Bakersfield Pediatrics

Patient information:

Last Name: _____

Middle Initial: _____

First Name: _____

Date of Birth: _____

Sex: M / F

Language: _____

Ethnicity: Hispanic Non-Hispanic Other

Race: _____

Primary Physician:

_____

Mobile # (>14yrs): _____

Primary Address: _____ **Apt:** _____ **Primary Phone: ( ) _____**

City: _____ **State:** _____ **Zip Code:** _____

Patient is living with: (circle one) Both Parents Father Mother Parent and Step Parent Other _____

Are Parents: (circle one) Married Single Divorced Separated Widowed

Who carries insurance? Name: _____ Relationship: _____

DOB: _____ Social Security #: _____

Parent 1- please circle M / F

Name: _____

SS# _____-_____-_____DOB _____

Employer: _____

Occupation: _____

Mobile Phone: (____) _____

Work Phone: (____) _____

Home Phone: (____) _____

Email: _____

IF DIFFERENT FROM PATIENT

Address: _____Apt. _____

City: _____State: _____Zip: _____

Parent 2- please circle M / F

Name: _____

SS#_____ _____DOB _____

Employer: _____

Occupation: _____

Mobile Phone: (____) _____

Work Phone: (____) _____

Home Phone: (____) _____

Email: _____

IF DIFFERENT FROM PATIENT

Address: _____Apt. _____

City: _____State: _____Zip: _____

Appointment Reminders: (please circle one) Parent 1 or Parent 2

☐ Primary Phone:(____) _____ ☐ Email: _____ ☐Text: (_____) _____

Preferred Pharmacy Name and location: _____

Acct#:

Bakersfield Pediatrics Patient History Form

Pregnancy and Birth History

Problems during pregnancy	no	yes_____
Medications	no	yes_____
Smoking/Alcohol/Drugs	no	yes_____
Diabetes	no	yes_____
Illness during pregnancy	no	yes_____

Other _____

Delivery: Vaginal Cesarean Section

Reason for C/S

Full Term Premature # weeks:_____

Birth Weight _____ Birth Length ___ _____

Problems immediately after birth:

Infection		no yes _____
Breathing Difficulty	no	yes_____
Jaundice		no yes_____
Home with mother	no	yes_____
Other		no yes_____

Medical History

Current Medication _____

_____

Medication Allergies_____

Food Allergies_____

Hospitalizations_____

_____

Previous infections/problems:

Anemia	no yes
Asthma	no yes
Bedwetting	no yes
Behavior problems	no yes
Bladder or kidney infection	no yes
Chicken pox	no yes
Constipation	no yes
Convulsions or seizures	no yes
Ear infection	no yes
Eczema	no yes
Hay fever	no yes
Hearing problems	no yes
Learning problems	no yes
Pneumonia	no yes
Sleep problems	no yes
Speech	no yes
Transfusion	no yes
Vision problems	no yes
Weight problems	no yes

Other_____

_____

Developmental History

Child was able to do the following at what age:

Smile _____

Roll over_____

Sit alone _____

Crawl _____

Walk alone _____

First words _____

Toilet trained _____

Family History

Alcohol or drug problems	no yes_____
Allergies	no yes_____
Asthma	no yes_____
Birth defects	no yes_____
Blood diseases	no yes_____
Blindness	no yes_____
Cancer	no yes_____
Convulsions	no yes_____
Elevated cholesterol/trig	no yes_____
Deafness	no yes_____
Death in childhood (incl. SIDS)	no yes _____
Diabetes	no yes_____
Headaches/migraines	no yes_____
Heart defects (incl. congenital)	no yes_____
Heart attacks	no yes_____
At what age?	_____
Hip dislocation	no yes_____
Hypertension	no yes_____
Immune deficiency (incl. AIDS)	no yes _____
Learning problems	no yes_____
Liver disease	no yes_____
Lung disease	no yes_____
Mental delay	no yes_____
Psychiatric disorders	no yes_____
Thyroid disease	no yes_____
TB test - positive results	no yes_____
Conditions that run in the family	_____

_____

Social History

Exposure to passive smoke	no	yes _____
Smoker in the household	no	yes _____

Household Parent/Caretaker:

Name	Age	Employer
_____	_____	_____
_____	_____	_____

Married Divorced Separated Widowed Other _____

Others in the home:

Name	Age	Relation to patient
_____	_____	_____
_____	_____	_____

Others important in childs life:

Name	Age	Relation to patient
_____	_____	_____
_____	_____	_____

Completed by: _____

Date:_____

This information has been reviewed with the parent(s)

Provider Signature: _____

Date:_____

Patient Name_____Date_____ Account # _____

Bakersfield Pediatrics Office Policies

Please check mark or initial all policies and sign and date at the bottom of the next page to indicate you understand each individual policy. If you have any questions, please ask a member of our staff.

