Pediatric Associates
of Kershaw County, PA
803-432-1931

New Patient Packet

(Please complete one packet per child)

Welcome to Pediatric Associates of Kershaw County, PA!

We are excited to be a part of your family's healthcare team and look forward to caring for your family.

In order for your child to establish care with our practice, we will need the following information:

1. SIGNED MEDICAL RECORDS RELEASE
    - (YOU CAN SIGN A RELEASE AT YOUR CURRENT PROVIDERS OFFICE AND THEY WILL FORWARD RECORDS)
2. PATIENT REGISTRATION FORM
3. PATIENT HISTORY FORM
4. FAMILY HISTORY QUESTIONNAIRE
5. COPY OF INSURANCE CARD (FRONT & BACK)
6. COPY OF DRIVER'S LICENSE
7. COPY OF LEGAL DOCUMENTS (DIVORCE/FOSTER CARE/ADOPTION)

Once we have received the above requested documents and the patient's medical records, we will contact you to set up an appointment.

Again, thank you for entrusting your child's healthcare needs with our practice.

Sincerely,

Pediatric Associates of Kershaw County, PA

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AUTHORIZATON TO DISCLOSE HEALTH INFORMATION

PLEASE SEND BY MAIL- DO NOT FAX ANY MEDICAL RECORDS

Patient Name: _____
Date of Birth: _____

1. I authorize Pediatric Associates to request my health information from:

Office: _____
Address : _____
Phone #: _____
Fax #: _____

2. Information to be released:

- ☐ **Entire Medical Record**
- ☐ **Immunization Record**
- ☐ **Xray or Imaging Reports - Date:** _____
- ☐ **Labs-Dates:** _____
- ☐ **Newborn Records – Date:**
- ☐ **EEG/Echo/EKG - Dates:**
- ☐ **Recent Office Notes - Date:**
- ☐ **ER Records - Date:**

3. Reason for Release:

- ☐ **Patient Request**
- ☐ **Continuity of Care/Other Provider**
- ☐ **Legal Representation**

4. Delivery Requested:

- ☐ **CD by mail**
- ☐ **Paper by mail**

5. I understand that I have the right to revoke this authorization at any time. I must revoke this authorization in writing; however, I understand that the revocation will not apply to information that has already been released. Unless otherwise revoked, this authorization will expire in 3 years from the date unless specified here _____.

6.Send requested information to: Pediatric Associates of Kershaw County, PA
1346 Haile St
Camden, SC 29020

_____
Signature of Patient or Legal Representative/ Date

_____
Relationship to Patient

_____
Signature of Witness

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IMMUNIZATION AUTHORIZATION

Patient: _____

Date of Birth: _____

Chart ID: _____

Dear Parent,

We believe that all children and young adults should receive all of the recommended vaccines according to the schedule published by the Centers for Disease Control and Prevention and the American Academy of Pediatrics.

In our practice, children must begin receiving their immunizations by age 2 months. Our providers welcome discussion about our vaccine policy with any of our families. We have created this vaccine policy to protect children, their families, and our communities from deadly, preventable diseases by administering safe and effective vaccines.

We encourage you to discuss any concerns, doubts or questions you may have about vaccines with your health care provider.

By signing this form, you are agreeing to vaccinate your child with all recommended vaccines as needed.

Parent Name: _____

Parent Signature: _____ Date: _____

Staff Name: _____

Staff Signature: _____ Date: _____

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Patient History Form:

Patient name: _____ Date of Birth: _____

Child's Birth and Development History: _____

Born at: _____ Birth Weight: _____
(Name of Hospital)

Full term at Birth? ☐Yes or ☐No If no, how many weeks at birth? _____

Type of Delivery (Vaginal or C-section): _____

NICU stay: ☐Yes or ☐No If yes, Reason for NICU hospitalization: _____

Hepatitis B Vaccine date (if Newborn): _____

Any Chronic Illness: Please circle or check all that apply.

☐ ADHD	☐ Cystic Fibrosis	☐Cerebral Palsy	☐ ODD
☐Asthma	☐ Deafness	☐ Sickle Cell Anemia	☐ Bipolar
☐ Blindness	☐ Diabetes	☐ Depression/Psychiatric	
☐ Cancer	☐ Epilepsy or Seizure	☐ Other:	

Any Surgeries? _____

Current Medications: _____

_____

Allergies to Medications: _____

School: _____ Grade in School: _____

Name of Person Completing Form: _____

Relationship to patient: _____

Signature:_____Date: _____

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Family History Questionnaire

Name: _____

Date: _____

Chart Number (In office use only):

☐ *Please check this box if*: you have completed this form previously and the history is unchanged

☐ *Please check this box if*: no current family history of if family history is unknown

Please indicate with a check (X) relatives with any of the following conditions, as it applies to the patient. If needed, list any other health issues in the extra spaces provided.

MEDICAL CONDITION	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Mom's Sister	Mom's Brother	Dad's Sister	Dad's Brother
ASTHMA												
CANCER												
DIABETES												
HEART DISEASE												
HEART MURMUR												
HIGH BLOOD PRESSURE												
HIGH CHOLESTEROL												
KIDNEY DISEASE												
SEIZURES												
SICKLE CELL												
DEPRESSION												
ANXIETY												
ADHD												
AUTISM												
Early death (< 50 yrs. Old)												
Heart Attack (<50 yrs. Old)												
OTHER:												

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Missed Appointment Policy:

We care about the well-being of all of our patients, and want all patients to have access to appropriate care. In order to reduce "no-show" and same day cancellations, we are implementing a new policy. When you make an appointment, we reserve time just for you/your child. We will make every effort to see you at your appointment time and would appreciate your promptness and consideration with your appointment.

