MILESTONE PEDIATRICS

4043 S Rt 59, Naperville, IL 60564
(630)420-4275

PATIENT(S) INFORMATION

Name: _____ **Male/Female** **Date of Birth:** ___/___/____ **Ethnicity:** _____

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Name: _____ **Male/Female** **Date of Birth:** ___/___/____ **Ethnicity:** _____

Family Status: Married ____ **Divorced** ____ **Widowed** ____ **Single** ____

Child(ren) live with: Mother Father Both

PARENT/GUARDIAN INFORMATION

Father's/Guardian's Name_____
Address: _____
City:_____ **State:**____ **Zip:**_____
Cell : _____**Work:**_____
Employer_____
Occupation: _____
Social Security #_____
Birthdate_____
Insurance Name _____
Eff Date: ___/___/____ **Primary or Secondary**
Are you the insurance holder? __Y __N

Mother's/Guardian's Name_____
Address: _____
City:_____ **State:**____ **Zip:**_____
Cell : _____**Work:**_____
Employer_____
Occupation: _____
Social Security #_____
Birthdate_____
Insurance Name _____
Eff Date: ___/___/____ **Primary or Secondary**
Are you the insurance holder? __Y __N

COMMUNICATION/EMERGENCY CONTACT

If we are unable to reach you, is it okay to leave confidential information on your voicemail? YES NO
If yes, please list phone number: _____
Would you like to receive health information and/or reminders via email from our office? YES NO
If yes, please list an email: _____
In case of an emergency who should we contact? (other than parent/legal guardian)
Name_____ **Relationship**_____ **Phone**_____

Name(s) of person authorized to ***accompany*** child for medical treatment and to make medical decisions in the event that a parent/legal guardian is unavailable. ***A parent/legal guardian *MUST* be present at visits where vaccines will be given.**

Name: _____ **Relation to patient:** _____
Name: _____ **Relation to patient:** _____

Print Name: _____ **Signature:** _____ **Date:** ___/___/____
Annual Review &/or updated: Date: _____ Signature: _____

MILESTONE PEDIATRICS

James R. Pera, MD
Kerry Brennan, CPNP
Michael J. Reicherts, MD
Laurie Strausberger, CPNP
Holly Loux, MD
Janel Hoffman, CPNP

MEDICAL HISTORY FORM

Date: _____

Child's Name: _____ Date of Birth: _____

Birth History:

Birth Weight: _____ Birth Hospital: _____ Boy: ____Girl:____
__Full-Term (>37wks) __Vaginal __Forceps __Vacuum
__Premature (<37wks) __C/Section – due to: _____
Pregnancy Concerns: _____
Newborn Concerns: _____

Child's Past Medical History:

Does your child have a history of any medical conditions? __None
Or please circle below any that apply:

Genetic:	chromosome abnormality			
Development:	delay-speech/language	delay-motor skills	autism	
Learning:	special education	dyslexia		
Behavior/Mood:	ADHD	anxiety	obsessive-compulsive	depression
Hearing:	ear tubes	hearing loss		
Vision:	glasses	amblyopia	strabismus	cataract
Neurologic:	seizures	migraines	head trauma	concussion
Respiratory:	seasonal allergies	asthma	RSV	pneumonia
Cardiac:	heart murmur	VSD/ASD	arrhythmia	
Endocrine:	diabetes	thyroid disease		
Gastrointestinal:	acid reflux	jaundice	bowel disease	
Urology:	bladder infections	kidney disease	kidney stones	
Genital:	vaginal discharge	menstrual problems	STD	
Muscle/Bone:	club foot	in toeing	scoliosis	broken bone(s) hypotonia spinal bifida
Skin:	eczema	acne	warts	MRSA vitiligo hemangioma
Infections:	meningitis	HIV	TB	scarlet fever other_____
Cancer:	leukemia	cancer/tumor		
Blood:	anemia	sickle cell	hemophilia	

Other Medical Conditions: _____

Has your child ever seen a specialist (medical or mental health) __Yes __No
Please describe who and why_____

For Females -Age at time of first period_____

Child's Past Surgeries:

__Tonsils/Adenoids __Ear Tubes __Hernia Repair __Circumcision __Appendectomy

Other Surgery related to: __heart __mouth/face __bones/muscles __kidney/bladder
__genitals __eyes __intestines/colon

Hospitalizations?: _____

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Name:_____ **DOB:**_____

Allergies:_____

Current Medications: _____

Family History:

	Name	DOB		Name	DOB
Brother (s):	_____	_____	Sister(s):	_____	_____
	_____	_____		_____	_____
	_____	_____		_____	_____

List any medical conditions with the **child's family members**:
(mom; dad; child's grandparents; child's aunts; uncles; cousins; siblings)

Disease/Condition	Who	Age	Comments
Heart Attack			
Other Heart Problems			
Diabetes			
Seizures			
High Blood Pressure			
High Cholesterol			
Cancer			
Blood Disorder			
Congenital Disorder			
Allergies or Asthma			
Mental Health			
Other			

Care/Education/Activities:
__home __day care __preschool __K -12th grade __home school __college

Participate in any sports: __yes __no if yes, type_____

Home Environment:
Parents: __married __live together __divorced __single parent
Patient lives with: both parents mom dad other_____
Occupation: mom_____ dad_____
Smokers: __yes __no
Pets: __yes __no type: _____

How did you hear about our practice: _____?

