



**GENERAL PEDIATRICS:      PLEASE PRINT**

Child's Name: \_\_\_\_\_ M F Birth date: \_\_\_\_\_ Student Status: FT PT N/A  
(First) (Last)

Child's Social Security #: \_\_\_\_\_ Who does the child live with? \_\_\_\_\_

Primary Care Physician: **if not in this office.** \_\_\_\_\_ Tel. No.: \_\_\_\_\_ Fax. No.: \_\_\_\_\_

**SIBLINGS:**

Name: \_\_\_\_\_ SocSec#: \_\_\_\_\_ M F Birthdate: \_\_\_\_\_

Pharmacy Name & Tel. No.: \_\_\_\_\_ Who referred you to this practice? \_\_\_\_\_

**PARENT / GUARDIAN INFORMATION:** Single Married Divorced Separated Widowed Partnered with ( Please circle )

Father/Parent/ Guardian's name: \_\_\_\_\_ Mother/Parent/Guardian's name: \_\_\_\_\_  
(First) (Last) (First) (Last)

Address: \_\_\_\_\_ Address: \_\_\_\_\_

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

SocSec#: \_\_\_\_\_ Birthdate: \_\_\_\_\_ SocSec#: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_

Cell: \_\_\_\_\_ Fax: \_\_\_\_\_ Cell: \_\_\_\_\_ Fax: \_\_\_\_\_

Email address: \_\_\_\_\_ Email address: \_\_\_\_\_

Profession/Employer: \_\_\_\_\_ Profession/Employer: \_\_\_\_\_

**Insurance Information ( Please present your insurance cards to the receptionist at every visit )**

**First Insurance:**

**Second Insurance: I do not have a secondary insurance:** \_\_\_\_\_  
Initial

Name of Insurance Co: \_\_\_\_\_

Name of Insurance Co: \_\_\_\_\_

ID#: \_\_\_\_\_

ID#: \_\_\_\_\_

Group #: \_\_\_\_\_

Group #: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

Soc Sec #: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Soc Sec #: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer: \_\_\_\_\_

Relationship to Insured: Child Stepchild Other \_\_\_\_\_

Relationship to Insured: Child Stepchild Other \_\_\_\_\_

**ASSIGNMENT AND RELEASE AND AUTHORIZATION FOR CARE OF MINOR**

I, the undersigned, assign directly to Pediatric Associates of Farmington, L.L.C. all medical benefits, if any, otherwise payable to me for services rendered to my child(ren). I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I give permission for the staff of Pediatric Associates of Farmington, L.L.C. and the clinical providers and their staff, to provide any necessary medical care to my minor charge(s) listed above

Signature of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_ **PLEASE TURN OVER**



**PLEASE PRINT**

**PERMISSION**

Please consider this a request for me to exercise my rights under Federal and State laws by requesting only the following people to communicate in every way any confidential communication about my child's protected health information (PHI) with the provider and / or staff when the legal guardian(s) are not present. I understand that the providers and staff will need to treat the child as if I was present and the PHI may be disclosed during these appointments. I will be contacted as necessary. This form remains in effect as long as I do not make any changes.

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_ Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_ Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_ Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_ Date: \_\_\_\_\_

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES AND PRIVACY PEDIATRIC ASSOCIATES OF FARMINGTON, LLC**

**Names of all children that apply to these restrictions:**  All the children listed on the first page.

Patient Name \_\_\_\_\_ Patient Name \_\_\_\_\_

Patient Name \_\_\_\_\_ Patient Name \_\_\_\_\_

**RESTRICTIONS QUESTIONNAIRE**

May we send statements and reminder cards to the address in the Registration sheet?	Yes	No
If no, what address should be used? _____		
May we contact you at work?	Yes	No
May we contact you at home or on the cell phone?	Yes	No
If not to both of the above, which number should we call? _____		
May we leave messages (including laboratory results) on your answering machine?	Yes	No
May we send you a fax? If yes, Fax No. _____	Yes	No
	Yes	No
May we contact you via email? If yes, Email address _____		

\_\_\_\_\_  
Name of Patient or Legal Representative                      Signature                      Date

**For the Staff only :                      To be completed only if unable to obtain written acknowledgement from patient:**

On \_\_\_\_\_, Pediatric Associates of Farmington, LLC attempted to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above-name patient. We were unable to obtain this acknowledgement because:

Patient declined to sign this written acknowledgement.  Patient did not understand the request to sign the written acknowledgement  
Other (please specify) \_\_\_\_\_

\_\_\_\_\_  
Signature & Date of Employee                      Signature & Date of Witness

For restrictions to your protected health information (PHI) other than noted above, please submit your request to the Compliance/Privacy Officer utilizing our "Restriction of Use or Disclosure of Protected Health Information (PHI) Form."



