BE WELL PEDIATRICS, LLC
1802 Baumberger Dr.
Uhrichsville, Ohio 44683
Ph.: 740-229-7097
Fax: 740-229-7035

Angela Simmerman,
Nurse Practitioner

Patient's Name _____ Patient Date Of Birth _____ Today's Date_____

New Patient Registration Form

A. Patient Demographics

Patient Name – First | Middle | Last

Patient Date of Birth | Social Security | Gender: Male / Female

Patient Address – | City | State | Zip Code

Primary Family Phone | Cell Phone | Primary Family E-mail

We are required to collect each patient's ethnicity/race. Please select all that apply before returning this form. Thank you.

O American Indian or Alaskan Native	O Asian	O Black or African American	O Hawaiian Native or Pacific Islander
O Hispanic or Latino	O White or Caucasian	O Unknown	O Decline to specify

Preferred Contact Method: O Mailing Address O Primary Phone O Cell Phone O E-mail

B. Family Contacts

Custodial Situation: O Joint O Single O Legal Guardian/Foster O Adoption

Patient's Biological Mother's First Name | MI | Last | Authority (access to patient's Medical Records)? O Y O N

Mothers Date of Birth | Social Security Number | Address | City | State | Zip Code

Mother's Primary Phone | Day Phone | Work Phone | Cell Phone | E-mail

Patient's Biological Father's First Name | MI | Last | Authority (access to patient's Medical Records)? O Y O N

Father's Date of Birth | Social Security Number | Address | City | State | Zip Code

Father's Primary Phone | Day Phone | Work Phone | Cell Phone | E-mail

C. Person Responsible For Payment If No Insurance – Custodial or Legally Appointed To Cover Medical Expenses

Parent/Guardian First Name | Middle | Last | Authority (access to patient's Medical Records)? O Y O N

Parent/Guardian Date of Birth | Social Security Number | Address | City | State | Zip Code

Parent/Guardian Address – | City | State | Zip Code

Parent/Guardian Primary Phone | Cell Phone | E-mail

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Your Relationship to the patient: O Biological Mother O Biological Father O Legal Guardian O Foster Parent O Adoptive Parent

FORM COMPLETED BY: _____ _____ _____ _____
Printed Signature Relationship to Patient Date

D. Insurance Information (this information can be found on your insurance card - PLEASE present ALL insurance cards)

_____
Policy Holder's First Name Middle Last Phone Number

Gender: O Male O Female _____
Policy Holder's Date of Birth Social Security Number

Patient Relationship to Policy Holder O Child O Other O Spouse O Self

_____
PRIMARY Insurance Carrier Name Provider Phone Number Policy ID Group ID Group Name (if applicable)

_____
Claims Mailing Address (found on insurance card) City State Zip

_____
Policy Holder's Employer Policy Effective Date PCP Co-Payment $ Amount

E. Additional Insurance Information if Applicable (please present ALL Insurance Cards)

_____
Policy Holder's First Name Middle Last Phone Number

Gender: O Male O Female _____
Policy Holder's Date of Birth Social Security Number

Patient Relationship to Policy Holder O Child O Other O Spouse O Self

_____
Secondary Insurance Carrier Name Provider Phone Number Policy ID Group ID Group Name (if applicable)

_____
Claims Mailing Address (found on insurance card) City State Zip

_____
Policy Holder's Employer Policy Effective Date PCP Co-Payment $ Amount

*** PLEASE NOTE: The insurance policy holder is not automatically responsible for patient account balances.***
The parent/guardian who holds custody of patient is responsible for any costs insured if no active insurance or if any claim amount is unpaid or non-covered by insurance, unless otherwise documented by the courts.