_____ Date: _____
Reviewed by Provider

Annual Review &/or updated: Date: _____ Signature: _____ **(Page 2 of 2)**

Milestone Pediatrics

Authorizations and Agreements

Authorization for Treatment

I agree to any examination, treatment, and procedure that may be performed during office visits, including emergency treatment, considered necessary by the physician and/or his/her healthcare providers.

Release of Information

I authorize the facility to release to my insurance carrier or its designated agents any information concerning medical care (physical or psychological) advice, treatment, or supplies provided to me for the purpose of administration, review, investigation, or evaluation. A photo static of this authorization shall be considered as effective and valid as the original. I will notify the facility in writing of any information I do not want released.

Assignment of Insurance Benefits

I authorize the assignment of benefits payable to Milestone Pediatrics and/or its designee for physician services and supplies by government and or any other private third party payer. **I understand I will be held responsible for payment of all co-payments, co-insurance, deductibles, and non-covered services.**

Financial policy

Co-Payments are required to be paid at the time of checking in for your appointment. If you are unable to pay at that time, a **$25.00** surcharge will be applied to the account if the co-pay is not paid within 3 business days.
Self-Pay Accounts are required to be paid at the time of check-in
Insurance- as a courtesy, our office will bill all insurance companies for the services provided. Upon response of insurance, you will be sent a statement stating your payment responsibility. Our office requires balances to be paid in full within 30 days of receiving the billing statement. It is your responsibility to notify our office of any insurance or demographic changes. Before making an annual physical appointment, check with your insurance company whether the visit will be covered as a healthy visit. Not all plans cover annual healthy physicals or hearing and vision screenings. It is your responsibility to know your insurance plan benefits. If it is not covered, you will be responsible for payments at the time of visit.
Divorced/Separated & Co-Parenting Parents-The parent/guardian that presents the child for medical services is the financially responsible party. If there is a financial arrangement between individual parental parties, this arrangement is between the two parties and does not absolve the parent that brings the child in for services from their financial obligation to our office. Our office will not be involved with separation or divorce disputes.

I agree to pay any outstanding balance within 3 days after receiving a statement from Milestone Pediatrics notifying me of such balance.

If previous arrangements have not been made with our billing department, any account balance outstanding greater than 30 days will be charged a **$5.00 re-bill fee**. Any balance over 60 days will be forwarded to a collection agency, additional charges may apply and your family may be dismissed from the practice.

Not all plans cover annual healthy (well) physicals, hearing/vision screenings, developmental questionnaires, and postpartum screens for mom, earwax removal, rapid strep, flu, RSV, mono and stool occult blood testing, vaccinations. If any of these services are not covered, you will be responsible for payment.

Referrals/Preauthorizations

It is your responsibility to understand your benefit plan and know if a written referral or authorization is required to see a specialist, if preauthorization is required prior to a procedure and what services are covered.

Advance notice is needed for all non-emergent referrals, most insurances require 7 to 10 business days. It is your responsibility to know if a selected specialist participates in your plan. Remember, your primary care physician must approve referrals before being issued.

Release of Medical Records

Consent for release of medical records is required to be signed by a parent/legal guardian of minor or adult patient prior to release of records completion. This includes school, camp, sports, FMLA, disability, etc. We follow Illinois law regarding record copying fees.

Milestone Pediatrics

Office Policies

Red Flag/Identity Theft

Our office strives to prevent the intentional misuse of patients names, identities, and medical records to report criminal activity relating to identity theft to appropriate authorities. As a result, a copy of your photo ID and insurance card will be collected during the patient registration process. A copy of our office's Identity Theft Policy is available for your review.

Additional Fees

In the event that any lawsuit or action is brought to collect this account or any portion thereof, the patient/guarantor will be responsible for any and all costs not limited to attorney's fees, court costs, collection fees, interest and any additional costs that this action may incur. A $35.00 fee will be charged for any checks returned for insufficient funds, plus any bank fees required.

Form Completion

We follow Illinois law regarding medical record copying fees. If your child has school , camp, or sports forms to be completed, we have a 3 to 5 day turnaround time for forms. **There is a $10.00 fee for FMLA or disability form completion.**

Missed Appointments

We request 24 hour notice for cancelling any appointments. If 3 or more appointments are missed or cancelled same day, you may be dismissed from the practice. **You may incur a $25 charge for each missed or same day cancelled appointment.**

Late Policy

Our office policy is to see our patients at their scheduled time. Sometimes, unforeseen situations occur that make our providers run behind schedule. We will always try to keep you informed if we are running late. We also ask that you make us aware if you are running late. In order to stay ontime, we need our patients to be on time. If you are running late, lease call our office and make us aware. If you are **15 minutes** or later for your scheduled time, we may ask that you reschedule your appointment in order to service all of our patients better.

Notice of Private Practices

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal healthcare information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations. As our patient, we want you to know that we respect your personal medical records and will do all we can to secure and protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment, or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operation. These entities are most often not required to obtain patient consent. You may refuse to consent to the use of disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose you Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or previously signed consent. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer. You have the right to review our privacy notice, to request restrictions, and revoke consent in writing after you have reviewed our privacy notice.

Patient Name_____ **Date of Birth**_____

Signature of Parent/Guarantor_____ **Date**_____

Print Name of Parent/Guarantor_____