**FOR PHYSICAL EXAMS OR PREVENTIVE HEALTH CARE VISITS:**

What is a preventive exam? As per your insurance carrier, this exam, also called a “physical”, “wellness exam” or “annual exam”, is designed to educate you on changes you can make to live a healthier life and to identify new health problems. It is a periodic exam that covers all prevention and health maintenance issues related to age, sex, and family history. This office visit is NOT designed to address specific complaints or to manage known medical issues.

A second service may be necessary: New problems or follow up of chronic issues may be addressed as a SECOND service during the visit or another appointment may be necessary. Examples of chronic issues include: behavioral issues like ADHD, feeding issues, rashes etc.

NOTE: If a SECOND service is provided, your insurance plan may require a co-pay or apply charges to your deductible for a SECOND service provided during a Preventive Exam visit. Please consult with your insurer or HR department to understand your insurance coverage requirement.

Please circle the option and sign below with the statement that best fits your needs.

**Option A:**

I choose to have only the services performed on myself/my child, which are included in the basic preventive exam. If there are other medical complaints or issues, I would like to have another appointment to address.

**Option B:**

I acknowledge that I may ask my provider to evaluate and manage my/my child’s medical problem(s) during my preventive exam and that this treatment may result in a separate office visit to be billed in addition to the preventive exam, and I will be responsible for the additional charges that my insurance may not cover.

**Name of Child(ren):** \_\_\_\_\_

**Signature and name of legal guardian of the child(ren) listed on registration sheet:** \_\_\_\_\_

\_\_\_\_\_ **Date:** \_\_\_\_\_

**INITIAL HISTORY QUESTIONNAIRE**

Pediatric Associates of Farmington, LLC, 200 Mountain Rd., Farmington, CT 06032  
Tel. No. (860) 676-9000 Fax No. (860) 676-1541

Form completed by: \_\_\_\_\_ Date completed: \_\_\_\_\_

Name of child: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ M / F

**Household:** Please List all those living in the child's home.

Name	Relationship to child	Birth Date	Health Problems

Are there siblings not listed? If so, please list their names and ages and where they live. \_\_\_\_\_

Who has custody of the child? \_\_\_\_\_ How often does the child see the parent/parents not in the home? \_\_\_\_\_

**Birth History:**

<b>Birth Wt:</b>		<b>Baby born at:</b>	weeks	<b>Type of delivery:</b>	Vaginal / Cesarean
<b>Feeding</b>	Breast / Bottle	<b>Hearing screen</b>	Pass / Fail		

Did mother have any illness or **problem with her pregnancy?** • Yes / • No \_\_\_\_\_

During pregnancy, did mother Smoke: •Yes / •No, Drink Alcohol: • Yes / • No, Use drugs or medications? • Yes / •No

Any **problems right after birth?** • Yes / • No Explain \_\_\_\_\_

**Medical History:**

Do you consider your child to be in **good health?** • Yes / • No Explain \_\_\_\_\_

Is your child on any **medications?** Please list. \_\_\_\_\_

Is your child **allergic to any medications or drugs?** • Yes / • No Explain \_\_\_\_\_

Is the water in your town **fluoridated?** • Yes / • No Is child is taking **fluoride supplements?** • Yes / • No

**The office policy regarding appointment cancellation and no-shows noted.**

**Hardship Waiver**

I certify that I am unable to pay my co-pay, deductible or account balance due to financial hardship.

I agree to notify you if my financial circumstances improve. Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Approved by: Deepa Limaye, MD. Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Does your child have or has ever had:

	Yes	No	Explain		Yes	No	Explain
Chickenpox			Age:	Frequent ear infections			
Nasal allergies				Problems with ears or hearing			
Frequent headaches				Problems with eyes or vision			
Use of alcohol or drugs				Convulsions or other Neurologic problems			
Blood transfusion				Anemia or bleeding problem			
Frequent abdominal pain				Constipation requiring doctor visits			
Any heart problem or heart murmur				Asthma, bronchiolitis, or pneumonia			
Bladder or kidney infection				Bed-wetting (after age 5)			
Diabetes				Thyroid or other endocrine problem			
(For Girls) Has she started her menstrual periods?				For Girls) Are there problems with her periods?			
Any chronic or recurrent skin problem				injuries or accidents			
Surgery				Hospitalization			
Any other significant problem							