I CONFIRM THAT THE ABOVE INFORMATION IS CORRECT:

_____
Signature of Parent/Guardian Date

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F. Notice of Financial Responsibility

1. All active insurance policies must be presented with their current insurance cards each time services are rendered. If no active insurance policies presented on behalf of the patient, then you will be considered Self-Pay.
2. If you or anyone else hold Private insurance as Primary for patient with Medicaid as Secondary, you must provide this information at the time of service. If you fail to disclose the primary insurance, your claim will be denied.
3. Our practice accepts all insurances; however, if a patient has insurance in which we do not participate, then it is the responsibility of the billing guarantor for payment in full at the time of service.
4. It is the patient/guarantor's responsibility to pay any copayment, deductible, or any portion of the charges as specified by the insurance policy(s). Payments for medical services not covered by an individual's insurance policy are the patient/guarantor's responsibility, and payment in full is due at time of visit.
5. Please notify our office if there are any changes in your insurance coverage (including the addition or change with insurance carriers).
6. In cases of child custody, the parent court ordered to cover medical expenses for the patient will be responsible for payment of services rendered. This is to certify that I the undersigned, voluntarily consent to the administration of the practice of diagnostic procedure/imaging/photography and medical treatment by providers, authorized agents and employees of the practice as may, in their professional judgment deemed necessary or beneficial. Unless otherwise specified, all healthcare providers may obtain additional consents for individual procedures. I (we) acknowledge that no guarantees have been made to me (us) as to the effect of such examination or treatment. I understand that the insurance benefits are provided directly for the patient/guarantor and I, the undersigned, further agree and understand that I am solely responsible for all financial obligations to Be Well Pediatrics, LLC If for any reason I fail to meet my financial obligations to Be Well Pediatrics, LLC. may seek a collection agency or court action as a means of collection. I understand that I will be responsible for the balance due on my collections plus all fees related to the collection.

G. Consent to Use or disclose information for Treatment, Payment, or Health Care Operations

I hereby consent to the use or disclosure of my individually identifiable health information ("protected health information")by Be Well Pediatrics, LLC to carry out treatment, payment, or health care operations. I understand that I can review Be Well Pediatric, LLC Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information, and I have the right to review such Notice prior to signing this Consent Form. Be Well Pediatrics, LLC reserves for itself the right to change the term for its Notice of Privacy Practices for Protected Health Information at any time. If Be Well Pediatrics, LLC does change the terms of Notice of Privacy of Practices for Protected Health information, I may obtain a copy of the revised notice by calling the office and requesting a revised copy be sent in the mail or asking at the time of my next appointment. I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations. Be Well Pediatrics, LLC is not required to agree to such requested restriction(s); however, if Be Well Pediatrics, LLC does agree to my requested restriction(s), such restriction(s) are then binding on Be Well Pediatrics, LLC. At all times, I retain the right to revoke this consent in writing to Be Well Pediatrics, LLC except to the extent that action has already been taken. Be Well Pediatrics, LLC may refuse to treat Patient if he/she (or authorized representative) does not sign this Consent Form (except to the extent Be Well Pediatrics, LLC is required by law to treat individuals). If Patient (or authorized representative) signs this Consent Form and then revokes Consent. Be Well Pediatrics, LLC has the right to refuse to provide further treatment to patient as of the time of revocation (except to the extent that Be Well Pediatrics, LLC is required by law to treat individuals). AUTHORIZED SIGNATURE I have read and fully understand the FINANCIAL/INSURANCE POLICY and the CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS and agree to abide by these policies.

_____ _____
Printed Name of Parent/Legal Relationship to Patient

_____ _____
Signature of Parent/Legal Guardian Today's Date

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H. Consent for Treatment of a minor in the absence of a parent or guardian

I, _____, hereby authorize the following person(s) to bring my child in for medical treatment. I also allow them to make any medical decisions that are in the best interest of my child. I understand that this person in required to bring a picture ID with them to the visit along with my child's insurance card(s) and any co-payment that is due at the time of visit. Failure to present insurance card(s) and any co-payments due may result in the child not being seen as scheduled.

In the event of an emergency, Be Well Pediatrics, LLC assumes we have implied consent since you sent child with someone not on this list. I can be reached at _____-_____-_____ for any questions and/or concerns.

