GERGELY PEDIATRICS, P.C.
34 ROUTE 403
GARRISON, NEW YORK 10524
TEL (845) 424 - 4444
FAX (845) 424-4664

PATIENT REGISTRATION

PATIENT REGISTRATION		DATE		
NAME	M F	DATE OF BIRTH		AGE
STREET ADDRESS		CITY STATE, ZIP		Home PHONE ( )
SCHOOL		REFERRED BY		
FATHER'S NAME	OCCUPATION/ EMPLOYER	DATE OF BIRTH	WORK ( ) Cell PHONE ( )	S.S.#
MOTHER'S Maiden NAME	OCCUPATION/ EMPLOYER	DATE OF BIRTH	WORK ( ) Cell PHONE ( )	S.S.#
GUARDIAN (OTHER THAN SELF)	OCCUPATION/ EMPLOYER	DATE OF BIRTH	WORK Cell PHONE ( )	S.S.#
EMERGENCY CONTACT (OTHER THAN PARENTS)		ADDRESS		PHONE ( )
CLOSEST RELATIVES (NOT AT YOUR ADDRESS)		ADDRESS		PHONE ( )

EMAIL ADDRESS:

INSURANCE & BILLING INFORMATION

PERSON RESPONSIBLE -	☐ FATHER ☐ MOTHER	☐	RELATIONSHIP	
BILLING ADDRESS				PHONE #

PAYMENT REQUIRED AT TIME OF SERVICE - UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

1) INSURANCE COMPANY	ADDRESS		EFFECTIVE DATE
SUBSCRIBER'S NAME	I.D. #	GROUP #	BENEFIT CODE
2) INSURANCE COMPANY	ADDRESS		EFFECTIVE DATE
SUBSCRIBER'S NAME	I.D. #	GROUP #	BENEFIT CODE
OTHER COVERAGE			

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Dr. Gergely for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. Gergely to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

MEDICAID

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be valid as the original.

PATIENT (please print) ______________________ DATE ______________

PARENT/GUARDIAN (please print) ______________________ SIGNATURE ______________

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PEDIATRIC - PATIENT QUESTIONAIRE

Completed by ______ Relation ______

Please check [Y] yes or [N] no, circle or explain where required. N/A-Not Applicable

Reason for today's visit -

Previous medical care - Dr. ______ Dental Care [Y] [N] Eye Exam [Y] [N]

PREGNANCY & BIRTH

Mother's age at pregnancy? ______

Any illness during pregnancy? [Y] [N] ______

Medications during pregnancy? [Y] [N] ______

(exclude vitamins & irons) ______

Smoking - alcohol - street drugs - during pregnancy? ______

Was baby early - late - on time? ______

Type of delivery? ______ Birth weight ______ Length ______

Complications? [Y] [N] ______ Apgar ______

Problems with baby at birth? Breathing [Y] [N] Jaundice [Y] [N]

Other ______

Problems soon after? Nursery or home? ______

PAST MEDICAL HISTORY

Allergic reactions? Medicine [Y] [N] Food [Y] [N] Animals [Y] [N]

Insect bites [Y] [N] ______

Medications taken on a regular basis? (exclude vitamins) ______

Immunizations - up to date? [Y] [N] Do you have a record? [Y] [N]

Hospitalizations - (when-where-why?) ______

Serious Injuries (when-where?) ______

Red Measles	[Y] [N]	Mumps	[Y] [N]	German Measles (3 day)	[Y] [N]
Chicken Pox	[Y] [N]	Whooping Cough	[Y] [N]	Rheumatic Fever	[Y] [N]
Scarlet Fever	[Y] [N]	Ear Infections	[Y] [N]	Strep Throat	[Y] [N]
Asthma/Wheezing	[Y] [N]	Eczema/Hives	[Y] [N]	Seizures	[Y] [N]
Anemia	[Y] [N]	Hepatitis	[Y] [N]	Problem with hearing	[Y] [N]
Bleeding Tendency	[Y] [N]	Urinary Infections	[Y] [N]	vision	[Y] [N]
Blood Transfusions	[Y] [N]	Joint Problems	[Y] [N]	Other ______	

