Developmental Pediatrics
Boston Children's Health Physicians
Until every child is well™

NEW PATIENT REGISTRATION & INTAKE PACKET

When your forms are complete, please send to:

Email: Nicole_Cretara@bchphysicians.org

Fax: 914-345-1752

Or by Mail: 400 Columbus Avenue, Suite 200E, Valhalla, NY 10595

****NO DROP OFF LOCATION AVAILABLE****

IN ORDER FOR US TO SCHEDULE AN APPOINTMENT FOR YOU, WE WILL NEED THE FOLLOWING:

1) **FRONT & BACK OF INSURANCE CARD(S)**
2) **DTD REFERRAL**
   (letter stating that patient is being referred to see Developmental Pediatrics)
3) **NEW PATIENT PACKET**
4) **ANY SEPARATION/DIVORCE PAPERWORK STATING CUSTODY OR MEDICAL DECISION MAKING MUST BE SENT TO US**

Currently we are placing all patients on a waiting list. Once an appointment becomes available, the office will give you a call to schedule an appointment.

***Please be advised, once forms have been received by the office, it can take up to 72 business hours to be processed.**

Developmental Pediatrics
Boston Children's Health Physicians
Until every child is well™

Office Address: 19 Bradhurst Ave, Suite 2400N, Hawthorne, NY 10532
Mailing Address: 400 Columbus Avenue, Suite 190E, Valhalla NY 10595
914-304-5250 | fax 914-345-1752
developmentalpediatrics@bchphysicians.org | www.bchphysicians.org

Thank you for choosing **Boston Children's Health Physicians Division of Developmental Pediatrics** for your child's care. In order to help you to continue to be an active part of your child's Health Care Team, we want to take this opportunity to share with you some aspects of how our office operates.

Our phones are answered on workdays from 8:30 AM until 4:30 PM. If you reach our voicemail during office hours, that means that all the receptionists are on another call, but if you leave a message, your call will be returned.

If you need to speak to your doctor, please call during office hours. On nights, weekends, and holidays, our phone system does not record messages. Prescription refills cannot be recorded after hours or on holidays.

If your child is on medication:

- At a visit here, your doctor will discuss with you when your child needs to come back for a follow up visit; very often renewing your child's medicine can be affected by whether or not a requested follow up appointment has been kept, or if a requested follow up appointment has been scheduled; we feel it is not good medical practice to renew medications without seeing the child on a regular basis.
- If you need a refill, please follow the prompts on the phone system. Please call while you still have 5-7 days of medication, as we may not be able to respond to a same day refill request. Please allow 24-48 hours to process your request.
- Also, please keep in mind that NYS regulations may prohibit us from adding refills to certain medication prescriptions.

If your child is under 18 years of age, and is being brought to a visit by someone other than a parent, a written note from the parent authorizing whomever is accompanying your child must be brought to the visit.

In order to protect the confidentiality of your child's records, we cannot release records, or discuss your child with anyone but a parent unless we have a signed HIPAA release form on file. Patients who are 18 or older are considered adults, and need to authorize their parents to participate in their care or receive records.

We want to make sure that your child is seen on time for a scheduled appointment. Please ensure that you check in for your appointment at least 15 minutes before the scheduled time, whether your appointment is scheduled for an in-office visit or via telehealth.

Lastly, the following registration and intake forms **must** *be returned before the appointment is scheduled. Please return these forms by* **fax 914-345-1752** *or by* **email,** DevelopmentalPediatrics@bchphysicians.org. *If you have any additional documents to provide, please send them along with these forms.*

Thank you,
The Division of Developmental Pediatrics

Developmental Pediatrics
Boston Children's Health Physicians
Until every child is well™

Office Address: 19 Bradhurst Ave, Suite 2400N, Hawthorne, NY 10532
Mailing Address: 400 Columbus Avenue, Suite 190E, Valhalla ,NY 10595
914-304-5250 | fax 914-345-1752
developmentalpediatrics@bchphysicians.org | www.bchphysicians.org

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Patient Address: _____ Gender: ☐ Male ☐ Female

_____ Home Phone: _____

Patients Email (12&Over): _____ Cell Phone: _____

Primary Care Physician: _____ Phone: _____

Parent / Guarantor #1: _____ D.O.B.: _____

Mailing Address: _____ Relationship: _____

_____ Preferred Phone: _____

Email Address: _____ Work Phone: _____

Parent / Guarantor #2: _____ D.O.B.: _____

Mailing Address: _____ Relationship: _____

_____ Preferred Phone: _____

Email Address: _____ Work Phone: _____

Emergency Contact Name: _____

Phone Number: _____ Relationship to Patient: _____

The federal government is asking all *physicians to collect race and ethnicity information to monitor the quality of medical care and to ensure that all patients, regardless of race and ethnicity, get the best care possible. We are committed to providing culturally-sensitive, whole-person medical care and collecting this information also gives us information that can help us serve your family better. If you choose to provide us with this information, we will keep your identity confidential.*

With this in mind, we ask that you complete the following. If you choose not to participate, please indicate it below.

