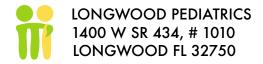
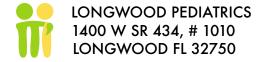


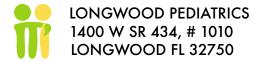
NEW PATIENT INFORMATION					
Child's Last Name, First Name	Birth Date	□ Male □ Female		SSN# Telephone #	
Street Address	Apt #	City		State	Zip Code
Language Race □ English □ Spanish □ Asian	□ African Ame	rican □ White □	Pacific Isla		hnicity Hispanic 🗆 Non-Hispanic
PARENTS / GUARDIAN INFORMATION					
Mother's Name	Birth Date	SSN#	Cell:	Email:	
Father's Name	Birth Date	SSN#	Cell:	Email:	
Consent to enroll in online patient portal (please circle one) Mother / Father					
Consent to receive text messages for Appointment Reminders (please circle one) Mother / Father					
GUARANTOR'S INFORMATION					
Insurance Name	ID#		Group #		
Guarantor's Name		Gu	arantor's R	Relationship to	Child
		□ S	elf □ Motl	her 🗆 Father	□ Other
Who if anyone other than parent or legal guardian has permission to access your child's medical records (PHI) and obtain results for labs tests including bringing your child in Longwood Pediatrics LLC without your presence and making medical decisions for his or her treatment.					
Name		Relation	nship		
Name		Relation	nship		
Name		Relation	nship		



Allergies Y/N									
Medications									
Food									
Current Medication	ons Y / N								
Name	De	Dosage		F	Frequency		Started on	Started on	
Pharmacy (for tra	nsmitting	electroni	ic prescri	ptions)					
□ CVS □ Walgreer	ns 🗆 Publ	ix 🗆 Targ	et 🗆 Wal	- Mart	□ Other	r:			
Address:									
Phone Number:									
Family History: F	irst Degre	ee relativ	es have r	no curr	ent pro	blems or disa	bility Y/N		
If Yes, then please	e mark X	in the bo	xes belov	w to al	l that a	oply			
Diagnosis	Siblings	Mother	Father	Mate Gran	rnal dmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	
Thyroid disease									
Heart disease									
High BP									
Cancer (type)									
Diabetes									
Depression									
ADHD									
Learning disability									



Social History (Please circle b	elow)			
Is child living with Mother / Father/	Grand parents / Foste	er parents (please circle one)		
Siblings Y / N		How many ?		
Passive smoke exposure Y / N		Pet's at home Y / N		
Can child swim Y / N		Care giver Y / N		
Smoke detectors in home Y / N		Seat belt use Y / N		
Daycare Y / N		School Grade		
Smoking Y / N (if >13 years of age)		Sexually active Y / N (if > 15 years of age)		
Birth History				
Prenatal History				
Birth Hospital				
Birth Weight				
Type of Delivery (circle one) Vaginal Delivery / C-		-Section		
Gestational Age				
Medical Problems after delivery				
Past Medical History - Has you	r child ever had a	ny of the following? (check as many as apply)		
□ ADHD □ Asthma □ Allergies □ Autism □ Eczema □ Bronchiolitis □ Pneumonia □ Multiple ear infections		 □ Developmental delay □ Cerebral palsy □ Seizure disorder □ Thyroid disease □ Learning disability □ Reflux disease □ Headaches / Migraines □ Other 		
Past Surgical History (check as many as apply)				
 □ Tonsils Removed □ Adenoids Removed □ Inguinal Hernia Repair □ Appendicectomy 		 □ Ear Tube Placement □ Heart Surgery □ Broken Bone □ Other 		



Consent and Authorizations

Your Signature Will Serve for All of the Following:

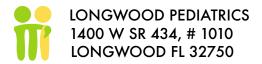
Consent: I hereby give consent to Longwood Pediatrics LLC to provide necessary treatments discussed. I have received a copy of the Privacy Policy of Longwood Pediatrics and authorize use/disclosure of information to coordinate and/or manage my child's healthcare and any related services, receive payment for services and perform general healthcare operations. Longwood Pediatrics may contact me at my primary phone number or e-mail or text me on my cell number I have provided. It may If I am not available Longwood Pediatrics may leave a message on voice mail in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations (TPO), such as appointment reminders, insurance items and any calls pertaining to clinical care, including laboratory and radiology results among others as per the Privacy Policy. Longwood Pediatrics may mail to my home, or other alternate address I have provided, any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, school immunization and or physical forms; all correspondence will be marked "Personal and Confidential".

<u>Medical Release</u>: I authorize any holder of medical or other documentation about my child to release to Longwood Pediatrics independent laboratories and insurance carriers any information needed for claims processing and payments. I permit a copy of this authorization to be used in place of the original.

<u>Insurance Authorization</u>: I authorize payment of medical benefits directly to the Longwood Pediatrics and/or the attending physician for services rendered.

<u>Financial Responsibility</u>: I have received a copy of Longwood Pediatrics Financial Policy and agree to abide by the terms set forth. I acknowledge that I am ultimately responsible for all charges incurred by my child(ren). It is my responsibility to provide the office with all necessary information to file insurance claims, and to notify the office of changes in coverage prior to any visits. I understand it is my responsibility to know my insurance coverage and benefits, including contracted laboratories/ hospitals where my child may receive care. I understand all co-pays, patient percentages and deductibles are due at the time services are rendered. I will be responsible for any charges not covered by my insurance policy.

Signature	Date:
Print Name	_Relationship:
Tim Hame	_kcianonamp



Records Release Authorization

Parent / Legal Guardian Name:	
Child's Name	Date of Birth
Child's Name	Date of Birth
Child's Name	Date of Birth
The Parent/Legal Guardian authorizes and reque	sts LONGWOOD PEDIATRICS (check one):
□ Release to	
□ Obtain from	
Please release following medical information (che	eck one)
□ All medical records	
□ Immunization records and last physical exam n	otes
The purpose of releasing this information:	
□ Changing Insurance □ Moving	□ Other
further understand that the information to be rele AIDS/HIV. In addition, information related to dru	hat information will be released and the need for that information. I ased may include information regarding drug and alcohol abuse or g and alcohol abuse in my child's records is protected under federa ritten consent unless otherwise provided in the 42 Code of Federal
Parent / Legal Guardian Signature	
Relationship	
 Date	