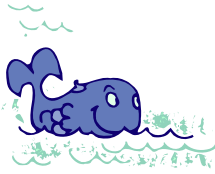


WEE CARE PEDIATRICS

JAMES A. BAKERINK, M.D.
TINA LANGERAAP, P.A.-C
CANDACE MOORE, P.A.-C



Patient and Parent Information

Please Fill Out Completely!

Child's Name:

Last: _____ First: _____ MI: _____

Other Names this Child has been known by: _____

Sex: _____ Birthdate: _____ Home Phone # _____

Alternate Phone # _____

Street Address: _____ Apt # _____ City _____

State _____ Zip _____

Mother's Name:

Last: _____ First: _____

Home Phone #: _____ Alternate Phone #: _____

Street Address: _____ State: _____ Zip: _____

Social Security #: _____ Birthdate: _____

Employer: _____ Employer's Phone: _____

Occupation: _____

Father's Name:

Last: _____ First: _____

Home Phone #: _____ Alternate Phone #: _____

Street Address: _____ State: _____ Zip: _____

Social Security #: _____ Birthdate: _____

Employer: _____ Employer's Phone: _____

Occupation: _____

Emergency Contact: (Not Living With You) _____

Phone # _____ Relationship _____

How were you referred to Wee Care Pediatrics? _____ Physician? _____ Friend? _____ Family? _____ Previous
Patient at another office? _____ Insurance? _____ Yellow Pages? _____

If this is a newborn, which hospital was the baby born? _____

Which pediatrician saw you in the hospital? _____

I authorize the providers of Wee Care Pediatrics to provide medical care for my child as necessary. I am financially responsible for any amount not covered by my insurance. I also authorize Wee Care Pediatrics to release to my insurance plan information concerning the health care provided. The information will be used for the purpose of evaluating and administrating claims for benefits. Information released for any other purpose will require my signature for release.

Signature _____ Date _____

Ofc Initials

WE E CARE PEDIATRICS

JAMES A. BAKERINK, M.D.
 CANDACE MOORE, P.A.-C
 CHRIS WLODARCZYK, P.A.-C

Protected Health Information (PHI) Disclosure Record

Patient Name: _____ DOB ____/____/____

Authorized Methods of Communication (✓ Check all that apply)

<input type="checkbox"/> Residence Phone	<input type="checkbox"/> Work Phone	<input type="checkbox"/> Written Correspondence	<input type="checkbox"/> Other (Specify)
Number ()	Number ()	Number ()	
<input type="checkbox"/> Leave call back number <input type="checkbox"/> Do not leave message	<input type="checkbox"/> Leave call back number only; do not leave message	<input type="checkbox"/> Mail/Delivery Service <input type="checkbox"/> Fax ()	
<input type="checkbox"/> Okay to leave detailed message with person	<input type="checkbox"/> Okay to leave detailed message with operator	<input type="checkbox"/> Email @ Residence	
<input type="checkbox"/> Okay to leave detailed message on answering machine	<input type="checkbox"/> Okay to leave detailed message on personal voice mail	<input type="checkbox"/> Email @ Work	

Parent/Guardian Signature _____ Date _____

Record of Disclosures

Date of Disclosure	Disclosed to Name & Address or Contact Number	Description of PHI Disclosed and Purpose of Disclosure (If a copy of the authorization or request is attached, check the box below.)	Type of Disclosure Enter T, P, or O	Person Disclosing	Method of Disclosure **Enter M, P, F, E, or OT
			<input type="checkbox"/>		
			<input type="checkbox"/>		
			<input type="checkbox"/>		
			<input type="checkbox"/>		
			<input type="checkbox"/>		
			<input type="checkbox"/>		

*T=Treatment, P=Payment, O=Health Care Operations Activities

**M=Mail, P=Telephone, F=Fax, E=E-Mail, OT=Other(and specify mode of deliver)

Initial History Questionnaire

Name _____

ID NUMBER _____

FORM COMPLETED BY _____

DATE COMPLETED _____

BIRTH DATE _____

AGE _____

M _____ F _____

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names and ages and where they live. _____

If mother and father are not living together or if child does not live with parents, what is the child's custody status? _____

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home? _____

Birth History

Birth weight _____

Was the baby born at term? _____ Early? _____ Late? _____

If early, how many weeks' gestation? _____

Did mother have any illness or problem with her pregnancy?
 Yes No Explain _____

During pregnancy, did mother
 Smoke Yes No Drink alcohol Yes No
 Use drugs or medications Yes No
 What _____ When _____

Was the delivery Vaginal? Cesarean?

If cesarean, why? _____

Did your baby have any problems right after birth?

Yes No Explain _____

Was initial feeding Breast? Bottle?

Did your baby go home with mother from the hospital?