Please list person(s) authorized to bring the child to medical appointments:

1) _____ Relationship _____ Authority (access to patient's medical records): O Y O N
2) _____ Relationship _____ Authority (access to patient's medical records): O Y O N
3) _____ Relationship _____ Authority (access to patient's medical records): O Y O N

I. Consent for immunization of a minor

As of today's date, I give Be Well Pediatrics, LLC permission to immunize my child during the duration of care, or until child turns 18. I understand that these immunizations will be as recommended by the State of Ohio and American Academy of Pediatrics and agree to maintain vaccination appointments in order to keep patient(s) up-to-date on all immunizations. AUTHORIZED SIGNATURE I have read and fully understand the CONSENT FOR TREATMENT OF A MINOR and the CONSENT FOR IMMUNIZATION OF A MINOR POLICIES and agree to abide by these policies.

_____ _____
Printed Name of Parent/Legal Guardian Relationship to Patient

_____ _____
Signature of Parent/Legal Guardian Today's Date

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Patient Medical History

History	Yes	No	If YES – Comment
Abdominal Pain/Gastroesophageal Reflux			
Allergic Rhinitis or Other Allergy			
Anemia or Bleeding Problem			
Asthma / Bronchitis / Bronchiolitis/ Pneumonia / Croup			
Bedwetting (after 5 years of age)			
Bladder or Kidney Infection or other Urologic Problem			
Blood Transfusion			
Chronic or Recurrent Skin Problems (acne, eczema, etc.)			
Constipation Requiring Doctor Visits			
Diabetes			
Emotional Problems			
Eye conditions or Corrective Lenses			
Frequent Ear or Sinus Infection			
Frequent Headaches			
Heart Problems or Heart Murmur			
Hospitalizations			
If female – Have periods started?			
If yes – date of first menses			
Known Allergens			
Mental Health Concerns			
Orthopedic Problems			
Other Infectious Illnesses			
Other Significant Problems			
Pharyngitis or Tonsillitis			
Problems with hearing/ears			
Seizures or developmental delays			
ADD/ADHD/OD			
Serious Injuries or Accidents			
Surgeries			
Thyroid or Other Endocrine Problems			
Use or History of Use of Alcohol or Drugs			

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Biological Family Medical History of Patient

Familial History	Yes	No	Relationship to patient (Biological Mother, Father, Sister, Brother or Maternal/Paternal Grandma/Grandpa
Nasal Allergies or Other allergies			
Asthma/Lung Disease			
Heart Disease or Condition			
High Blood Pressure (Hypertension)			
High Cholesterol (Dyslipidemia)			
Diabetes or Other Endocrine Problem			
Cancer			Specify Type:
Anemia			
Bleeding Disorder			
Epilepsy or Seizure Disorder			
Developmental Disorders			
Neurological Disorders			
ADHD/ADD/OD or Other Psych Diagnosis			
Liver Disease			
Other Gastrointestinal Disorder			
Kidney Disease			
Bedwetting after 10 years of Age			
Hearing Impairment			
Vision Impairment or Eye Disorder			
Immune Problem, Recurrent Infection. Or HIV/AIDs			
Alcohol Abuse			
Drug Abuse			
Mental Illness			
Tuberculosis			
Additional Pertinent Conditions			

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Patient's Social History

Date of last physical exam: _____ Previous Physician: _____

History Question	Yes	No	Comment
Residential Parent			
Siblings? List number of sister & brothers			Sisters _____ Brothers _____
If applies – visitation schedule			
Smoke Exposure – including vapes			
Pets			
Guns in the home			
Guns are locked and kept separate from ammunition			

Patient's Birth Information

Birth Statistics	Comment
Birth date and time	
Part of multiple birth?	
Complications	
Gestational Age	
Type of Delivery – Vaginal/C-Section	
Feeding – Formula or Breast	
Blood Type	
Normal Newborn Screen	
Adopted	
BIRTH LOCATION	
Birthplace (Hospital Name and Location)	
If Applicable - Additional Hospitalization and Location	
At birth – Length, Weight	