Pediatric Professionals

310 NE Tudor Rd.
Lee's Summit, MO. 64086
816-347-0303

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PleasePrint

Patient's Legal Name_____Date of Birth_____Sex_____

Address_____City_____State___Zip_____ Home Phone_____Alternate Phone_____ Sibling's Legal Name____

_____Date of Birth_____Sex_____

Sibling's Legal Name_____Date of Birth_____Sex_____

Sibling's Legal Name_____Date of Birth_____Sex_____

Sibling's Legal Name_____Date of Birth_____Sex___

Parent/LegalGuardianInformation

Name_____Date of Birth_____Relationship_____ Address_____

City_____State_Zip_____ Home Phone_____Cell Phone_____

_____ Employer_____Work Phone_____

_____

Social Security No._____

Name_____Date of Birth_____Relationship_____ Address_____

City_____State_Zip_____ Home Phone_____Cell Phone_____

_____ Employer_____Work Phone_____

_____

Social Security No._____

EmergencyContact (other than parents)

Name_____Home Phone_____ Address_____Alt. Phone_____

Who referred you to our office?_____

PrimaryInsurance EFFECTIVE DATE_____

Insurance Company and Address_____ Name of Policy Holder_____ ID No._Group Name/No._____

SecondaryInsurance EFFECTIVE DATE_____

Insurance Company and Address_____ Name of Policy Holder_____

ID No._____Group Name/No._____

SIGNATURE _____DATE_____

NAME_____BIRTH DATE_____SEX MALE ☐ FEMALE ☐

PAST HISTORY

HOSPITALIZATIONS_____SURGERIES_____

INJURIES_____

ALLERGIES_____

CURRENT MEDICATIONS_____

OTHER ILLNESSES_____

_____

BIRTH HISTORY

Pregnancy Problems/Medications Taken_____

Gestational Age at Birth_____Vaginal Delivery ☐ C-Section Delivery ☐

Birth Statistics Height_____Weight_____Which Hospital?_____

Nursery Problems_____

FAMILY HISTORY

If Yes, Who?

Diabetes ☐_____Mental/Psychiatric ☐_____

Heart Attacks ☐_____Lung Diseases/Asthma ☐_____

High BP ☐_____Seizures ☐_____

Blood Disorders ☐_____Allergies ☐_____

Mental Retardation ☐_____Migraine ☐_____

SIDS □_____

SOCIAL HISTORY

NUMBER OF PEOPLE IN HOUSEHOLD_____ EXPOSURE

TO CIGARETTE SMOKE YES ☐ NO ☐ IF YES, WHO?_____

PETS_____

COMPLETED BY_____

DATE_____

PEDIATRIC PROFESSIONALS
310 NE TUDOR RD., LEE'S SUMMIT, MO 6486
816-347-0303 FAX 816-347-0610

FINANCIALPOLICY

Thank you for selecting Pediatric Professionals as your child's health care facility. It is our hope that providing you with an outline of our financial policy will eliminate any future misunderstandings.

A parent or legal guardian must complete our "Patient Information Form" before child/children are seen. If there is a change in address, telephone number, family status, insurance, etc. please notify us, so that we can update the change in our computer and patient's chart.

All co-pays are due at the time of service. If co-pay is not paid you may be asked to reschedule your child's appointment. If insurance information is not provided, you will be responsible for child/children's fees at the time of service. Refunds are only made after your insurance company makes a payment.

All balances are the parent/guardian's responsibility. We will do our best to file claims in a timely and professional manner. If there are any questions or concerns reguarding our billing and collection practices, please ask. Thank you for allowing us to serve you.

CONSENTPOLICY

I give these family members permission to consent for any or all medical appointments, including immunizations, or any necessary medical treatment including lab work for my son/daughter. I also give Pediatric Professionals permission to release necessary documented information regarding my child to these persons.

1._____

2._____

3._____

I have read and understand Pediatric Professionals financial policy and parental consent form.
Parent/Legal
Guardian_____Date_____

PEDIATRIC PROFESSIONALS

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

(Please Check One)

☐ I, _____, have received a copy of Pediatric Professionals Notice of Privacy Practices.

☐ I, _____, do not want a copy of Pediatric Professionals Notice of Privacy Practices.

Signature of Patient or Guardian _____Date_____

StatementofFinancialResponsibility

I authorize all insurance payments to be made to the provider, Pediatric Professionals. I understand that I am financially responsible for all charges not covered by my insurance carrier and that it is my responsibility to insure the provider is given the correct insurance information **at the time of service**. Any delay in providing the correct insurance information or providing your insurance company with yearly coordination of benefits information will cause claims to be denied, and they will become member responsibility for payment.

Notice: Medicaid, BCBS Blue Advantage Plus and Family Health Partners are secondary to your primary insurance. Please provide the correct information.

Should the insurance company deny my claim, I agree that I will be liable for payment.

Signed: _____Date:_____