

**JEANNE M. SCHAEFER, M.D., PLLC  
FIRST CHOICE PEDIATRICS**

**Patient Information**

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Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle I \_\_\_\_\_  
Nickname: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M / F  
Social Security #: \_\_\_\_\_ Ethnicity: Hispanic or Latino / Not Hispanic or Latino  
Race: American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian or Other Pacific Islander / White

**Guarantor / Parent Information**

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Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle I \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M / F  
Marital Status: S / M / W / D / SEP Email: \_\_\_\_\_ Preferred Method of Contact: Home / Cell / Work  
Home Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_  
Place of Employment: \_\_\_\_\_ Job Title: \_\_\_\_\_

**Insurance Information**

**\* We will also need to make a copy of your insurance card(s)**

Primary Insurance: \_\_\_\_\_ Insured: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Insured's Relationship to Patient: \_\_\_\_\_  
Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Secondary Insurance: \_\_\_\_\_ Insured: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Insured's Relationship to Patient: \_\_\_\_\_  
Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

**Emergency Contact Information**

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Emergency Contact (someone in different household): \_\_\_\_\_  
Relationship: \_\_\_\_\_ Phone Number: ( ) \_\_\_\_\_ Work / Home / Cell

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I verify the above information is correct and complete to the best of my knowledge. I also authorize Jeanne M. Schaefer, MD, PLLC to file claims and for the release of medical records to the insurance company for claims purpose. The records authorized for release may include information which may indicate the presence of a venereal or other communicable disease. This includes, but is not limited to, Hepatitis, Syphilis, Gonorrhea and the Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**First Choice Pediatrics  
Patient's Health History  
Newborn to 12 month**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Physician: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

**Pregnancy:**

Maternal illnesses or problems during pregnancy? \_\_\_\_\_

Any medications taken? \_\_\_\_\_

Smoke cigarettes? \_\_\_\_\_ Drink alcohol? \_\_\_\_\_ Use recreational drugs? \_\_\_\_\_

**Birth History:**

Birth Weight: \_\_\_\_\_ Place of Birth: \_\_\_\_\_ Obstetrician: \_\_\_\_\_

Vaginal delivery or C-section? \_\_\_\_\_ Gestational age: \_\_\_\_\_ wks

NICU admit? \_\_\_\_\_ If yes, why? \_\_\_\_\_ How long? \_\_\_\_\_

If breast fed, how long? \_\_\_\_\_ If bottle fed, what formula? \_\_\_\_\_

Was Hep B given in hospital? \_\_\_\_\_

**Medical History:**

Surgeries: \_\_\_\_\_

Allergies or reactions to medications: \_\_\_\_\_

Current Medications: \_\_\_\_\_

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**\*PLEASE GIVE THE NURSE A COPY OF THE PATIENT'S IMMUNIZATION RECORD.**

**Family:**

Please list those who currently live in the home, their age, and relationship.

\_\_\_\_\_  
\_\_\_\_\_

**Other:**

Please provide any other medical history that you think might be helpful.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# First Choice Pediatrics Family Health Screening

Please circle any of the child's family members if they have or had any of the medical conditions listed below.

