Developmental
Behavioral Pediatrics
Boston Children's Health Physicians

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
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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 requests cannot be recorded after hours or on holidays. Please do not send urgent messages through the patient portal.

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 or make request though the patient portal 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. Requests made through the patient portal will be attended to in 1-2 business days.
- Also, please keep in mind that NYS regulations 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 whoever 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. Your child must be present for the appointment, unless specified by the physician.

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 Behavioral Pediatrics
Boston Children's Health Physicians

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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.0.8.: _____

Mailing Address: _____ Relationship: _____

_____ Preferred Phone: _____

Email Address: _____ Work Phone: _____

Parent / Guarantor #2: _____ D.0.8.: _____

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

INSURANCE INFORMATION

*Please notate if Mental Health benefits are covered separately

Primary Insurance Name: _____ Effective Date: _____

Insurance Address: _____

Member ID #: _____ Group #: _____

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

Mental Health Benefits Insurance Name:---------- ID #: ----------

Effective Date: _____

Secondary Insurance Name: _____

Insurance Address: _____ Group #:_____

Member ID #: _____

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 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
Behavioral Pediatrics
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Maria Fareri
Children's Hospital
Westchester Medical Center Health Network

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Intake Questionnaire

Please take the time to complete this packet prior to your child's first appointment. This will allow us to learn more about your child so that we can better help him or her. If a particular question or section does not apply, please skip to the next item.

General Information

Child's Name:	
Preferred name (if any):	Gender: ☐ Male ☐ Female
Date of Birth:	Age:
Person Completing Form:	Relationship to Child:

URGENT CONCERNS: Do you have any of the following urgent concerns about your child? **New onset / Sudden**		
☐ Seizures	☐ Difficulty swallowing or choking	☐ Suicidal thinking or attempt of child
☐ Severe headache	☐ Severe Weakness or lack of coordination	☐ Hearing voices or seeing things/ Hallucinations
☐ Loss of vision or hearing	☐ Inability to use one or more extremities	☐ Safety of any family members (including this child)

Please explain:

_____

_____

_____

Please understand that BCHP Developmental-Behavioral Pediatrics has a waiting list. Because some concerns need more urgent attention, if your child has any of the above problems, please also contact your pediatrician while you are waiting for your appointment.

Please list three things about your child that give you joy or your child is good at.

_____

_____

Your Child's Development & Behavior

Do you have concerns about any of the following areas of development or behaviors? Please describe them below.

Area of Development	Comments
☐ General overall development	
☐ Cognitive/thinking skills	
☐ Speech/language	
☐ Motor skills	
☐ Social skills	
☐ Self-help skills	
☐ Sleeping, feeding, or eating	

Behavior	Comments
☐ Hyperactivity, impulsivity, and/or inattention	
☐ Intense or unusual interests	
☐ Limited social interaction	
☐ Repetitive behaviors	
☐ Sensory interests or aversions	
☐ Irritability and/or aggression	
☐ Stubborn or oppositional behavior	
☐ Worries or anxiety	

Please provide additional information about any areas above, as well as any other concerns you may have regarding your child's development, behavior, and mental health.

As best as you can remember, list the age or check off the appropriate time at which your child reached the following developmental milestones.

Developmental Skill		Age	*If age cannot be recalled*			
			Early	Average	Late	Not Yet
Cognitive & Language	Said first words		☐	☐	☐	☐
	Looked for hidden objects		☐	☐	☐	☐
	Followed simple one-step directions		☐	☐	☐	☐
	Spoke in 2-word phrases		☐	☐	☐	☐
	Spoke in sentences		☐	☐	☐	☐
	Speech was fully understood by strangers		☐	☐	☐	☐
Gross Motor	Sat without support		☐	☐	☐	☐
	Pulled to stand		☐	☐	☐	☐
	Walked independently		☐	☐	☐	☐
	Ran with coordination		☐	☐	☐	☐
	Climbed stairs with alternating feet		☐	☐	☐	☐
Fine Motor	Scribbled spontaneously		☐	☐	☐	☐
	Stacked objects		☐	☐	☐	☐
	Picked up food with fingers and ate it		☐	☐	☐	☐
	Used a pencil grasp (thumb & fingers)		☐	☐	☐	☐
	Cut with scissors		☐	☐	☐	☐
	Drew a person with 3 body parts		☐	☐	☐	☐
Personal-Social & Play	Smiled responsively		☐	☐	☐	☐
	Turned when name was called		☐	☐	☐	☐
	Pointed to ask for something		☐	☐	☐	☐
	Engaged in pretend/imaginative play		☐	☐	☐	☐
	Played alongside other children (parallel)		☐	☐	☐	☐
	Played cooperatively and shared		☐	☐	☐	☐
Self-Help	Helped dress/undress self		☐	☐	☐	☐
	Ate using a spoon & fork		☐	☐	☐	☐
	Toilet trained		☐	☐	☐	☐
	Ate independently		☐	☐	☐	☐