Receiving special resource classes  Yes  No \_\_\_\_\_

**Family History:** Have any family members had the following:

	Yes	No	who		Yes	No	who
Deafness				Nasal Allergies			
Asthma				Tuberculosis			
Anemia				Bleeding Disorder			
Kidney Disease				Immune problems			
High Cholesterol				Liver Disease			
Mental Illness				Epilepsy or Convulsions			
Drug Abuse				Alcohol Abuse			
Mental Retardation				HIV, or AIDS			
Diabetes (before age 50)				Heart Disease (before age 50)			
Bed-wetting (after age 10)				High Blood Pressure (before age 50)			

Additional family history: \_\_\_\_\_



**PLEASE PRINT**

**To make it easier for the providers to concentrate on the care of your child we ask you to review these policies and cooperate with us in ensuring the best care for your child.**

Thank you for understanding and please let us know if you have any questions

1. **AT EVERY VISIT:** Please bring the patient's insurance card, your photo-ID and any payment/co-pay applicable at each visit.

**Federal trade commission identity theft: 'RED FLAGS RULE': We have to check photo identification at every office visit to comply with this rule.**

2. **APPOINTMENTS:** please make your next physical exam or follow up appointment before you leave.

3. **FLU VACCINE:** Please call us in September to schedule your flu vaccine.

4. **CALL REMINDERS:** A courtesy call is given prior to the appointment but we expect the caregivers to make note of their appointments.

5. **FAILURE TO KEEP APPOINTMENTS:**

a. A fee of \$100 will be charged for any missed appointments or for failure to cancel the appointment 24 hours prior to the appointment.

b. We shall be unable to schedule any more appointments if either the initial appointment or more than three appointments are missed.

6. **CO-PAYS:** All payments are expected at the time of the visit. We will be charging an administrative fee of \$5.00 if asked to bill.

7. **RETURNED CHECKS:** A fee of \$25.00 will be charged for every returned check.

8. **PRESCRIPTION REFILLS AND FORMS:** Please give us 24-48 hours. Forms not requested at the annual physical exam will be charged an administrative fee of \$5.00 each.

9. **QUESTIONS AT THE VISIT:** If you are here for a specific visit such as a vaccine, please understand that any concern expressed and addressed has to be documented as an office visit. Please let us know earlier if you have any other concerns besides the vaccine administration.

10. **ACCOMPANYING CHILDREN:** Please let us know when you come, if the accompanying child(ren) also need(s) to be seen so we can inform you if it is possible without inconveniencing the next patient.

11. **ELECTRONIC DEVICES:** Please do not use any electronic devices while in the office. Our patients and providers need your full attention and we request all to respect that.

**The policies written above have been reviewed and understood.**

**Signature and name of legal guardian of the child(ren) listed on registration sheet:** \_\_\_\_\_

\_\_\_\_\_ **Date:** \_\_\_\_\_

**Please take this informational sheet to review: For all patients**



Pediatric Associates of Farmington, LLC. 200 Mountain Road, Farmington, CT 06032. Tel. (860) 676-9000. Fax: (860) 676-1541

1. **AT EVERY VISIT:** Please bring the patient's insurance card, your photo-ID and any payment/co-pay applicable at each visit.  
**Federal trade commission identity theft: 'RED FLAGS RULE': We have to check photo identification at every office visit to comply with this rule.**
2. **APPOINTMENTS:** Please schedule the next physical exam or follow up appointment before you leave.
3. **FLU VACCINE:** Please call us in September to schedule your flu vaccine.
4. **CALL REMINDERS:** A courtesy call is given prior to the appointment but we expect the caregivers to make note of their appointments.
5. **FAILURE TO KEEP APPOINTMENTS:** a. A fee of \$100 will be charged for any missed appointments or for failure to cancel the appointment 24 hours prior to the appointment. b. We shall be unable to schedule any more appointments if either the initial appointment or more than 3 appointments are missed.
6. **CO-PAYS:** All payments are expected at the time of the visit. We will be charging an administrative fee of \$5.00 if asked to bill.
7. **RETURNED CHECKS:** A fee of \$25.00 will be charged for every returned check.
8. **PRESCRIPTION REFILLS AND FORMS:** Please give us 24-48 hours. Forms not requested at the annual physical exam will be charged an administrative fee of \$5.00 each.
9. **QUESTIONS AT THE VISIT:** If you are here for a specific visit such as for a vaccine, please understand that any concern expressed and addressed has to be documented as an office visit. Please let us know earlier if you have any other concerns besides the vaccine administration.
10. **ACCOMPANYING CHILDREN:** Please let us know when you come, if the accompanying child(ren) also need to be seen so we can inform you if it is possible, without inconveniencing the next patient.
11. **ELECTRONIC DEVICES:** Please do not use any electronic devices while in the office. Our patients and providers need your full attention and we request all to respect that.

Thank you for understanding and please let us know if you have any questions.

