SARMIENTO, M.D., INC., FAAP

APPOINTMENT REMINDERS

Our office is pleased to announce that we can now offer appointment reminders via phone call and email. We will continue to verbally confirm appointments by phone call; however you can now receive an email reminder too. Please fill out all of the following information and indicate your preferred method of contact with a check mark.

(Please Print)

Today's date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Birth date: / /

CONTACT INFORMATION

Please check the box next to your preferred contact number

Home Phone no.: ( ) ❑

Mobile Phone no.: ( ) ❑

Work Phone no.: ( ) ❑

Email Address:

How would you like to receive appointment reminders?

❑ Phone call ❑ Phone call & Email

Initial History Questionnaire

FORM COMPLETED BY _____ DATE COMPLETED _____

Name _____

ID NUMBER _____

BIRTH DATE _____ AGE _____ M F

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names, ages, and where they live. _____

What is the child's living situation if not with both biological parents?

☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody

☐ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

Birth History ■ Don't know birth history

Birth weight _____ Was the baby born at term? _____ OR _____ weeks

Were there any prenatal or neonatal complications?

☐ Yes ☐ No Explain _____

Was a NICU stay required? ☐ Yes ☐ No Explain _____

During pregnancy, did mother

Use tobacco ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No

Use drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins

What _____ When _____

Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, why? _____

Was initial feeding ☐ Formula ☐ Breast milk How long breastfed? _____

Did your baby go home with mother from the hospital?

☐ Yes ☐ No Explain _____

General DK = don't know

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ DK Explain _____

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ DK Explain _____

Has your child had any surgery? ☐ Yes ☐ No ☐ DK Explain _____

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ DK Explain _____

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ DK Explain _____

Do you feel your family has enough to eat? ☐ Yes ☐ No ☐ DK Explain _____

Biological Family History DK = don't know

Have any family members had the following?

Childhood hearing loss	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Asthma	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tuberculosis	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Heart disease (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
High cholesterol/takes cholesterol medication	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Anemia	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bleeding disorder	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Dental decay	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Cancer (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

(Biological Family History continued on back side.)

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

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Biological Family History *(Continued from front side.)* DK = don't know

Liver disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Kidney disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Diabetes (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bed-wetting (after 10 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Obesity	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Epilepsy or convulsions	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Alcohol abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Drug abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Mental illness/depression	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Developmental disability	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tobacco use	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

Additional family history _____

Past History DK = don't know

Does your child have, or has your child ever had,

Chickenpox	☐ Yes	☐ No	☐ DK	When _____
Frequent ear infections	☐ Yes	☐ No	☐ DK	Explain _____
Problems with ears or hearing	☐ Yes	☐ No	☐ DK	Explain _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Explain _____
Problems with eyes or vision	☐ Yes	☐ No	☐ DK	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	☐ DK	Explain _____
Any heart problem or heart murmur	☐ Yes	☐ No	☐ DK	Explain _____
Anemia or bleeding problem	☐ Yes	☐ No	☐ DK	Explain _____
Blood transfusion	☐ Yes	☐ No	☐ DK	Explain _____
HIV	☐ Yes	☐ No	☐ DK	Explain _____
Organ transplant	☐ Yes	☐ No	☐ DK	Explain _____
Malignancy/bone marrow transplant	☐ Yes	☐ No	☐ DK	Explain _____
Chemotherapy	☐ Yes	☐ No	☐ DK	Explain _____
Frequent abdominal pain	☐ Yes	☐ No	☐ DK	Explain _____
Constipation requiring doctor visits	☐ Yes	☐ No	☐ DK	Explain _____
Recurrent urinary tract infections and problems	☐ Yes	☐ No	☐ DK	Explain _____
Congenital cataracts/retinoblastoma	☐ Yes	☐ No	☐ DK	Explain _____
Metabolic/Genetic disorders	☐ Yes	☐ No	☐ DK	Explain _____
Cancer	☐ Yes	☐ No	☐ DK	Explain _____
Kidney disease or urologic malformations	☐ Yes	☐ No	☐ DK	Explain _____
Bed-wetting (after 5 years old)	☐ Yes	☐ No	☐ DK	Explain _____
Sleep problems; snoring	☐ Yes	☐ No	☐ DK	Explain _____
Chronic or recurrent skin problems (eg, acne, eczema)	☐ Yes	☐ No	☐ DK	Explain _____
Frequent headaches	☐ Yes	☐ No	☐ DK	Explain _____
Convulsions or other neurologic problems	☐ Yes	☐ No	☐ DK	Explain _____
Obesity	☐ Yes	☐ No	☐ DK	Explain _____
Diabetes	☐ Yes	☐ No	☐ DK	Explain _____
Thyroid or other endocrine problems	☐ Yes	☐ No	☐ DK	Explain _____
High blood pressure	☐ Yes	☐ No	☐ DK	Explain _____
History of serious injuries/fractures/concussions	☐ Yes	☐ No	☐ DK	Explain _____
Use of alcohol or drugs	☐ Yes	☐ No	☐ DK	Explain _____
Tobacco use	☐ Yes	☐ No	☐ DK	Explain _____
ADHD/anxiety/mood problems/depression	☐ Yes	☐ No	☐ DK	Explain _____
Developmental delay	☐ Yes	☐ No	☐ DK	Explain _____
Dental decay	☐ Yes	☐ No	☐ DK	Explain _____
History of family violence	☐ Yes	☐ No	☐ DK	Explain _____
Sexually transmitted infections	☐ Yes	☐ No	☐ DK	Explain _____
Pregnancy	☐ Yes	☐ No	☐ DK	Explain _____
(For girls) Problems with her periods	☐ Yes	☐ No	☐ DK	Explain _____

