



New Patient Financial Responsibility Form

Patient's Name: _____ **DOB:** _____

Address: _____
Street City State/Zip

Mother's Information:

Name: _____
Date of Birth: _____
Phone: _____
E-Mail: _____
Previous Patient of Reading Pediatrics: Yes No

Father's Information:

Name: _____
Date of Birth: _____
Phone: _____
Email: _____
Previous Patient of Reading Pediatrics: Yes No

Patient Siblings (include half and step siblings):

Last Name	First Name	Date of Birth	Same Mother as Patient	Same Father as Patient	Same Insurance as Patient
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient's Primary Insurance Name: _____

ID #: _____ Effective Date: _____
Subscriber* Name : _____ Subscriber DOB : _____
Subscriber Relationship to Patient: _____ Copy Card: _____

Patient's Secondary Insurance Name (If Applicable): _____

ID #: _____ Effective Date: _____
Subscriber* Name : _____ Subscriber DOB : _____
Subscriber Relationship to Patient: _____ Copy Card: _____

** Subscriber is the primary insurance holder – this could be yourself, your spouse/partner, or your parent*

Guarantor (Person Responsible for Payments): Mother Father Other: _____

Address of Guarantor if different from above:

Street City State/Zip

I hereby authorize READING PEDIATRICS, INC to apply for benefits on my behalf for covered services rendered by him/her, or by his/her order. I request that payment from my insurance company be made directly to READING PEDIATRICS, INC. I understand that I am financially responsible for any balance not paid by my insurance. Balances are to be sent to the guarantor listed above. Payment is expected within 30 days of receipt.

Date: _____ Signature: _____ Print: _____

Date: _____ Received By: _____



New Patient Intake Form

Patient Name: _____ **Preferred Name:** _____ **Date of Birth:** _____

Patient Sex: Male Female

Primary Contact Number: _____

Alternate Contact Number: _____

Mother's Name: _____ **Age:** _____ **Date of Birth:** _____

Father's Name: _____ **Age:** _____ **Date of Birth:** _____

Parent's Relationship Status: Married Unmarried Same household Separate Households

Custody Agreement: Yes – please provide a copy

Primary Address: _____

Street

City/State

Zip

Alternate Address: _____ **Relationship:** _____

Street

City/State

Zip

Preferred Language: English Spanish Other: _____

Patient Ethnicity: Hispanic or Latino NOT Hispanic or Latino

Patient Race (Check all that apply): American Indian/Alaskan Native Asian Black/African American White
 Native Hawaiian or Pacific Islander

Medical History:

Hospitalizations or Surgeries:

Date: _____ **Reason:** _____ **Hospital:** _____

Date: _____ **Reason:** _____ **Hospital:** _____

Date: _____ **Reason:** _____ **Hospital:** _____

Medical Problems: (Check all that apply) – Provide Specific Details Below

- | | | | | |
|--|--|---|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Psychiatric Disorder | <input type="checkbox"/> Orthopedic Disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Seizures | <input type="checkbox"/> Behavior Problems | <input type="checkbox"/> Sickle Cell |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Recurrent Infections | <input type="checkbox"/> Learning Disabilities | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Elevated Lead Level | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Eczema/Skin Problems | <input type="checkbox"/> Genetic Disorder | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Vision Problems | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> ADHD | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Other |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Delayed Speech | <input type="checkbox"/> Delayed Development | <input type="checkbox"/> Sleep Issues | |

Details: _____

Allergies: (List Medication/Food and Reaction): None

Medications: (List Medication Name, Dose, Frequency and Prescriber): None

Specialists: (List Name and Specialty of all other physician's your child sees): None

Family History:
(Check all that apply)

Mother Father Sibling
(Specify) Details

	Mother	Father	Sibling (Specify)	Details
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Epilepsy(Seizures)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer (Type)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sickle Cell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Psychiatric (Specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Genetic Disorder (Specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other: Specify	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Social History (If Applicable):

Grade in school: _____ Doing Well Struggling Does Child Have IEP/504 accommodations? Yes No

Extracurricular Activities: _____

Alcohol Use: Yes No How Often? _____ Tobacco Use Yes No How Often? _____

Vape/E-cigarette Use: Yes No How Often? _____ Marijuana Use: Yes No How Often? _____

Sexual Activity Yes No LGBTQ+ _____

Has Experienced: Bullying Poor Self Esteem Disordered Eating School Avoidance Anxiety/Depression Suicidal Thoughts

Safety:

Is there a working smoke alarm on each floor of the child's home/apartment? Yes No

Is your child restrained in a car seat/seat belt when riding in the car? Yes No

Are there any smokers in the household (cigarette, vape, THC)? Yes No

Is your child wearing a helmet if riding a bike/scooter? Yes No

Are there any firearms in the home? Yes No If yes, are they locked with ammunition stored separately? Yes No

Concerns to address at today's visit:

Signed: _____

Date: _____

Print: _____

Relationship: _____

Reviewed By: _____ Date: _____



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Maria S. Bell, CRNP
Krislyn Milligan, CRNP
Whitney Trompeter, MD, FAAP
Tarah Bird, PMHNP

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I, _____,
Parent/Guardian Name

have been given access to a copy of Reading Pediatrics Notice of Privacy Practices.

Signature of Parent or Guardian

Date

Patient Name

Patient DOB

Account Number

To read a copy of RPI Notice of Privacy Practices please visit:

<https://www.readingpediatrics.com/policies>