Which category best describes the patient's race?

☐ American Indian or Alaska Native ☐ Asian ☐ Black/African American

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other

Which category best describes the patient's ethnicity?

☐ Hispanic/Latino ☐ Non-Hispanic/Latino

If Hispanic/Latino: ☐ Mexican ☐ Puerto Rican ☐ Cuban ☐ Other

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

☐ I do not wish to provide this information

**Please notate if Mental Health benefits are covered separately*
(I.E.- GHI/HIP/Emblem/UH Empire Plan - Mental Health Benefits are Beacon Health Options)

INSURANCE INFORMATION

Primary Insurance Name: _____ Effective Date: _____

Insurance Address: _____

Member ID #: _____ Group #: _____

Policyholder Name: _____ Policyholder DOB: _____ Gender: ☐ M ☐ F

Mental Health Benefits Insurance Name: _____ ***ID #:*** _____

Secondary Insurance Name: _____ Effective Date: _____

Insurance Address: _____

Member ID #: _____ Group #: _____

Policyholder Name: _____ Policyholder DOB: _____ Gender: ☐ M ☐ F

Employer: _____

Employer Address: _____

Mental Health Benefits Insurance Name: _____ **ID#:** _____

Pharmacy Benefits: _____ **ID#:** _____

RxBIN # : _____ **RxPCN# :** _____ **RxGRP#:** _____

Release of Information and Assignment of Benefits

I hereby authorize BCHP to release information regarding treatment or services rendered to Medicare/other insurance carriers responsible for my or my dependent's care. I request that payment of authorized Medicare/ other insurance company benefits be made to either me or on my behalf to BCHP for any services rendered. I have been advised that if my insurance requires a co-pay, it is due at the time of my visit. Otherwise, a $15 surcharge will be added to my bill.

_____ _____

Signature of Patient or Authorized Representative Date

INSURANCE CARDS

Insurance cards must be presented at each visit. If you do not present the insurance card at the time of the visit, you will be responsible for the payment of services rendered by Boston Children's Health Physicians, LLP.

REFERRALS

Please be advised that a complete referral from your primary care provider in order for services to be billed to your insurance company for each service rendered. Please contact your Primary care provider to obtain a referral. If we do not receive the approprite referral, you will be responsible for payment of services rendered b y Boston Children's Health Physicians, LLP.

Name of Patient (please print)	Date of Birth
Name of Parent/Guardian (please print)	Relationship to Patient
Signature of Patient (if over 18) or Parent/Guardian	Today's Date

NO-SHOW POLICY

In an effort to serve to serve our patients and to ensure that available appointment times are used appropriately, BCHP has implemented a no-show policy for all our patients effective October 5, 2009.

You will be billed $40 if your child misses an appointment and you have not contacted us to cancel at least 24 hours prior to the scheduled appointment time. If the appointment is on Monday, you must contact us by noon on the Friday before.

To cancel an appointment, please call the office at 914-304-5250. If are not able to speak with a member of the administrative staff, please leave a detailed message with the date and time of your call. You may not cancel an appointment via email or through the patient portal.

Thank you for your cooperation.

Name of Patient (please print)	Date
Name of Patient/Guardian (please print)	Relationship to Patient
Signature of Patient (if over 18) or Parent/Guardian	Today's date

Developmental Pediatrics
Boston Children's Health Physicians
Until every child is well℠

Office Address: 19 Bradhurst Ave, Suite 2400N, Hawthorne, NY 10532
Mailing Address: 400 Columbus Avenue, Suite 190E, Valhalla, NY 10595
914-304-5250 | fax 914-345-1752
developmentalpediatrics@bchphysicians.org | www.bchphysicians.org

Dear Parent/Guardian:

Please answer the following questions as best as you can, and send it via email or fax prior to your visit. If you have any questions about a specific item of information being asked, you can call before your appointment as the information will be covered during the visit.

Thank You.

Name of Child: _____ **Date of Birth:** _____

What concerns do you have about your child?

☐ **development** ☐ **learning** ☐ **speech/language** ☐ **attention** ☐ **behavior**

Please describe your concerns briefly:

_____

_____

_____

_____

Current or prior diagnoses (if any):

_____

_____

MEDICATIONS

Current medications: _____

Prior medications: _____

ALLERGIES

Does your child have known allergies to food or medication? ☐ Yes ☐ No

If yes, please list: _____

BIRTH HISTORY

Child's weight at birth: _____ lbs. _____ oz. How many weeks of gestation? _____ weeks

What type of delivery did you have?