☐ **DEDUCTIBLES, CO-PAYMENTS AND COINSURANCE**- All applicable copays, coinsurance and deductible amounts are due and expected at the time of service. If a deductible is applicable, Bakersfield Pediatrics will collect $100 as an estimated amount for the office visit. Any remaining balance will be billed to the guarantor. If your plan has a coinsurance amount for Preventative visits, an estimated patient responsibility amount will be due at the time of service.

☐ **COVERAGE TERMS**- Your insurance policy is a contract agreement between you and your insurance company. You are responsible for knowing the terms and conditions of your policy. It is not the responsibility of Bakersfield Pediatrics to know your policy details. As a courtesy Bakersfield Pediatrics will attempt to verify eligibility and benefits, however, we are unable to obtain the exact details of payment until the claim is processed.

☐ **OUTSTANDING BALANCES**- Outstanding balances for all family members are due prior to the physicians visit. Bakersfield Pediatrics has the right to refuse service for non-urgent medical services if balances are not paid in full before the scheduled visit.

☐ **INSURANCE UPDATES-** You are a responsible for providing us any updates to your insurance. If any charges are denied due to not providing current insurance information, the guarantor will be responsible for any unpaid balances.

☐ **BILLING POLICY-** As a courtesy, Bakersfield Pediatrics will bill your insurance for all procedures performed at the time of service. When the Explanation of Benefits and insurance payment is received, your account will be credited. Any remaining patient responsibility will be expected when you receive a statement or at the time of your next appointment (whichever comes first).

☐ **INSURANCE COMPANY DISPUTES-** It is the plan holders' responsibility to negotiate payments with his/her insurance company. Remember, Bakersfield Pediatrics bills your insurance company as a courtesy to you.

☐ **PPO's and HMO's-** We are in network with most PPO plans. We will do our best to verify your plan is in network with Bakersfield Pediatrics, but it is ultimately the plan subscriber's responsibility to confirm their benefits and in network providers. If you have an HMO plan, you will need to select one of Bakersfield Pediatrics physicians as your primary care provider (PCP) before your first scheduled appointment.

☐ **COLLECTION POLICY-** If payment is not made at the time the billing statement is received, you may be responsible for interest and penalties. Bakersfield Pediatrics utilizes an outside collection agency for any unpaid debt. If your account goes to collections, you will be responsible for attorney fees, interest, and penalties. Bakersfield Pediatrics cannot remove an account from of collections after it has been sent.

☐ **FINANCIAL HARDSHIP-** If you encounter financial hardship, Bakersfield Pediatrics will consider a payment arrangement. Payment arrangements can be set up through our internal billing department. You may contact a member of the billing department for assistance at 949-599-2434.

Bakersfield Pediatrics Office Policies - continued

☐ **CHECK AS FORM OF PAYMENT AND RETURNED CHECKS-** Checks will not be accepted as up-front payment for visits that include vaccines, only credit card will be an acceptable form of currency. There will be a $35.00 returned check fee applied to your bill for any returned check to cover the charge incurred from our bank. If Bakersfield Pediatrics receives a returned check, checks will no longer be an acceptable form of payment, only credit will be accepted.

NORMAL OFFICE HOURS:

Monday- Thursday: 8:00am to 5:00pm
Friday: 8:00am to 4:00pm

☐ **NO SHOWS AND CANCELLATIONS-** If an appointment is missed or is not cancelled 24 hours in advance a fee may apply to the patient's account. This fee is not covered by insurance and therefore will not be billed to insurance.

☐ **COPY OF MEDICAL RECORDS-** A written request must be received prior to the release of each medical record. Bakersfield Pediatrics charges a reasonable clerical fee of $20.00 for each patient's physical copy of medical records and $6.50 for an electronic copy. We have 7-10 days from time of written request and payment in full to provide the records.

☐ **FILE REVIEW CHARGES/ LETTER WRITTEN-**There will be an additional charge for all requests for review of records or letters written on the patient's behalf. This charge will be billed to your insurance company and any remainder balances will be your responsibility.

By my signature below, I state that I have read and understand the policies of Bakersfield Pediatrics.

SIGNATURE _____ **DATE:** _____ _____

Patient Name: _____

Bakersfield Pediatrics

Acct: _____

Authorization to Release Test
Results For Patients Under 18 Years
of Age

In order to efficiently convey lab results, test results and/or other communication, Bakersfield Pediatrics is requesting that you provide secure telephone number(s), for our staff to call and leave messages regarding test results. This will help prevent the delay of pertinent information relating to your child. If you have not heard from Bakersfield Pediatrics regarding your lab or test results, please do not hesitate to contact our office.

I, (parent/guardian) _____ , give Bakersfield Pediatrics permission to leave messages regarding my child's (patient) _____ results, on the numbers listed below.

Primary contact Name: _____Phone: (____)_____

Secondary Contact Name: _____Phone: (____)_____

Signature _____ Date _____