

**PEDIATRICS BY THE BAY  
PATIENT REGISTRATION**

DATE \_\_\_\_\_  
CHART # \_\_\_\_\_

Patient \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(First) (Middle) (Last)

Sex: M F Age \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security # \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Race: American Indian/Alaskan Asian Black/African American White Hispanic Other \_\_\_\_\_

Language Spoken: English Spanish Other \_\_\_\_\_

Mother's Name \_\_\_\_\_

Father's Name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_

Employer \_\_\_\_\_

Home Telephone Number \_\_\_\_\_

Home Telephone Number \_\_\_\_\_

Work Telephone Number \_\_\_\_\_

Work Telephone Number \_\_\_\_\_

Cell Number \_\_\_\_\_

Cell Number \_\_\_\_\_

Date of Birth \_\_\_\_\_

Date of Birth \_\_\_\_\_

Social Security Number \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Social Security Number \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Email Address \_\_\_\_\_

Email Address \_\_\_\_\_

(\*\*\*Social Security numbers are required for insurance claims and any lab work that the Doctor may order\*\*\*\*)

Child lives with: Mother \_\_\_\_\_ Father \_\_\_\_\_ Both \_\_\_\_\_ Legal Guardian \_\_\_\_\_

Emergency Contact Person (other than mother/father/guardian)

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

**INSURANCE INFORMATION**

Name of Primary Insurance Company \_\_\_\_\_

Policy/ID# \_\_\_\_\_ Group # \_\_\_\_\_ Effective Date \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Name of Secondary Insurance Company \_\_\_\_\_

Policy/ID# \_\_\_\_\_ Group # \_\_\_\_\_ Effective Date \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Chart # \_\_\_\_\_

**ADDITIONAL INFORMATION**

If you would like to list any family member(s) that we may discuss medical advice or treatment other than you, please list them below:

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

Please list any other children that are currently under the care of Dr. Raymond D. A. Peterson:

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

How did you hear about us? Hospital \_\_\_\_\_ Friend/Family \_\_\_\_\_ Other Doctor \_\_\_\_\_

Other (Please specify) \_\_\_\_\_

**PLEASE READ AND SIGN:**

I understand there may be certain services that are necessary for the maintenance of my child's good health that are not covered by his/her insurance and **I agree to pay for those services in full.** I hereby authorize my child's insurance benefits to be paid directly to the physician. I also authorize the physician to release any information required in the processing of any claim. In instances where my child has been referred to another physician or medical facility, I hereby give my permission to fax or mail pertinent medical information for continuity of my child's care. I have read the Financial Policy and agree to pay for services not covered by my child's insurance. I also agree to pay reasonable attorney's fees and costs of collection if this matter is referred to an attorney.

**Parent or Guardian**

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Please let us know if you would like your child's records transferred to our office.**

**The Receptionist will need to scan your child's insurance card and your Driver's License.**

Chart # \_\_\_\_\_

I, \_\_\_\_\_ give permission to the following person(s) to bring my child,  
(Parent or Guardian's Name)

\_\_\_\_\_, to Pediatrics by the Bay and to have medical information  
(Child's Name)

released to or be discussed with. This notice is from this date forward unless otherwise noted.

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

I want this permission authorization to expire: Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, expire on this date \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

### ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE

Our Notice of Privacy Practice is posted in our Lobby. If interested, you may request a paper copy at any time. Please notify the receptionist or call our office at (251) 300-2030 to request a copy. By signing below you agree that you were informed of the displayed Privacy Practice Notice.

Printed Name of Parent or Guardian \_\_\_\_\_

Signature of Parent or Guardian \_\_\_\_\_

Date \_\_\_\_\_

Chart # \_\_\_\_\_

**PEDIATRICS BY THE BAY  
HEALTH QUESTIONNAIRE**

Patient's Name \_\_\_\_\_ DOB \_\_\_\_\_

Sex: Male \_\_\_\_\_ Female \_\_\_\_\_

**GENERAL HEALTH HISTORY:**

Has your child had Chicken Pox \_\_\_\_\_ If yes, when \_\_\_\_\_ ?

Has your child had Scarlet Fever \_\_\_\_\_ If yes, when \_\_\_\_\_ ?

If your child has been treated for any of the following, please put a checkmark next to those applicable:

- |                                 |  |
|---------------------------------|--|
| _____ Anemia                    | _____ Dental Problems                                    |
| _____ Ear Infections            | _____ Hearing Problems                                   |
| _____ Stomach Problems          | _____ Breathing Problems (Croup, Pneumonia, Asthma, etc) |
| _____ Muscle/Bone Problems      | _____ Behavioral Problems                                |
| _____ Kidney/Bladder Conditions | _____ Persistent Skin Conditions                         |

Please list any Allergies your child has: \_\_\_\_\_

Has your child ever been hospitalized? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, when and why \_\_\_\_\_

Has your child ever had tubes placed in his/her ears? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list when and the physician's name \_\_\_\_\_

Is your child currently on any medications? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please list:

List the date of your child's last well check-up \_\_\_\_\_ Where \_\_\_\_\_

Was your child bottle fed or breast fed? \_\_\_\_\_

Please list any other problems you would like Dr. Peterson to be aware of: \_\_\_\_\_

## **PEDIATRICS BY THE BAY FINANCIAL POLICY**

We here at Pediatrics By The Bay are doing everything possible to hold down the cost of medical care. You can help a great deal by eliminating the need for us to bill you. The following is a summary of our financial policy.

### **ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE**

Payment is expected at the time services are rendered unless other arrangements have been made in advance. This includes deductibles, coinsurance and copayments for participating insurance companies. Failure to pay these items on the service date may result in an additional fee. Pediatrics By the Bay accepts cash, checks, debit cards, Visa and Master Card. There is a service charge for returned checks and we reserve the right to make your account a "cash only" account for future visits.

Patients with an outstanding balance are asked to pay their balances in full at the time of receipt of their statement. We do realize that patients may have financial difficulty. Therefore, we advise you to call our Billing Coordinator at 300-2033, Monday through Friday, 9:00 a.m. to 4:00 p.m. to discuss your account.

### **INSURANCE**

We bill participating insurance companies as a courtesy to you. You are expected to be familiar with what your copayment amounts are, what your yearly deductible is, what your insurance does or does not cover, etc. There are too many plans within plans for us to be able to know them all. Your employer will provide numbers for you to call to ask these questions. When we check for eligibility at the time of your appointment and your insurance shows ineligible, you are responsible for the entire bill at the time of service.

### **MISSED APPOINTMENTS / LATE CANCELLATIONS**

**Cancellations should be made no later than 4 hours prior to your scheduled appointment time. Appointments not cancelled at least 4 hours prior will be considered "no-shows". Arriving more than 30 minutes late for an appointment will also be considered a no-show. No-show appointments represent a cost to us, to you, and to other patients that could have been seen at the time set aside for you. We reserve the right to bill you \$25.00 for each no-show. This fee will be your responsibility and will not be billed to your insurance company. After three (3) no-shows, we reserve the right to dismiss your family from our practice.**