☐ Vaginal delivery: ☐ normal/spontaneous ☐ Pitocin-induced

☐ Cesarean Section: If so, was this due to ☐ repeat ☐ fetal distress

How old was the mother at the time of delivery? _____ years

What number pregnancy was this? _____ What number delivery was this? _____

Were there any maternal medical problems during the pregnancy? ☐ Yes ☐ No

If yes, what was/ were the problem(s)? _____

_____

Were there any medications taken during the pregnancy? ☐ Yes ☐ No

If yes, what medication(s) and why? _____

_____

Was your child in the NICU? ☐ Yes ☐ No

If yes, for how long and why? _____

DEVELOPMENTAL HISTORY

Please list age at which your child:

Sat up	_____	Walked alone	_____
Started babbling	_____	Spoke in single words	_____
Spoke in 2-word phrases	_____	Spoke in few-word phrases/sentences	_____
Speech understood by strangers	_____		

Describe peer interactions (interactions with same age children who are not siblings):

_____

_____

School & Services

Name of School _____ District _____

Grade _____ Classroom Type & Size _____

Are any of the following therapies being currently provided?

☐ Physical Therapy ☐ Speech Therapy

☐ Occupational Therapy ☐ Resource Room

☐ Counseling ☐ Other: _____

Has your child ever had any evaluations such as audiology, psychology, or speech/language? ☐ Yes ☐ No

Please send a copy of each evaluation by email or fax.

SLEEP HISTORY

Child usually goes to sleep at _____PM

Does your child fall asleep independently? ☐ Yes ☐ No How long does it take to fall asleep? _____

Does your child sleep through the night? ☐ Yes ☐ No

Child ☐ gets up, *OR* ☐ is wakened at _____AM

Does your child snore – 2 or more times a week? ☐ Yes ☐ No

Does your child maintain a stable bedtime and wake time seven days a week? ☐ Yes ☐ No

Do you have any concerns about your child's sleep? _____

MEDICAL HISTORY

Are your child's immunizations up to date? ☐ Yes ☐ No

Please list any/all operations, hospitalizations (including ER visits), and procedures your child has had:

Where	When	Why

When was your child's last vision screening or evaluation? _____ ☐ Normal ☐ Other _____

hearing screening or evaluation? _____ ☐ Normal ☐ Other _____

Did/does your child have frequent ear infections? ☐ Yes ☐ No

Does your child have

- Poor growth? ☐ Yes ☐ No
- Heart problem? ☐ Yes ☐ No
- Asthma or other respiratory problems? ☐ Yes ☐ No
- Stomach or bowel problems? ☐ Yes ☐ No
- Urine problems? ☐ Yes ☐ No
- Motor weakness or coordination problems? ☐ Yes ☐ No
- Headaches? ☐ Yes ☐ No
- Seizures? ☐ Yes ☐ No
- Anemia or other blood disease? ☐ Yes ☐ No

If you answered 'Yes' to any of questions above, or if your child has any other health care problem/s that are not listed, please explain:

FAMILY & SOCIAL HISTORY

Family Composition

Who lives at home? _____

Mother's highest grade completed _____ Occupation _____

Father's highest grade completed _____ Occupation _____

Please list all other brothers and sisters of child:

Name	Age	Gender
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female

Do any other members of the family have problems with attention, behavior, learning, using language, have developmental disabilities including autism, or died from a heart condition prior to the age of 50? ☐ Yes ☐ No

If yes, please explain: _____

_____

*For children **4** years and older* only*:*

Would you say that your child displays the following behaviors?

1. Is "on the go" or "driven by a motor" ☐ Yes ☐ No
2. Has difficulty engaging in quiet activities ☐ Yes ☐ No
3. Fidgets or squirms ☐ Yes ☐ No
4. Has difficulty staying seated ☐ Yes ☐ No
5. Restlessness ☐ Yes ☐ No
6. Runs about and excessively and inappropriately ☐ Yes ☐ No
7. Talks excessively ☐ Yes ☐ No
8. Blurts out answers before questions completed ☐ Yes ☐ No
9. Has difficulty awaiting his or her turn ☐ Yes ☐ No
10. Interrupts or intrudes on others ☐ Yes ☐ No
11. Avoids tasks which require sustained mental effort ☐ Yes ☐ No
12. Has difficulty organizing tasks and activities ☐ Yes ☐ No
13. Has difficulty sustaining attention ☐ Yes ☐ No
14. Does not seem to listen ☐ Yes ☐ No
15. Is easily distracted ☐ Yes ☐ No
16. Is forgetful in daily activities ☐ Yes ☐ No
17. Loses necessary items such as school books and materials ☐ Yes ☐ No
18. Has difficulty following through on instructions from others ☐ Yes ☐ No