Peer Interactions

Describe your child's peer interactions:

Are you child's peer interactions negatively affected by problems with impulsivity, non-verbal communication, or respecting personal space? ☐ Yes ☐ No

Diet, Nutrition, and Elimination

Is your child a picky eater? ☐ Yes ☐ No

Is your child sensitive to food textures? ☐ Yes ☐ No

Does your child have regular bowel movements? ☐ Yes ☐ No

Sleep

What time does your child go to bed? _____ PM What time does your child wake up? _____ AM

Does your child fall asleep independently? ☐ Yes ☐ No

Does your child have difficulty falling asleep? ☐ Yes ☐ No

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

Does your child snore? ☐ Yes ☐ No

Is your child a restless sleeper? ☐ Yes ☐ No

Does your child maintain a stable bedtime ☐ Yes ☐ No

7 days a week? ☐ Yes ☐ No

Is your child tired during the day? ☐ Yes ☐ No

Other Activities

On average, how much time does your child spend with a screen each day (e.g., TV, iPad/tablet, phone)?

☐ 1 hour or less ☐ More than 1 hour, please estimate time: _____

What activities does your child typically engage in when online?

☐ YouTube / Streaming ☐ Video Games ☐ Social Media ☐ Other: _____

Does your child have any extracurricular activities or do sports? What are your child's strengths? What are his/her favorite interests and activities?

Your Child's Education

Please complete the following information about your child's current school/pre-school/daycare.	
School Name/District	
Current Grade/Classroom	
Type of Class	☐ Regular ☐ Integrated or Co-taught ☐ Special education
Number of students in class	
Number of teachers/aides in class	

Does your child have an Individualized Family Service Plan (IFSP), Individualized Education Plan (IEP), or 504 Plan?

☐ IFSP ☐ IEP ☐ 504 Plan ☐ None

What is your child's educational classification?

☐ Autism ☐ Preschooler with a Disability ☐ Speech/Language Impairment
☐ OHI-ADHD ☐ Specific Learning Disability ☐ Other _____

Does your child receive any accommodations or special services at school or through early intervention?

Service	Describe
☐ Special Education	
☐ Behavioral Support (e.g., ABA)	
☐ Physical Therapy	
☐ Occupational Therapy	
☐ Speech/Language Therapy	
☐ Other (specify)	

Does your child receive any other therapies or services outside of school or privately?

Service	Describe
☐ PT, OT, or Speech	
☐ Behavioral Support (e.g., ABA)	
☐ Counseling or Psychotherapy	
☐ Other (specify)	

Your Child's Birth

How many weeks was your child born at? _____ Birth weight: _____

Delivery type: ☐ Vaginal ☐ C-section If C-section, why? _____

Mother's age at delivery: _____ Father's age at delivery: _____

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

Please check if any of the following happened during your pregnancy:		
☐ High blood pressure	☐ Diabetes	☐ Trouble gaining weight
☐ Early labor/bed rest	☐ Bleeding	☐ Infection
☐ Medication prescribed	☐ Abnormal amniocentesis/fetal screening test	☐ Thyroid problems
☐ Fertility treatments	☐ Recent miscarriage	☐ Tobacco Use
☐ Alcohol Use	☐ Drug Use	☐ Other problems/illnesses

If you checked any of the above, please explain:

_____

_____

_____

Were there any problems during labor or delivery? If yes, please explain:

_____

_____

_____

Please check if there were problems with the following right after birth or during the first year of life:		
☐ Intensive Care/Special Care nursery stay	☐ Jaundice	☐ Weight gain
☐ Feeding	☐ Sleeping	☐ Stooling
☐ Colic/Excessive crying	☐ Hearing	☐ Vision
☐ Infections	☐ Hospitalizations	☐ Other problems

If you checked any of the above, please explain:

_____

_____

_____

Your Child's Health

When was your child's last visit with his/her primary care provider? _____

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

hearing screening or evaluation? _____ ☐ Normal ☐ Other result _____

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

Please check if your child *currently has*, or *had in the past*, any of the following medical problems listed below:		
☐ Asthma	☐ Vision problem	☐ Hearing problem
☐ Seizures or staring spells	☐ Genetic or metabolic problems	☐ Anemia/low blood count
☐ Elevated lead level	☐ Heart problem	☐ Constipation
☐ Abnormal newborn screen	☐ Fainting/Dizziness	☐ Other problems:

If you have checked any of the above, please explain. Additionally, please provide information about any serious illnesses your child has experienced.

_____

_____

_____

Please list all the medications that your child is ***currently taking***, including any over-the-counter medications, vitamins, or nutritional supplements. Also, please tell us if your child is on a special kind of diet or is avoiding certain foods.

Medications/Supplements/Diet	Start Date	Dose & Frequency	Comments

Please list any medications that your child has taken ***in the past*** for mood, behavior, or other developmental/behavioral issues.

Medications	Start/End Date	Dose & Frequency	Comments

Please list any allergies your child has to medications, foods, or the environment below.

Allergy	Describe Reaction

Please list any medical specialists your child has seen now or in the past and provide approximate date of most recent visit.

Specialist	Date	Reason for Visit

Please list any specialized medical testing your child has had (e.g., EEG, EKG, MRI, chromosome test, genetic testing, hearing testing, vision testing), and the results if known.

Test	Date	Result

Please list any major injuries, hospitalizations, or surgeries your child has had.

Injury/Hospitalization/Surgery	Age	Comments

Prior Evaluations

Has your child had any educational and/or psychological testing or evaluations?
If available, please bring or send us a COPY of the most recent tests. The office staff will not be able to make copies.

Date	Setting/Facility (e.g., Early Intervention, CPSE, CSE, neuropsychologist, another practitioner)	Results

Your Child's Home and Environment

Who lives at home?

Name	Age	Relationship to Child	Level of Education

Are the child's parents ☐ Married ☐ Partners ☐ Separated/Divorced, since _____ ☐ Other

Please describe current custody arrangements: _____

_____

Parents' Occupation: Mother _____ Father _____

Childcare: ☐ Parents ☐ Other (please describe) _____

Primary language spoken at home: ☐ English ☐ Spanish ☐ Other _____

Is your child bilingual? ☐ Yes ☐ No

If so, what are the languages: _____

Your Child's Family Health

Please indicate if any of your child's relatives (grandparents, aunts, uncles, first cousins, siblings parents). have any of the following disorders. Please do not include people what have married into the family.

Disorder	Relationship to Child	Mother's side	Father's Side	Describe
ADHD, Attention or Hyperactivity Problems		☐	☐	
Autism Spectrum Disorder, Asperger Syndrome, PDD		☐	☐	
Developmental Delay		☐	☐	
Intellectual Disability Mental Retardation		☐	☐	
Learning Problems Dyslexia		☐	☐	
Physical Disabilities		☐	☐	
Anxiety, Obsessive-Compulsive Disorder, PTSD		☐	☐	
Bipolar disorder		☐	☐	
Depression		☐	☐	
Schizophrenia or psychosis		☐	☐	
Alcohol / drug use		☐	☐	
Neurological disorders		☐	☐	
Seizures / Epilepsy		☐	☐	
Heart problems		☐	☐	
Genetic disorders		☐	☐	
Sudden / unexplained death		☐	☐	
Other		☐	☐	

Thank you for taking the time to provide this information.
If you have any questions or concerns, please contact the office at (914) 304-5250.