**This is the only location of our office. Office Hours:** Mon/Tue/ Fri – 8.30 to 12 & 12.30-4.00 pm. Wed/Thu - 8.30 to 12 & 12.30- 5.00 pm

**Calls during office hours:**

Every call is answered as fast as possible. If the call is deemed urgent, the staff will get the provider out of the room. If it is a routine call, you can expect an answer either at lunch time or before the end of the day.

**After hours care**

**On call service** after hours at all times. Please call the office number 860-676-9000 to reach the on call provider.

Dr. Limaye prefers to take calls for all her patients. When not available via phone, she has arranged for another colleague of hers to take the calls. Please do not hesitate to call back if you have not received a call back in 15-30 minutes.

We shall give advice to help you take care of your child's illness over the phone, but if necessary, will refer you to the ER at the CT children's hospital or any ER of your choice.

**Please take this informational sheet to review: General pediatrics**

Our providers: **Deepa Limaye, MD, Elizabeth Donovan, APRN, Emily Molina, APRN**

**Guidelines followed:**

We follow the guidelines of the American academy of pediatrics.

We are strong advocates of immunization and preventive care. We like our patients to read and ask us questions so we can always have an open discussion about the care of your child.

**Appointments:**

Sick visits: We believe that every child should be seen as soon as possible and will offer you an appointment the same day with any provider (You may have to wait a little if patients are double booked). If an appointment cannot be made for the same day, we shall certainly advise you about what needs to be done to make your child comfortable till seen.

All physical appointments are made as per the schedule. A schedule of the physicals and vaccinations advised by the AAP is available.

To establish a rapport with the providers, we request that you schedule visits with them at different visits. The providers discuss the care of each child and update each other at the end of the day. Dr. Limaye will come in at the end of the visit to answer any questions you may have.

We participate in most **major insurance** plans.

We are affiliated with The Connecticut Children's Medical Center, Hartford Hospital

<b><u>WELL CHILD CARE SCHEDULE</u></b>			
<b>Age</b>	<b>Physical Exam</b>		<b>Immunization</b>
<b>At Birth</b>	<b>PE (In hospital)</b>	<b>Newborn screen #1, Hearing Screen</b>	<b>Hep B#1, Parental TdaP</b>
<b>1-2 weeks</b>	<b>Ht, Wt, HC</b>		
<b>1 mth</b>	<b>Ht, Wt, HC</b>		
<b>2 mths</b>	<b>Ht, Wt, HC</b>		<b>HepB #1, DTaP#1, IPV#1, Hib#1, PCV#1, Rotavirus#1,</b>
<b>4 mths</b>	<b>Ht, Wt, HC</b>		<b>HepB #2, DTaP#2, IPV#2, Hib#2, PCV#2, Rotavirus#2</b>
<b>6 mths</b>	<b>Ht, Wt, HC,</b>	<b>Fluoride in water</b>	<b>HepB #3, DTaP#3, IPV#3, Hib# 3, PCV# 3,</b>
<b>9 mths</b>	<b>Ht, Wt, HC,</b>		
<b>12 mths</b>	<b>Ht, Wt, HC,</b>	<b>Hb, Lead levels, (PPD- If at risk)</b>	<b>MMR#1, Varivax#1, Hep A#1,</b>
<b>15 mths</b>	<b>Ht, Wt, HC,</b>		<b>Hib# 4, PCV#4.</b>
<b>18 mths</b>	<b>Ht, Wt, HC,</b>	<b>Assessment for autism</b>	<b>DTaP#4, HepA#2,</b>
<b>2 years</b>	<b>Ht, Wt, HC,</b>	<b>Hb, Lead levels, (chol, PPD- If at risk)</b>	
<b>3 years</b>	<b>Ht, Wt, BP, Hearing, Vision</b>	<b>(Hb, Lead, lipid profile, PPD-as indicated)</b>	
<b>4 -5 yrs</b>	<b>Ht, Wt, BP, Hearing, Vision</b>	<b>Hb. (Lead, lipid profile, PPD-as indicated)</b>	<b>DTaP#5, IPV#4, MMR#2, Varivax#2,</b>
<b>6-10 yrs</b>	<b>Ht, Wt, BP, Hearing, Vision</b>	<b>Lipid profile, (PPD-If at risk).</b>	<b>HPV #1, #2 and #3 (after 9 years of age)</b>
<b>≥11 yrs</b>	<b>Ht, Wt, BP, Hearing, Vision</b>	<b>Adolescent / depression screen. Hb in 5-6<sup>th</sup> and 10<sup>th</sup> grade. (Lipid profile, PPD-If at risk)</b>	<b>Meningococcal #1, #2, TdaP, HPV # 1, #2 and #3 Meningococcal B #1, 2</b>