Metro Pediatrics, P.C.

Derrol Dawkins, MD, FAAP
Ebonee Lyons, MSN, FNP-BC
Susanne S. Matthews, MD, FAAP
Virginia M. Thomas, MSN, FNP-BC

401 Valley Avenue
Birmingham, Alabama 35209
Office (205) 941-1414 Fax (205) 941-1313
MetroPediatricsPC.com

"Metro Excellence. . .Current, Comprehensive, Compassionate."

Patient Information

Last Name | First Name | MI | DOB | Sex | Age

Address | Apt. # | City | State | Zip

Home Phone | Cell Phone | Alternate Phone | Social Security #

Guarantor Information

Mother's Name | DOB | Driver's License # | Social Security #

Father's Name | DOB | Driver's License # | Social Security #

Other children in the household: _____

Nearest friend or relative not residing with you (for emergency contact purposes only):

Name | Relationship to Patient | Phone

Insurance Information

Primary Company | Subscriber # | Group # | Secondary Company | Subscriber # | Group #

Guarantor's Name | Address | City | State | Zip

Home Phone | Relationship to Patient | Occupation | Employer

Employer's Address | City | State | Zip | Phone

Preferred E-mail Address: _____

Referred by: ❑ Website ❑ Internet Search Engine ❑ Facebook ❑ Twitter
❑ Family/Friend (please list):_____ ❑ Other (please specify):_____

Payment Agreement

In consideration of Metro Pediatrics, P.C. rendering medical treatment to the specified patient, I (guarantor) hereby guarantee full payment for services rendered. Unless prohibited by agreement between Metro Pediatrics, P.C. and my insurance carrier, I will pay for all services rendered. Upon my failure to pay the entire charges for services, I agree to pay reasonable attorney and/or collection fees and waive my right of exemption as to personal property. I understand that my payment responsibility exists whether or not I have medical coverage. This agreement is effective as long as the patient remains under the care of Metro Pediatrics, P.C.

Signature of Guarantor | Date

New Patient Questionnaire (To be filled out by parent)

Pregnancy and Birth

Mother's age at birth:	
Did mother have any illnesses during pregnancy?	❑ Yes ❑ No
Did she take any medications other than vitamins/iron?	❑ Yes ❑ No
Was the baby on time?	❑ Yes ❑ No
What was the birthweight?	❑ Yes ❑ No
Did the baby have any trouble starting to breathe?	❑ Yes ❑ No
Did the baby have any trouble while in the hospital?	❑ Yes ❑ No
What kind (jaundice, infections, other?)	❑ Yes ❑ No
Please specify:	

Past Medical History

Where has your child gone for check-ups until now?	
Date of last check-up:	
Date of last dental check-up:	
Has your child had allergic reactions to any medications, food, or insect bites?	❑ Yes ❑ No
Which ones?	
Has your child had reactions to any immunizations?	❑ Yes ❑ No
Which ones?	
Any hospitalizations other than for birth?	❑ Yes ❑ No
For what?	
Any serious injuries?	❑ Yes ❑ No
What kind?	
Are any medications taken regularly?	❑ Yes ❑ No
Which ones?	

Family History

Indicate any illnesses that this child's parents, grandparents, brothers, sisters, aunts, or uncles have had:

Anemia	❑ Yes ❑ No	Drug problems	❑ Yes ❑ No
Allergies	❑ Yes ❑ No	Alcohol problems	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Inherited illness	❑ Yes ❑ No
High blood pressure	❑ Yes ❑ No	Venereal disease	❑ Yes ❑ No
Heart problems	❑ Yes ❑ No	Cancer	❑ Yes ❑ No
Tuberculosis	❑ Yes ❑ No	AIDS	❑ Yes ❑ No
Mental Illness	❑ Yes ❑ No	Other:	
Have any of your children died?			❑ Yes ❑ No

Feeding and Nutrition

Is your child's appetite usually good?	❑ Yes ❑No
Is it good now?	❑ Yes ❑ No
Was there severe colic or unusual feeding problems during the first 3 months?	❑ Yes ❑No
Do any foods disagree with him/her?	❑ Yes ❑ No
For the first 6 months, how was/is your child fed?	❑ Breast ❑ Bottle
If still on formula, which one do you use?	
Does your child take vitamins?	❑ Yes ❑ No

Review of Systems

Has your child had frequent ear infections?	❑ Yes ❑
Any eye problems?	❑ Yes ❑
Has he/she had any problems with teeth?	❑ Yes ❑
Does he/she have any heart problems?	❑ Yes ❑
Is there asthma, pneumonia, or recurrent cough?	❑ Yes ❑
Any problems with urination?	❑ Yes ❑
Any problems with diarrhea or constipation?	❑ Yes ❑
Any problems with convulsions/seizures?	❑ Yes ❑
Any eczema, hives, or other skin conditions?	❑ Yes ❑
Has your child ever been anemic?	❑ Yes ❑