FEEDING & NUTRITION

Food Allergies ______

Appetite usually good? [Y] [N]

Colic or feeding problems during the first 3 months? [Y] [N]

Breast fed? [Y] [N] Number of month's? [Y] [N]

Formula? [Y] [N] Current brand? ______

Vitamins? [Y] [N] Brand? ______ Fluoride? [Y] [N]

Special Diet? [Y] [N] ______

FAMILY PROFILE

Parents - Married? ☐ Separated? ☐ Divorce? ☐

Father's age? ______ Highest school grade? ______ Health? ______

Mother's age? ______ Highest school grade? ______ Health? ______

(List child's brothers, sisters & their ages)

FAMILY MEDICAL HISTORY

List all blood relatives of your child who have had the following problems - use abbrev. (F) Father, (M) Mother, (B) Brother, (S) Sister, (MM) Mother's Mother, (MF) Mother's Father, (FM) Father's Mother, (FF) Father's Father, (A) Aunt, (U) Uncle, (C) Cousin

Anemia/Blood Dis ______

Asthma ______

Mental Retardation ______

Drug Problem ______

Alcoholism ______

Cancer ______

AIDS ______

Cystic Fibrosis ______

Musc. Dystrophy ______

Tuberculosis ______

Arthritis ______

Epilepsy/Seizures ______

Heart Disease ______

High Blood Pressure ______

Cholesterol Problem ______

Migraine ______

Sudden Infant Death ______

Birth Defects ______

Early Deafness ______

Diabetes ______

DEVELOPMENT & BEHAVIOR

Age at which child-

Sat alone ______ Walked ______ Used sentences ______

Toilet trained ______ Bicycled ______

Development compared to other children? ______

Grade in school ______ Problems in school? [Y] [N] ______

Learning problems? [Y] [N] ______

Getting along with other children? [Y] [N] ______

Behavior problems? [Y] [N] ______

Bad habits? ______ Bedwetting? [Y] [N] ______

Nail biting? [Y] [N] Sleeping? [Y] [N] Hobbies-sports? [Y] [N]

Use of street or illegal drugs? [Y] [N] ______

SYNOPSIS

Gergely Pediatrics
34 Route 403
Garrison, NY 10524
phone: 845-424-4444
fax: 845-424-4664

PATIENT AUTHORIZATION FORM

Patients (children):
Name ______________________________ **DOB** ______________________________
Name ______________________________ **DOB** ______________________________
Name ______________________________ **DOB** ______________________________
Name ______________________________ **DOB** ______________________________
Name ______________________________ **DOB** ______________________________

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below.

Description of the specific information to be used or disclosed:

- Diagnoses and Treatment
- Doctor and Nurse Practitioner Notes
- Growth Chart
- Immunization Records
- Medical Sheets
- Lab Records

Person or entity requesting the information and authorized to make the requested use or disclosure:

- Parents or Legal Guardians

Recipient of the information:

- Schools, Daycare Centers, Hospitals, Pharmacies

This information is being requested for the following purpose(s):

- To demonstrate compliance with state law
- To clear patients pre-operatively
- To share medical data with consenting specialists
- To alert other providers of patient’s known allergies or special health conditions

The authorization shall remain in effect from the date signed below until March 1, 2030.
I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office at the address above.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA.
- I may refuse to sign this authorization and that you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment.)
- Medical messages can be left at my home, on my cellphone or at work.

Patient Name: ____________________________ **Signature:** ________________________________
Relationship to Patient: ____________________________________ **Date:** ____________________
(if signed by personal representative of Patient)

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosers of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ______________________________________

Relationship to Patient: ______________________________

Signature:____

Date:____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:______________ **Initials:**__________ **Reason:** _____________________________________

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (“HIPAA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. “HIPAA” provides penalties for covered entities that misuse personal health information.

As required by “HIPAA”, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-managment analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable request to receive confidential communications or protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.