HUNTSVILLE PEDIATRIC AND ADULT MEDICINE ASSOCIATES
PATIENT INFORMATION

Patient's Name ______________________________________ Sex __ Male __ Female **Date of Birth** __________
Address ___________________________________City/State________________________ Zip Code____________
Home Phone _________________ Cell Phone ________________ E-mail address _________________________
Driver License # ______________ Marital Status __ Single __ Married __ Widowed
Occupation ____________________ Employer's Name ________________________ Work Phone _________
Spouse's Name _________________ Employer's Name ________________________ Work Phone _________
In case of emergency, notify____________________ Relation to Patient__________ Phone _________
Your Pharmacy ____________________ Phone ___________ Referred by ________________________

Complete the Following if the Patient is a Minor or a College Student
Responsible Party's Name ________________________________ Relationship to Patient _________________
Father's Name __________________________ Home Phone_______________ Cell Phone_________________
Date of Birth ________________ **Driver License #** _________________
Employer ___________________________ Work Phone _______________ OK to call ____ Yes ____ No
Mother's Name __________________________ Home Phone_______________ Cell Phone_________________
Date of Birth ________________ **Driver License #** ________________
Employer ___________________________ Work Phone _______________ OK to call ____ Yes ____ No
Hospital where child was born ____
Other Children (Names and Ages) ____
Is there anyone other than a parent authorized to seek treatment for your child? If so, please list below:
Name _____________________________________ Relationship to patient ______________________________
Name _____________________________________ Relationship to patient ______________________________

INSURANCE INFORMATION: (Please provide copy of current insurance card)
Insurance Name ___________________________ Policyholder's Name ___________________ **D.O.B**. _________
Policy Number ____________________ Group #_____________ Group Name _____________________________
Medicare # _______________________ Medicaid # __________________________

RELEASE OF INFORMATION:
I authorize Huntsville Pediatric and Adult Medicine Associates to release any medical or other information necessary to process claims for services provided to me.
ASSIGNMENT OF BENEFITS:
I authorize payment of government or other medical benefits to Huntsville Pediatric and Adult Medicine Associates for any services provided to me.
FINANCIAL POLICY:
I acknowledge that I have read and/or been offered a copy of this office's Financial Policy.
PRIVACY POLICY ACKNOWLEDGEMENT:
I acknowledge that I have read and/or been offered a copy of this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

I have read and agree to the Release of Information, Assignment of Benefits, Financial Policy, and Privacy Policy Acknowledgement paragraphs as stated above.

____ DATE ________________
Patient or Responsible Party Signature

____
Relationship to Patient If Not Parent or Legal Guardian

HUNTSVILLE PEDIATRIC AND ADULT MEDICINE ASSOCIATES

PEDIATRIC PATIENT HISTORY

Patient Name ___________________________________ D.O.B. ______________ Date ______________

BIRTH HISTORY

Type of Delivery ___________ Term________
Premature at _____________ Months ________
Pregnancy Number ____________________
Hospital Born At __________________
Birth Weight _________ Blood Type _______
Circumcision __________________________
Other ______________________________

INOCULATION HISTORY

Please provide us with a copy of your child's immunization record Today or at your next visit

ILLNESS HISTORY

General ________________________________
Allergies ________________________________
Chicken Pox _____________________________
Tonsillitis/Pharyngitis ____________________
Ear Infections ___________________________
Asthma/Bronchitis _______________________
Hospitalized _____________________________
Serious Injuries __________________________
Operations ______________________________
Other __________________________________

FAMILY HISTORY

High Blood Pressure _________ Cancer _________
High Cholesterol ___________ Allergies _________
High Triglyceride __________ Asthma __________

NUTRITION HISTORY

Breast _____________ Formula ________________
Vitamin Supplement __________ Type __________
Soft Foods Added _____________________________
____
____

DEVELOPMENT HISTORY

	AGE		AGE
Held Up Head	___________	First Teeth	_________
Smiled	_________________	Crept	_____________
Sat Aided	______________	Stood Alone	________
Stood Aided	____________	Walked	_____________
Sat Alone	_____________	Said Words	_________
Reached for Objects	______	Sentences	__________

HABITS: Sleep ______________________________
Bed Wetting ________________________
Naps _______________________________
Play _______________________________
School _____________________________
Other ______________________________

Acknowledgement of Financial Policy

- **I understand Huntsville Pediatric and Adult Medicine Associates (HPAM) will copy my insurance card and driver's license. I further understand it is my responsibility to notify HPAM in the event of insurance coverage change.**
- **I understand HPAM will obtain demographic information including mailing address, contact phone numbers, and email address. I further understand it is my responsibility to notify HPAM if any demographic information changes.**
- **I understand HPAM does not accept Worker's Comp.**
- **I understand payment for co-payments, deductibles, and percentages not covered by insurance carrier are due at the time services are rendered.**
- **I understand if I do not have insurance coverage I will be responsible for services rendered at the time of service.**
- **If I am a Medicare recipient, I understand I will be responsible for annual deductibles, 20% co-insurance, non-covered services, and any charges Medicare states I am responsible for.**
- **I understand a $30.00 service charge will be applied to all returned checks.**
- **I understand a $25.00 fee will be charged for missed appointments and for appointments cancelled less than 4 business hours prior to my appointment time.**
- **I understand I will receive a separate statement from the Radiologist that interprets all x-rays done at HPAM.**
- **I understand that a fee is charged for copies of medical records and is due prior to the release of records.**

For Insurance Billing:

I hereby authorize Huntsville Pediatric and Adult Medicine Associates (HPAM) to furnish my insurance company with all the information which the insurance company may request concerning my present illness or injury. I hereby assign Huntsville Pediatric and Adult Medicine Associates all money to which I am entitled for medical expenses related to the service reported. I understand I am financially responsible to Huntsville Pediatric and Adult Medicine Associates for charges not covered by this assignment.

Patient Name: ____ Patient DOB: ___________

Responsible Party: ___________________________________ Printed Name

Patient/Responsible Party: ____________________________ Signature

Date: _________

Huntsville Pediatric & Adult Medicine

ASSOCIATES

Patient Authorization to Release Protected Health Information

I, ______________________________, give my authorization to release my protected information including results of my laboratory tests, x-ray, and/or other test results to the following designated representative(s).

______ (Initial) Spouse Name ____

______ (Initial) Child(ren) Name(s) ____

______ (Initial) Other Name(s) ____

______ (Initial) Parent(s) Name(s) ____

______ (Initial) Authorize Huntsville Pediatric and Adult Medicine to call the following numbers and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items, and any calls pertaining to my clinical care such as test results.

______ (Initial) Home Number (as on file)

______ (Initial) Cell Number (as on file)

______ (Initial) Work Number (as on file)

______ (Initial) Other Number(s): ______________________________

______ (Initial) Authorize Huntsville Pediatric and Adult Medicine to mail to the following address any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminder cards, unable to reach patient by phone letters, and statements as they are marked Personal and Confidential.

______ (Initial) My home address as on file.

______ (Initial) Other address: ____

____

I understand that this release of information is considered valid until a new release of information is submitted or my child turns 18. The office will not disclose any information to any items above that do not have an initial beside it.

Patient or Legal Guardian Signature: ____

Patient Name: _________________________________ Patient DOB: ____/____/_____ Age: _____

Date: ___/___/_____

***Office Use Only:**

____ This patient is a child and will be 18 as of _____/_____/______ and will need a new release of information form.