



Lake Forest Pediatric Associates

New Patient Questionnaire

Today's Date _____

Name of Child _____ Date of Birth _____

Household

Please list all those living in the child's home

Name	Relationship to Child	Birth Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If mother and father are not living together or if child does not live with parents, what is the child's custody status?

Birth history

Were there any complications during the pregnancy? No Yes Please give details:

Did mother take drugs or prescribed medications? No Yes

Did mother smoke? No Yes

Was the baby full term or premature how early?

Where was the baby born?

What was the birth weight?

Were there any complications of labor or delivery? No Yes

Were there any newborn problems after birth? No Yes Please give details:

Your Child's Health

- Has your child ever been seen by a subspecialist? No Yes
- Do you consider your child to be in good health? No Yes
- Has your child ever been hospitalized overnight? No Yes
- Has your child ever had surgery? No Yes
- Has your child had any chronic or serious illnesses? No Yes
- Has your child had any major injuries? No Yes
- Is your child **allergic** to any medications? No Yes
- Is your child **allergic** to anything else? No Yes
- Is your child currently taking any medication? No Yes
- Are your child's immunizations [shots] current? No Yes

Development

- Has your child had any problems or delays in development? No Yes
- Does your child receive any therapy or any special services at school? No Yes
- Does your child have any behavioral or discipline problems? No Yes
- Has your child failed or repeated a grade in school? No Yes

Past Medical History (Skip this section if your child is a newborn)

Does your child have or has he/she ever had:

- Frequent ear infections No Yes
- Problems with ears or hearing No Yes
- Nasal allergies No Yes
- Problems with eyes or vision No Yes
- Asthma, bronchitis, or bronchiolitis No Yes
- Pneumonia No Yes
- Chickenpox or shingles No Yes
- Heart problem or murmur No Yes
- Anemia or bleeding problem No Yes
- Blood transfusion No Yes
- Frequent abdominal pain No Yes

- Frequent constipation No Yes
- Bladder or kidney infection or bedwetting No Yes
- [for girls] has she started her menstrual periods? No Yes
- [for girls] any problems with her periods? No Yes
- Skin problems – eczema, acne No Yes
- Frequent headaches No Yes
- Seizures, convulsions, or epilepsy No Yes
- Diabetes No Yes
- Thyroid or other endocrine problems No Yes
- Use of alcohol or drugs No Yes
- Learning or attention problems No Yes
- Any other significant problem No Yes

Your child's environment

- Does anyone in the household smoke? No Yes
- Does someone else care for your child during the day or after school? No Yes
- Is your home childproofed? No Yes
- Are there firearms in your home? No Yes
- If yes, are they locked up? No Yes
- Are there working smoke and carbon monoxide detectors at home? No Yes
- Does your family always use seat belts / car seats? No Yes
- Is anyone in your family getting hit or abused? No Yes
- Has your child been exposed to anyone with tuberculosis? No Yes
- Does your drinking water come from a well? No Yes
- Are there any pets in the home? No Yes

Family Medical History

- Has any blood relative on either side of the family had: who?
- Heart disease, or heart attack before age 50 No Yes
- High blood pressure No Yes
- Elevated cholesterol or triglycerides No Yes

- Diabetes or sugar problems No Yes
- Cancer No Yes
- Thyroid disease No Yes
- Kidney disease No Yes
- Asthma No Yes
- Emphysema No Yes
- Cystic fibrosis No Yes
- Tuberculosis No Yes
- Hepatitis No Yes
- Cirrhosis No Yes
- Ulcerative colitis No Yes
- Crohn's disease No Yes
- Bleeding or clotting disorder No Yes
- Immune deficiency disorder No Yes
- HIV or AIDS No Yes
- Arthritis No Yes
- Seizures or convulsions No Yes
- Stroke No Yes
- Neurologic disorder No Yes
- Psychiatric disorder No Yes
- Attention or learning disorder No Yes
- Birth defects No Yes
- Height of Father _____ Mother _____

Person completing this form

Signature

Date

Provider reviewing this form

Signature

Date

**Lake Forest Pediatric Associates
Financial Policy**

Account Responsibility

When a patient is registered with Lake Forest Pediatrics, we ask that the parent or guardian seeking care accept final responsibility for payment. Patient due balances are expected to be paid within 14 days of receipt of the statement. If there is an insurance dispute or financial difficulty, contact our business office at 847-295-2260 within 14 days of receipt of statement.

An account that is sent to a collection agency will be assessed a 30% collection fee. Even in divorce situations, we consider both parents responsible for the account. In the event the account is referred to a collection agency, both parent's names and social security numbers will be submitted.

Payment Will Be Expected At Time Of Service When:

- We are not contracted with your insurance plan.
- We are unable to verify eligibility.
- There is no insurance coverage.
- If there is new insurance and you are unable to provide an insurance card.

Co-pays

If required by your insurance plan, you will be expected to pay your co-pay **each time** your child is seen in our office. We accept cash, checks and all major credit cards.

Professional Services Rendered

If your child is seen for a scheduled preventive visit and another condition is treated at the same time, the provider will bill for each service performed.

Fees:

After Hours Phone Calls	\$25
Sunday/Holiday	\$25
NSF Check	\$35
No Show (regular visit)	\$35
No Show (extended visit)	\$70
Replacement Forms	\$10

I agree to pay for any and all medical services I receive from this practice that my insurance company refuses to pay, for whatever reason. This office will file a claim on my behalf; however, if my insurance company refuses to pay, for whatever reason (e.g., non-covered services, does not pay for preventive medicine visits), I will pay for same upon written/verbal notice of their refusal.

I further agree and understand that this office can only code and file a claim for my child's visit with a diagnosis that was encountered and documented in the medical record. Thus, to ask this office to change a diagnosis solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and fraudulent.

I authorize the release of any medical information necessary to process any claims, either to myself or any parties who request this information.

Signature of Parent/Legal Guardian	Name (please print)	Date
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A copy of Lake Forest Pediatric Associates, Ltd. **Notice of Privacy Practices** has been made available to me.

Print Name	Signature Parent or Legal Guardian	Date
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This receipt covers the following family members:

_____ LFFPA Acct #

Lake Forest Pediatric Associates, Ltd.

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM.

Please visit http://www.lakeforestpediatrics.com/files/privacy_notice.pdf to view our Notice of Privacy Practices.

A copy of Lake Forest Pediatric Associates Notice of Privacy Practices has been made available to me.

Signature of Patient or Legal Guardian

Date

This receipt covers the family members listed below.

