Katherine J. Scoville, D.O. P.C.
311 North Street, Suite 307
White Plains, NY 10605
914-358-9559

Today's Date:____________________

Please print the following:

Patient's Name:__________________________ Patient's Date of Birth:_____-_____-______

Address:________________________________ SS#:_________________________

________________________________ Email:______________________

Parents:

Mother__________________________ Father_____________________

Date of Birth:_____-______-______ Date of Birth: _____-______-______

Address:________________________ Address_________________________

________________________________ ________________________________

Please identify all that apply and check ( ) if OK to leave messages:

Phone:____________________home ( ) Phone:____________________home ( )

____________________work ( ) ____________________work ( )

____________________cell ( ) ____________________cell ( )

____________________email ____________________email

Employer:_________________________ Employer_________________________

Occupation:________________________ Occupation:________________________

Who is responsible for the patient's medical bills?______________________

Insurance Company: ______________________ Policy Number:_______________________

Name on Policy:_________________________Group #:___________________________

Policy Holder SS#:_______________________Date of Birth:_________________________

Referred by:__________________________________

Allergies:____

Physicians from whom the patient is currently receiving medical care:

Physician	Phone Number	Condition being treated	Medications

Surgeon	Date	Phone Number	Procedure done

PLEASE ALSO READ AND SIGN THE NEXT 3 PAGES, THANK YOU.

peds revised 05/13

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Welcome:

To help you get acquainted with the office, we have prepared this statement about our policies and fee schedules. Please sign below to indicate that you have read and understand our guidelines.

Office Hours:
Mon: 10:00 am–8:00 pm., Wed: 8:00 am-8:00 pm, Thurs: 8:00 am-4:30 pm, Fri: 8:00 am–4:00 pm.

Your Appointment:
Your appointment is time set aside for you to see the Doctor. We have a ***twenty-four (24) hour cancellation policy***. If you cancel an appointment less than 24 hours prior to its scheduled time, you will be billed the full visit fee. A message may be left on our voice mail at any time to cancel your appointment. The earlier you can inform us of a change in your plans, the more efficient use we can make of our time. We also respect your time and endeavor to be punctual for your appointment.

Children:
Children *must be supervised by their caretaker and remain in the waiting area* unless they are being seen by the doctor.

Fragrances:
Some of our patients are allergic to environmental pollutants such as perfumes and hair sprays; we would appreciate it if you would refrain from wearing these to the office.

Fees & Payments:
For all patients, we require payment for services at the time they are provided. We are unable to accept assignment from private insurance carriers, but we supply a standard, itemized receipt that you may submit to your non-Medicare insurance company to request reimbursement. Because Dr. Scoville has opted out of Medicare, Medicare patients will need to sign a Private Pay Contract, which the doctor will explain prior to treatment. The Contract affirms that the patient accepts responsibility for all treatment costs, and will not seek Medicare reimbursement. Our practice is not a Medicaid practice.

The parent or guardian of a minor patient is responsible for payment.

Checks returned from the bank will incur a $30.00 “returned check” fee to your account.

Thank you for taking the time to read this policy sheet. If you have any questions about our policy please ask them now.

We understand that you have come here to seek specialized treatment and we will endeavor to assist you in a speedy recovery, but of course we cannot guarantee any specific result.

I have read and understand the above office policies and consent to treatment by Dr. Scoville and her staff.

____________________	____________________	__________
Signature of Patient or Authorized Guardian if under 18 years old	Print Name	Date

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Today's Date: ___________________

Name: __________________________________ Date of Birth: ______/______/______

1. Permission to release information to Insurance Carriers:

We must have your authorization in order to respond to any correspondence from your insurance carrier or to submit Medicare forms. Please sign below so that we may send out any needed information and/or letters to help you obtain reimbursement.

I give permission to this office to release medical information to my health insurance company.

Signature ___________________________________ Date ____________________

- ○ Please contact me when you receive **any** requests for information from my insurance carrier.
- ○ Please contact only when there are requests for copies of your office notes.

2. Permission to Share Information with Health Care Providers:

If you want the doctor to share your medical information with other health care providers so that we may function as a team please give permission by signing below.

Signature ___________________________________ Date _____________________

- ○ Please contact me before sharing any information with my other health care providers.

3. Patient Privacy Policy:

I have read and understand Dr. Scoville attached Patient Privacy Policy. In respect of patient's privacy and security, and the requirements of the Health Information Privacy Act (HIPA), I agree to maintain the Patient Privacy Policy of this office.

Signature ___________________________________ Date _____________________

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Patient Privacy Policy

In order to protect sensitive personal and medical information, we have instituted a number of measures aimed at maintaining your privacy. The National Institutes of Health have newly developed the Health Information Privacy Act (HIPA) that requires every medical provider to make available to patients a privacy policy. This effort is to maintain privacy of patient information in an era of high technology and data-laden medical systems. The end result will be a more streamlined system of medical information with a higher degree of information security in the process. The following is the policy for patients in this office regarding patient privacy and confidentiality of information collected and stored in this office:

1. Payments and scheduling will be done by the office manager or Dr. Scoville. Patients must remain in the waiting area and NOT at the office manager's desk so that the scheduling book and computer screen are NOT visible to them.

2. An information sheet with demographic data, insurance information, consents for treatment and medical disclosure will be completed by every patient as part of his/her record. A copy of this sheet and the insurance card(s) will be released to the office manager for billing records and to help process medical claims. This form will include the patient's preferences for where appointment reminders may be left (home, work, or cell phones).