When you schedule an appointment you are expected to show up 10 minutes early for that appointment time. If you show up late, we may need to reschedule your appointment.

If you need to reschedule, you must give a 24 hour courtesy notice. We understand that life happens, so please call our office should anything arise.

** Effective November 1, 2023, after the 3rd missed appointment your child and other children in your immediate family will be dismissed from our office and will not be permitted to schedule another appointment. You will have 30 days to transfer care, and during that time only sick visits are allowed should you need them.

Patient Name: _____

Parent Signature: _____

Date: _____

(For office staff: One signature per family is allowed. Please write other child/children's names and scan into each child's chart)

PEDIATRIC ASSOCIATES OF KERSHAW COUNTY, PA
Patient Registration

PATIENT

Child's Name: _____ **Gender(Please Mark One):** ___ M ___ F
(First) (Middle) (Last)

Date of Birth: _____ **SS#:** _____
(mm/dd/yyyy)

Home Address: _____
(Street) (City) (State) (Zip)

If child is 17 or older, patient cell phone number: _____

PARENT/GUARDIAN INFO

Mother/Guardian's Name: _____ **DOB:** _____ **SSN:** _____

Occupation: _____ Employer: _____

Home#: _____ **Cell#:** _____ **Alternate#:** _____

Home Address(if different from child): _____

City: _____ **State:** _____ **Zip:** _____

Father/Guardian's Name: _____ **DOB:** _____ **SSN:** _____

Occupation: _____ Employer: _____

Home#: _____ **Cell#:** _____ **Alternate#:** _____

Home Address(if different from child): _____

City: _____ **State:** _____ **Zip:** _____

INSURANCE

Primary Insurance: _____ Policy #: _____ Group #: _____

Policy Holder's Name: _____ DOB: _____ SSN: _____

Patient's Relationship to Insured: Child / Self / Other: _____

Employer's Name: _____ Effective Date of Insurance: _____

Secondary Insurance: _____ Policy #: _____ Group #: _____

Policy Holder's Name: _____ DOB: _____ SSN: _____

Patient's Relationship to Insured: Child / Self / Other: _____

Employer's Name: _____ Effective Date of Insurance: _____

Emergency Contact

Name: _____ Phone Number: _____

Relationship to Patient: _____

FINANCIAL RESPONSIBILITY

(PLEASE READ AND SIGN BELOW)
I AUTHORIZE Pediatric Assoc. to render medical care to my child
I AUTHORIZE Pediatric Assoc. to file my health insurance and ASSIGN any benefits payable to Ped Assoc.
I UNDERSTAND AND ACKNOWLEDGE that I am ultimately responsible for any fees incurred for services provided to my child (regardless of insurance status).
Patient responsibility amounts are due in full at the time services are provided. This may include but is not limited to co-payments, co-insurance or account balances.
I UNDERSTAND AND ACKNOWLEDGE that if I do not have insurance I am responsible for any fees incurred for services rendered. I AGREE and ACKNOWLEDGE that it is my responsibility to notify Ped. Assoc immediately of any changes in my insurance.

Print Full Name: _____

Signature: _____ Relationship: _____ Date: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____

Pediatric Associates of Kershaw County, P.A. is authorized to release protected health information about the above named patient to the entries named below. This will include all Medical information including Appointment information, Lab results, and Financial information and give the parties listed below consent to bring the child to the office for care.

Name: _____ Relation: _____ Phone #: _____

Name: _____ Relation: _____ Phone #: _____

Name: _____ Relation: _____ Phone #: _____

Name: _____ Relation: _____ Phone #: _____

Pharmacy Info

Pharmacy/Escribe:

I agree that Pediatric Associates of Kershaw County, P.A. may request and use my child's prescription medications history from other healthcare providers or third party pharmacy benefit payers for treatment purposes. This will permit our office to send prescriptions to the pharmacy electronically.

PHARMACY: _____

Portal Info

Patient Portal:

SRSsoft Patient Portal is a secure online access to your child's clinical summary. In the future this will expand to allow for secure messaging to communicate with the practice.

❑ Yes, I would like to be set up on the Patient Portal. ❑ No, I do not wish to participate with the Patient Portal.

Email Address: _____
Please Print Legibly

Preferred Contact Method:

Phone: _____ E-Mail: _____ Text: _____

Other Children

Siblings Names & Dates of Birth: 1.) _____ DOB: _____

2.) _____ DOB: _____ 3.) _____ DOB: _____

4.) _____ DOB: _____ 5.) _____ DOB: _____

The Federal Government requires all medical practices to collect the following information from patients.
There is a provision in the law that allows patients to not answer these questions.
Please answer the following three questions or select the "I decline to provide this information" answer.

Child's Ethnicity is: (Please Select One)

A. Hispanic or Latino
B. Not Hispanic or Latino

Child's Race is: (Please Select One)

A. American Indian/Alaskan Native
B. Asian
C. Black or African American
D. Native Hawaiian or Pacific Islander
E. White/Caucasian
F. Other

Child's Preferred Language is: (Please Select One)

A. English
B. Spanish
C. Other:

❑ I decline to provide this information.

Notification of Patient Privacy Policy: The Health Insurance Portability and Accountable Act (HIPAA) has mandated that all health care providers make available The Notice of Privacy Practices. This notice is posted in our waiting room for your review and is available on our website: pedakc.com. Upon request a copy of the Privacy Notice will be made available to you. In signing below, you acknowledge and understand the above information.

Signature: _____ Date: _____
Parent/Guardian

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