Renaissance Pediatrics, P.C.
4012 Raintree Road, Suite 200A
Chesapeake, VA 23321
Office: (757) 488-2223 Fax: (757) 488-8398

Child's Name: ____ Birth date: ____/____/____ Social Security #: _______________________
First Middle Last

Gender: □ Male □ Female □ ___________________

Ethnicity: □ Hispanic □ Non-Hispanic

Race: ___________________

How were you referred to us? ______________________________

I prefer to be reminded of appointments by text: □ Yes □ No

If not, how? ___________________________________

Email address__________________________________

Address: ____

City, State & Zip: ____

Preferred Language: _______________________________________

Cell Phone#: ____

Secondary Telephone #: _____________________________________
□ Home □ Cell □ Work □ Other

□ **Mother** □ **Father** □ **Guardian** □ ____________

Name: ____

Address: ____

City, State & Zip: ____

Employer: ____

SS# _______________DOB: ____________Cell #:_______________

Home #: ______________________ Work #: ____________________

Preferred Primary Contact #: C□, H□, or W□

□ **Mother** □ **Father** □ **Guardian** □ ____________

Name: ____

Address: ____

City, State & Zip: ____

Employer: ____

SS#_______________ DOB: ______________Cell#:______________

Home#: ___________________ Work#: _______________________

Preferred Primary Contact #: C□, H□, or W□

Primary Insurance

Policy Holder's Name: __________________________________

Relationship to patient: __________________________________

Birthdate: ____/____/____ S.S. #: _______________________

Employer: ____

Insurance Co.: ____

Group #: ________________ Policy ID #: ____________________

Co-Pay: _____ Deductible: ________ Eff. Date: ______________

Secondary Insurance

Policy Holder's Name: __________________________________

Relationship to patient: __________________________________

Birth date: ____/____/____ S.S. #: ________________________

Employer: ____

Insurance Co.: ____

Group #: _______________ Policy ID #: ____________________

Co-Pay: _______ Deductible: __________ Eff. Date: _________

I authorize Renaissance Pediatrics, P.C. to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. **If it becomes necessary to forward my account to a collection agency, I am aware that I will be responsible for all costs of collections, which is currently $25.00 (subject to change).**

______________________________ ______________________________ ____________________
Signature of Patient or Parent if Minor (**Responsible Party**) Social Security Number Date

RENAISSANCE PEDIATRICS, P.C.
Phone: (757) 488-2223 Fax: (757) 488-8398

Pediatric Health History Form

Date: ______________

Patient's Name: ____________________ Birth date: ___/___/___

Mother's Name: ____________________ Age: _______ Health Problems: ____________________

Father's Name: ____________________ Age: _______ Health Problems: ____________________

Sibling(s) Name & Age: ____________________

Patient current medical problem(s): ____________________ Date Began: ____________________

Current Medications: ____________________

Serious Illness, Injury, Hospitalizations:

Year	Type of Illness, Injury, Surgery
_______	____________________
_______	____________________

List any know drug allergies/reaction: ____________________

Birth Weight: __________ Length: ____________ Gestation Age of Delivery: Early <38 wks Term 38-42 wks Late > 42 wks
Home with mom/dad? Yes No Why not: ____________________
Prenatal Complications: ____________________
Was your baby: Jaundiced - Yes / No Breast fed / Formula fed how long? ____________________
Delivery Hospital____________________

Has your child ever had wheezing or bronchitis?	Yes	No	
Has your child ever had chicken pox?	Yes	No	Date/Age: __________
Do you have questions concerning the insertion of your car safety seat?	Yes	No	
Do you have the phone number to poison control?	Yes	No	
Do you wish to learn CPR?	Yes	No	
Do you have any questions to discuss with the provider?	Yes	No	

Please identify health problems in the patient or blood relatives:

Condition	***Patient/Relative***	***Condition***	***Patient/Relative***
Alcohol/Drug Addiction	___________	Genetic Disorders	___________
Allergies	___________	Heart Disease	___________
Anemia/Blood Disorders	___________	HIV/AIDS	___________
Asthma	___________	Kidney Disease/Bed Wetting Issues	___________
Behavior Problems	___________	Lung Disease	___________
Birth Defects	___________	Mental Illness/Retardation	___________
Bone/Joint Disease	___________	Muscle Disorders	___________
Cancer	___________	Rheumatic Fever	___________
Chronic Diseases	___________	Rheumatoid Arthritis	___________
Diabetes	___________	Seizures/Epilepsy	___________
Digestive Disorders	___________	Thyroid Disorders	___________
Eye/Ear Disorders	___________	Tuberculosis	___________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the doctor's office of any changes in my child's medical status. I authorize the healthcare staff to perform the necessary healthcare services my child may need.

Signature of Parent: ____________________ Date: ______________

Reviewed by provider: ____________________ Date: ______________

Provider Comments: ____________________

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I, ________________________________ the parent/legal guardian of ________________________________
(Please print) (Please print)

Give the following person(s) permission to seek medical care for the above mentioned child in my absence. This is to be effective on date signed and to remain in effect until further written notice is given.

The listed person(s) should be also considered as "emergency contacts" in the event that I am unable to be reached.

Name	***Relationship to patient***	***Phone Number(s)*** ***(Please indicate home, cell, work)***	***Access to records*** ***(check if yes)***	***Access to financials*** ***(check if yes)***

****A photo ID will be required for all persons listed.****

________________________________ ________________
(Signature) (Date)

I also give the person(s) listed above to sign for any vaccinations that are due to be given at the time of service.

________________________________ ________________
(Signature) (Date)

PATIENT ACKNOWLEDGMENT AND CONSENT

I have read and reviewed a copy of Renaissance Pediatrics' Notice of Privacy Practices, version effective September 23, 2013. I consent to the uses and disclosures of my health information as outlined in the Notice. A copy of this notice will be provided upon request.

______________________________	______________________________
Signature of Patient or Representative	Date
______________________________	______________________________
Print Name	Patient Name
______________________________	______________________________
Relationship of Representative to Patient	Patient DOB

Please describe the Representative's authority to act on behalf of Patient: ______________________

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FOR RENAISSANCE PEDIACTICS USE ONLY

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain acknowledgment and the reason you could not obtain it:

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