Has had first period ☐ Yes ☐ No Age of first period _____

Any other significant problem _____

This American Academy of Pediatrics Initial History Questionnaire is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 3rd Edition.

HE0328

9-52/Rep0615

Our Financial Policy

Thank you. For choosing us as your healthcare provider. We appreciate you trust in us and we appreciate the opportunity to serve you. We have implemented a new Financial Policy. Which we require that you read, agree to and sign prior to any treatment.

PATIENT PAYMENT.

Payment is due at the time of service. You may use cash, check , credit or debit card. A $1.00 fee will be added to every card transaction. In the event that you wish to be billed, a $15.00 billing fee will be added to your account, in cases of financial hardship, please contact manager to request payment arrangements.

INSURANCE PAYMENT.

Payment for any treatment provided to you is consider to be your responsibility. If your insurance company does not pay for the services rendered to you for any reason, it will be your responsibility to pay any unpaid amount in full within 60 days of determination of non-payment, If the insurance information is not up to date by you; You will be responsible for any unpaid amount.

TRIPLICATE PRESCRIPTIONS/FORMSCOMPLETION.

Out of office services have a charge. Our office charge $5.00 for each triplicate prescription written without and office appointment. FMLA, disability forms and formal letters will be charger $15.00 for each form or letter. Physical forms with out and appointment will be charged $5.00 each. There is also a $5.00 charge for each duplicate shot record and end of the year payment summary.

MISSED OR CANCELLED APPOINTMENTS.

Please give us at least 24 hours notification if you cannot keep an appointment. This courtesy will allow others to be seen. We do realize that emergencies arise and therefore do not charge for the first missed appointment. However, you will be charged $15.00 for subsequent missed appointments

RETURNED CHECKS.

Our bank charges us whenever a patient presents a check that does not have funds available. therefore we must charge you a $25.00 handling fee.

We welcome the opportunity to discuss with you any aspect of our financial policy. Please ask to speak with our financial manager if you have any questions, comments or concerns. We thank you for your support and we look forward to serving you.

PATIENT AUTHORIZATION.

I have read, understand and agree to abide by the terms stipulated above. I request that payment or benefit be made to **Marta S Sarmiento M.D.,Inc.** I hereby authorize the release of any information necessary to determine liability for payment and obtain reimbursement on any claim. I further authorize the use of my signature below to all insurance submissions for services rendered or to be rendered. I agree that a photocopy of this agreement shall be as valid as the original. This authorization shall remain valid until revoked by me in writing.

PatientName_____**DOB**_____**Date**_____

Signature of Parent of minor/Legal Guardian_____

Name and relationship of the person completing form is other than patient_____