1690 Big Oak Road, Yardley, PA 19067 Telephone (215) 493-1750 Fax (215) 493-1470

Web: www.lowerbuckspediatrics.com

Demographics

Child	Name		
	Date of birth		
	Gender		
	Social security number		
	Language preference (if not English)		
	Race/Ethnicity		
	Please describe any vision or hearing impairment that requires accommodation		
	Adopted or in foster care		
Parent(s)/ Legal Guardian(s)	Name		
	Date of birth		
	Gender		
	Social security number		
	Street address		
	City, State, Zip code		
	Home phone number		
	Work/cell phone number		
	Email		
	Occupation/employer		
	Name		
	Date of birth		
	Gender		
	Social security number		
	Street address		
	City, State, Zip code		
	Home phone number		
	Work/cell phone number		
	Email		
	Occupation/employer		
Subscriber	Name of person who holds insurance		
Emergency Contact	Name		
	Relationship to child		
	Address		
	Phone number		
Sibling(s)	Name	Date of Birth	Gender
	1.		
	2.		
	3.		
	4.		

Birth History

Mother's age at child's birth
Did mother have any problems/illnesses during pregnancy?
Did mother use the following during pregnancy? (circle if yes) tobacco alcohol other drugs
Was the child born on time? (circle one) full term premature late If premature, number of weeks early _____
Was the delivery (circle one): vaginal or c-section
What problems did the child or mother have during/after delivery?
What was the baby's birth weight?
Was the baby (circle one): breast-fed or bottle-fed

Past Medical History

Date of last check up Where/previous PMD?					
Date of last dental check up					
Does your child have any allergies to medications, foods, or latex?					
Does your child take any medications regularly?					
Has your child had any reactions to any immunizations?					
Any hospitalizations?					
Any surgeries?					
Any serious injuries? Fractures? Concussions?					
Does child have any of the following illnesses?					
Allergy		Anemia		Epilepsy/seizures	
Asthma		Bleeding Disorder		Psychiatric/Mental Illness	
Constipation		Liver Disease		Immune problems	
Diarrhea		Kidney Disease		Cancer	
Ear Infections		Diabetes		Strep throat	
Heart Disease		Bed Wetting		Pneumonia	

Family History

Is there a family history of any of the following? Please circle			
Allergies	Asthma	Anemia	Birth defects
Cancer	Heart disease	High cholesterol	High blood pressure
Arthritis	Deafness	Stroke	Kidney disease
Seizures	Mental/psychiatric illness	Drug use	Alcohol use

Safety/Environment

Does your child always use car seat/seat belt when riding in a car?
Are there working smoke alarms and a fire extinguisher in the house?
Are there any guns in the home?
Are there any smokers in the household?
Does your child always wear a helmet when riding a bicycle?
Do you have a pool? Is it fenced in?

Lower Bucks Pediatrics, P.C.

1690 Big Oak Road
Yardley, PA 19067

Telephone (215) 493-1750
Fax (215) 493-1470

Web: www.lowerbuckspediatrics.com
Email: info@lowerbuckspediatrics.com

PATIENT/PARENT/GUARDIAN RELEASE

PATIENT NAME:_____

PATIENT DATE OF BIRTH:_____

THE ABOVE NAMED PATIENT IS MY (circle one):

SON DAUGHTER SELF FOSTER CHILD OTHER:_____

I certify the demographic and insurance information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies for the purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I acknowledge that interest or fees, including collections and legal fees, at the provider's current rate, may be charged on all balances owing to the provider that are past due.

I permit a copy of this release to be used in place of the original.

SIGNED (if not the patient, I also certify that I am parent/legal guardian of the patient):

_____ DATE:_____

Lower Bucks Pediatrics, P.C.

1690 Big Oak Road
Yardley, PA 19067

Telephone (215) 493-1750
Fax (215) 493-1470

Web: www.lowerbuckspediatrics.com
Email: info@lowerbuckspediatrics.com

EXHIBIT 4

RECEIPT OF NOTICE OF PRIVACY PRACTICES

WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have been offered a copy of Lower Bucks

(Patient/Legal Guardian Name)

Pediatrics' Notice of Privacy Practices and have received a copy if so requested.

(A copy is available in each waiting room).

_____ _____

Signature of Patient/Legal Guardian Date