Development and Behavior

At what age did you child sit alone?			
At what age did your child walk alone?			
Did your child say any words by age 15 months old?			❑ Yes ❑
Does he/she have any trouble sleeping?			❑ Yes ❑
What grade is he/she in?			
Does he/she get along with other children?			❑ Yes ❑
Does he/she have problems with any of the following:			
Nail biting	❑ Yes ❑ No	Hyperactivity	❑ Yes ❑
Thumb sucking	❑ Yes ❑ No	Nightmares	❑ Yes ❑
Bed wetting	❑ Yes ❑ No	Speech	❑ Yes ❑
Problems with toilet	❑ Yes ❑ No	Bad temper	❑ Yes ❑
Discipline problems	❑ Yes ❑ No	Grades	❑ Yes ❑

Safety and Environment

Do you live in a private house, apartment, mobile home, other? (Circle one)	
Do you know the hottest temperature of the water in your pipes?	❑ Yes ❑ No
Is there a working smoke alarm on each floor in the house?	❑ Yes ❑ No
Does your child always use a car seat/seat belt?	❑ Yes ❑ No
Are there any smokers in the household?	❑ Yes ❑ No
Are there any problems with the condition of your home (peeling paint, insects, rats, or mice?)	❑ Yes ❑ No
Does your child always wear a helmet when riding his/her bicycle?	❑ Yes ❑ No
Do you have a record of immunizations?	❑ Yes ❑ No

Assignment of Medical Care

Child's Name _____

Parent/Guardian's Name _____

Child's Home Address _____

I (parent/guardian) give permission for the following individuals to seek medical care for my child in the event that I am unable to accompany my child to his/her medical appointment *(please list names of responsible parties):*

_____

_____

_____

_____

_____

This authorization is for routine medical care and/or emergency care that is deemed necessary. I understand that in the event of an extraordinary emergency, Metro Pediatric, P.C. will make every reasonable effort to contact me. The following information may be used to contact me:

Home _____

Cell _____

Work _____

E-mail _____

Consent for Use and Disclosure of Protected Health Information

You hereby consent for **Metro Pediatrics, P.C.** to use or disclose information about you (or another person for whom you have authority to sign) that is protected under federal law for purposes of treatment, payment, and healthcare operations. due to recent changes involving federal laws regarding your privacy, our authorizations are more extensive than ever before. Please understand that the goal of Metro Pediatrics, P.C. is to administer the best medical care available in the most efficient manner. We will strive at all times and to the best of our ability to protect your privacy. Please understand that in the normal course of operating our office, discussions can sometimes be overheard. Ask at any time if you would like to assure a totally confidential discussion with one of the doctors, nurse practitioners, lab technicians, medical assistants, or business staff members.

Please read carefully the authorizations below and sign appropriately.

I hereby authorize Metro Pediatrics, P.C. to communicate confidential information to any referring or consulting physician, medical facility, or to insurance carrier by facsimile, electronic transmission, telephone, or U.S. mail. My personal information is protected under federal law, and I have the right to revoke this consent at any time. By signing below, I recognize that the protected health information used or disclosed may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

_____ _____

Signature of Patient (If under age 14, must be signed by parent or guardian) *Date*

Adolescent Patients (Ages 14-18 years)

I hereby authorize Metro Pediatrics, P.C. to discuss my medical condition and treatment plan with my parent or guardian. I understand that if my parent or guardian assumes financial responsibility, they will have the right to review services rendered. I may ask for a private consultation with my doctor or nurse practitioner at any time.

_____ _____

Signature of Patient (Ages 14-18 years) *Date*

Agreement to Pay

I acknowledge full financial responsibility for all services provided, both those covered by my insurance contract and also those non-covered services that may be deemed necessary for appropriate medical care. I accept full responsibility for knowing my insurance benefits and will advise the staff of Metro Pediatrics, P.C. accordingly. I understand that any charges incurred and remaining unpaid may be referred to an attorney or collection agency. All costs of collections, including reasonable attorney's fees, will be my responsibility.

_____

Patient's Name (Please print)

_____ _____

Signature of Patient (If under age 14, must be signed by parent or guardian) *Date*

Health Insurance Portability and Accountability Act (HIPAA)
Notice of Privacy Practices

The Metro Pediatrics, P.C. Notice of Privacy Practices is located in our office and online at metropediatricspc.com under patient forms. Please review.

I have received a copy of the Metro Pediatrics, P.C. Notice of Privacy Practices. I am aware that Metro Pediatrics, P.C. is HIPAA compliant and follows federally regulated guidelines regarding my protected health information.

_____
Name of Patient

_____
Signature of Parent or Guardian

_____
Signature of Patient (Required for patients ages 14-21 years)

_____
Date