Medical Conditions

Heart Attack / Heart Problems	Father	Mother	Sister	Brother	P. Grandpa	P. Grandma	M. Grandpa	M. Grandma
High Cholesterol	Father	Mother	Sister	Brother	P. Grandpa	P. Grandma	M. Grandpa	M. Grandma
High Blood Pressure	Father	Mother	Sister	Brother	P. Grandpa	P. Grandma	M. Grandpa	M. Grandma
Asthma	Father	Mother	Sister	Brother	P. Grandpa	P. Grandma	M. Grandpa	M. Grandma
Intestinal Problems / Colitis	Father	Mother	Sister	Brother	P. Grandpa	P. Grandma	M. Grandpa	M. Grandma
Urinary Tract Infections / Kidney Problems	Father	Mother	Sister	Brother	P. Grandpa	P. Grandma	M. Grandpa	M. Grandma
Migraines	Father	Mother	Sister	Brother	P. Grandpa	P. Grandma	M. Grandpa	M. Grandma
Seizures	Father	Mother	Sister	Brother	P. Grandpa	P. Grandma	M. Grandpa	M. Grandma
Diabetes	Father	Mother	Sister	Brother	P. Grandpa	P. Grandma	M. Grandpa	M. Grandma
Hyperthyroidism	Father	Mother	Sister	Brother	P. Grandpa	P. Grandma	M. Grandpa	M. Grandma
Hypothyroidism	Father	Mother	Sister	Brother	P. Grandpa	P. Grandma	M. Grandpa	M. Grandma
Allergies	Father	Mother	Sister	Brother	P. Grandpa	P. Grandma	M. Grandpa	M. Grandma
Eczema	Father	Mother	Sister	Brother	P. Grandpa	P. Grandma	M. Grandpa	M. Grandma
Depression	Father	Mother	Sister	Brother	P. Grandpa	P. Grandma	M. Grandpa	M. Grandma
Death of a Sibling / SIDS	Father	Mother	Sister	Brother	P. Grandpa	P. Grandma	M. Grandpa	M. Grandma
Smoke Cigarettes	Father	Mother	Sister	Brother	P. Grandpa	P. Grandma	M. Grandpa	M. Grandma
Other:	Father	Mother	Sister	Brother	P. Grandpa	P. Grandma	M. Grandpa	M. Grandma

Parent's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# FIRST CHOICE PEDIATRICS

## Identification Verification

Federal law requires patients/guarantors to validate their identity before services are provided. Section 114 of the Fair and Accurate Credit Transaction (FACT) Act of 2003, mandates implementation of a Red Flag Program that is consistent with the policies and procedures issued under section 326 of the USA PATRIOT Act, 31 U.S.C. 5318(1), requiring verification of the identity of persons opening new accounts. In order to be in compliance with the Federal regulations, please provide your photo identification and the policy holder's social security number when required by your insurer. This information will be maintained in a secure location and used only for identity validation. If you are unable to provide a photo ID, your account will be flagged for possible identity theft.

- Guarantor was unable to provide photo ID
- Guarantor refused photo ID to be copied.
- Guarantor was unable to provide social security number of policy holder as required by insurer.
  
- Guarantor was able to provide photo ID
- Guarantor was able to provide social security number of policy holder as required by insurer.

ID was viewed and verified by: \_\_\_\_\_ (employee signature)

Print Patients Name: \_\_\_\_\_

Patient/Guarantor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FIRST CHOICE PEDIATRICS**

**AUTHORIZATION FOR TREATMENT OF A MINOR**

I/We parent(s) or legal guardian, do hereby give permission for medical treatment of:

\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

The following person(s) is/are authorized to bring the above named minor to the physician's office for medical treatment.

	<u>NAME</u>	<u>PHONE NUMBER</u>	<u>RELATIONSHIP</u>
1.)	_____	_____	_____
2.)	_____	_____	_____
3.)	_____	_____	_____



# First Choice Pediatrics

## Acknowledgement of Receipt of Financial Policy

I, \_\_\_\_\_, have received a copy of the Financial Policy.

\_\_\_\_\_ Signature of Parent/Guardian

\_\_\_\_\_ Relationship to Patient

\_\_\_\_\_ Date

I certify that I have read, understand and will comply with the Financial Policy for First Choice Pediatrics. I acknowledge full financial responsibility for the services provided to me or my minor children by First Choice Pediatrics. I understand that I am responsible for prompt payment of any portion of the charges not covered by my insurance, including co-pays, co-insurance, deductibles and non-covered services. I understand that I am responsible for prompt payment of all charges in the event that I do not have health insurance, or that First Choice Pediatrics is not a participating provider with my health insurer. I consent to the assignment of authorized insurance benefits by my health insurer to First Choice Pediatrics for any services furnished to my minor children.

*If the patient is under 18 years old or is otherwise incompetent to consent, this document must be signed by the patient's parent, legal guardian, or other duly authorized representative.*