3. All super bills for office visits will be shared with the office manager/billing supervisor in order to process insurance claims and record business transactions for tax purposes.

4. Any paper trash with patient information will be shredded prior to discarding it.

5. Employees and staff are required to sign a confidentiality agreement regarding any information they are exposed to in the office setting which is not to be discussed or revealed to any person(s)/business(es) outside of the office setting without prior written consent by the patient/legal guardian.

6. Medical release forms are required to be signed by the individual or parent/guardian in order to release any medical information to themselves, medical offices, insurance companies, or to any other desired location. A copying charge may apply for extensive record copying.

7. Only first names will be used when addressing patients in the office.

8. All medical related conversations will occur in private.

9. All papers related to patient care will be stored in cabinets when not in use where only authorized medical staff has access to them.

10. Any breech of confidentiality must be submitted in writing to Dr. Katherine Scoville, D.O. for a proper action to be taken to amend the situation/or policy.

Date: _________________ Name: ________________________________

Chief Complaint: ____

____

____

History of present illness: ____

____

____

____

Work-up/Diagnosis____

____

____

Illness/hospitalization:____

____

____

Medication: ____

Surgeries____

Vaccines: (reaction to: fever, excessive crying, seizure, rash, change in personality)____

Traumas/Accidents/Injuries: ____

____

____

Birth History: ______of___ siblings; Pregnancy welcomed /planned: Yes No Prenatal care?______________________________

Medicines/ caffeine /tobacco/alcohol/substances used during pregnancy:____

Complications with Pregnancy: ____

Delivery: Gestational age/weeks pregnant at delivery: _____Type of delivery_______ Time ruptured Membranes_____________

Hours Labor/Problems: ____

Time Pushing: ______________________Medicines used: ____

Epidural: Yes No Pitocin augmentation: Yes No Forceps: or vacuum Yes No

C-Section: Yes No Reason: ____

Presentation Vertex ___________________Breech_____________________Transverse______________________________

APGAR_____/______ First Cry: strong weak Wt _____________ Ht ___________ Length______________________________

Complications Mother:____

Complications Baby: ____

Immediately to breast? Yes No Breast/Bottle Suck strong: Yes No __________ Spit-up: Yes No________

Vomit: Yes No______ Failure to thrive: Yes No_______ Formula name_____________ changed? Yes No

Colic: Yes No Sleeps well: Yes No_________ start solids: Yes No___ Feed self: Yes No

Personality____Was baby placed on belly as infant? Yes No

Milestone:	**Age:**	**Milestone:**	**Age:**
Chest up in prone (often approximately 2m)		**Coos, Smiles (2m)**	
Up on hands, rolls front/back (4m)		**Reaches, laughs, vocalizes after speaker (4m)**	
Rolls back/front, lifts head (5m)		**Smiles in mirror, object hand to mouth, mimic (5m)**	
Sit supported (6m)		**Babbles, strangers, looks to floor for fallen object**	
Sits unsupported (7m)		**Bangs/shake, toy, feet to mouth, (7m)**	
Gets into sitting position (8m)		**Peek-A-Boo**	
Pulls to stand, creeps, grasp with fingertips (9m)		**Words have meaning**	
Walk with hands held, pincer grasp (10m)		**Look at picture in book (10m)**	
Stands alone (11m)		**Looks for person named, First word (11m)**	
Walks (12m)		**2 words (12m**	
Climbs stairs (16m)		**5-10 words, tower of 3 cubes, fetches (16m)**	
Throws Ball		**10-25 words, Points to self, scribbles (18m)**	
Walks up stairs(20-22)		**2 word combination (20-22m)**	

Toilet Trained?____

Dentition? (Circle teeth present and identify age of emergence if other than age indicated below.)

6m-central incisors_______ 8m-lateral incisors______ 14m-1st molar______19m-canines____24m-2nd molars_____

Diet: Breakfast ____

Lunch:____

Dinner:____

Food Intolerances/allergies/restrictions:____

____

Water Intake____________________Supplements:____

Interests/Hobbies/School:____

Home environment:____

Family Illness History:____

____

____

Review Of Systems: General: Weight:_______ Energy:_________ Fevers/Chills:_________ Skin/Hair/Nails:_____________________

Eyes:____________________________ HEENT: ear infections_______________________ Hearing_____________________________

Nose/Sinus:____Mouth/throat/tonsils:_____________________________________

Respiratory: Cough/Asthma:____________________________________Snoring:____

Cardiac: Murmur/congenital_________________________ Chest Pain:____

Gastrointestinal: Nausea or vomiting_____ Constipation: ____________________________ Reflux:______________________________

Feeding/Sucking or swallowing problems____

Genital/urinary/UTI:______________________Reflux:____________________Enuresis:______________Diaper Rashes:_____________

Neurological: Fainting, Seizure, tremor, weakness, N/T, memory/concentration problem:____

Musculoskeletal: Joint/muscle pain/swelling:________________________Stiffness:______________________Hypotonia:____________

Scoliosis:___________________________________ Leg Length discrepancy: _________________________dystonia/paralysis:________

Psych: Depression, Anxiety thought disorder: ____Sexual Abuse:________________

Endocrine/Hematology: Thyroid, DM, Anemia, Transfusion:____

Congenital:____