Yes No Explain _____

General

Do you consider your child to be in good health? Yes No Explain _____

Does your child have any serious illness or medical condition? Yes No Explain _____

Has your child had serious injuries or accidents? Yes No Explain _____

Has your child had any surgery? Yes No Explain _____

Has your child ever been hospitalized? Yes No Explain _____

Is your child allergic to any medicines or drugs? Yes No Explain _____

Development

Are you concerned about your child's physical development? Yes No Explain _____

Are you concerned about your child's mental or emotional development? Yes No Explain _____

Are you concerned about your child's attention span? Yes No Explain _____

If your child is in school:

How is his/her behavior in school? _____

Has he/she failed or repeated a grade in school? _____

How is he/she doing in academic subjects? _____

Is he/she in special or resource classes? _____

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



Initial History Questionnaire

Family History

Have any family members had the following:

Deafness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Nasal allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Heart disease (before 50 years old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
High blood pressure (before 50 years old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
High cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Bleeding disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Liver disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Kidney disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Diabetes (before 50 years old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Bed-wetting (after 10 years old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Epilepsy or convulsions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Alcohol abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Drug abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Mental illness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Mental retardation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Immune problems, HIV, or AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Additional family history	_____			

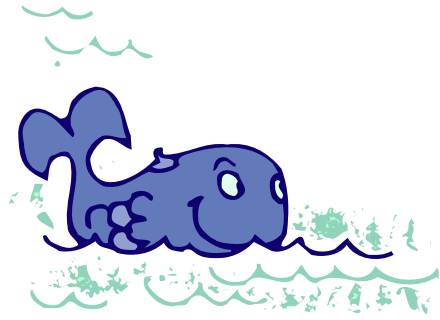
Past History

Does your child have, or has he/she ever had:

Chickenpox	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When _____
Frequent ear infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain _____
Problems with ears or hearing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain _____
Nasal allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain _____
Problems with eyes or vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain _____
Any heart problem or heart murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain _____
Anemia or bleeding problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain _____
Blood transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain _____
Frequent abdominal pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain _____
Constipation requiring doctor visits	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain _____
Bladder or kidney infection	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain _____
Bed-wetting (after 5 years old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain _____
(For girls) Has she started her menstrual periods?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When _____
(For girls) Are there problems with her periods?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain _____
Any chronic or recurrent skin problem (acne, eczema, etc)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain _____
Frequent headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain _____
Convulsions or other neurologic problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain _____
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain _____
Thyroid or other endocrine problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain _____
Any other significant problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain _____
Use of alcohol or drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain _____

WEE CARE PEDIATRICS

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Treatment Authorization

The following people other than the parent are authorized to bring:

_____ to Wee Care Pediatrics
(Name of Child/Children)

For Treatment:

(Name)

(Relationship to child)

(Name)

(Relationship to child)

(Name)

(Relationship to child)

Parent or Guardian:

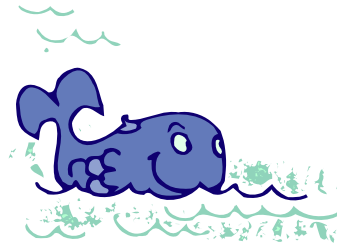
(signature)

Date: _____ Witness: _____

Ofc Initials

WEE CARE PEDIATRICS

JAMES A. BAKERINK, M.D.
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CANDACE MOORE, P.A.-C



PAYMENT POLICY

- Our medical services are provided on a cash basis until appropriate documentation has been presented to substantiate insurance eligibility, and that your annual deductible has been satisfied.
- Private paying patients must pay at time of visit (sick/well/new/established). There may also be additional charges for services, procedures, medications, or lab tests. Private paying patients not prepared to pay at their visit will be referred to the University Medical Center.
- We do not accept Secondary Insurance plans. We will only send claims to you primary insurance plan.
- We will bill insurance companies for which we are providers. Claims unpaid by your insurance after 60 days become your responsibility.
- After 60 days you must have paid your balance in full or made payment arrangements to keep your account in good standing. You must call the office if payment arrangements are needed.
- After 90 days if no payments have been received, and no extended payment arrangements have been made, then collection proceedings will begin. If your account is referred to a collection agency, you will be responsible for any collection fees and/or legal fees.
- Services rendered that are deemed not covered by your insurance carrier will become your responsibility. It is your responsibility to know your insurance plan benefits.
- Regretfully, Wee Care Pediatrics cannot provide care to patients with accounts in collections.
- Co-payments are due at the time of service and by law we cannot wave co-payments.
- **Returned check charge is \$25.00**
- All charges are due and payable within 10 days for patients receiving monthly statements.

I have read the previous information and agree to all policies of payment herein.

Signed: _____ Date: _____

Patient's Name: _____

Ofc Initials