TLC PEDIATRICS, LLC
10 Mott Avenue, Norwalk, Connecticut 06850

TLC Pediatrics., LLC Registration Form

Child's Name(s): Today's Date: _____

	Last Name	First Name	Birth Date	Sex	
1.	_____	_____	_____/_____/_____	M	F
2.	_____	_____	_____/_____/_____	M	F
3.	_____	_____	_____/_____/_____	M	F
4.	_____	_____	_____/_____/_____	M	F
5.	_____	_____	_____/_____/_____	M	F

Home Address:

_____
Street City State Zip Code

Parent Information:

Mother's Name: _____ D.O.B: _____/_____/_____

Address: _____
Street City State Zip Code

Preferred Contact #: _____ Alternate Contact #: _____ 3rd Contact #: _____

Father's Name: _____ D.O.B: _____/_____/_____

Address: _____
Street City State Zip Code

Preferred Contact #: _____ Alternate Contact #: _____ 3rd Contact #: _____

Guardian's Name: _____ D.O.B: _____/_____/_____

Address: _____
Street City State Zip Code

Preferred Contact #: _____ Alternate Contact #: _____ 3rd Contact #: _____

NOTE: Our front desk staff is required to ask for each child's insurance card at every visit!

Health Insurance:

Primary Health Insurance: _____ Effective Date: _____/_____/_____

Policy Holder's Name: _____ D.O.B. _____/_____/_____

Home/Mailing Address: _____
Street City State Zip Code

Secondary Health Insurance: _____ Effective Date: _____/_____/_____

Policy Holder's Name: _____ D.O.B. _____/_____/_____

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Emergency Contact:

Names & Relationships of others who have permission to bring & are authorized to make medical decisions for your child:

			Emergency Contact?	
Name: _____	Relationship: _____	Phone Number: _____	Yes	No
Name: _____	Relationship: _____	Phone Number: _____	Yes	No
Name: _____	Relationship: _____	Phone Number: _____	Yes	No

We are required to collect the following information for each patient. Please complete this section before returning the form. Please keep in mind by choosing a "Preferred Doctor", this applies to Well Child Checkups. If your child is sick, he/she will be seen by the doctor available that day. Thank you

Preferred Doctor: (circle one) Patricia Jorquera, MD Betsy Clachko, MD Cindy Perry, MD

Providing this information is optional and voluntary. All patients receive the same medical care regardless of the answer or answering "*I prefer not to answer*".

Your Child's Race:

- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Black/African American
- ☐ Caucasian
- ☐ Hispanic
- ☐ Hawaiian Native/Pacific Islander
- ☐ Decline to answer

Ethnicity:

- ☐ Unknown
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Decline to specify

Your preferred language: _____

Signature of parent/guardian: _____ Date: _____/_____/_____

Print name of parent/guardian: _____ Date: _____/_____/_____

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Authorization of Treatment and Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless insurance coverage is verified and TLC Pediatrics is a participating provider. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including private insurance and any other health/medical plan, to issue payment check(s) directly to TLC Pediatrics for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize TLC Pediatrics to: (1) release any information necessary to insurance carriers regarding myself and/or my dependent's illness and treatments; (2) process insurance claims generated in the course of examination or treatment. This order will remain in effect until revoked by me in writing.

I have requested medical services from TLC Pediatrics on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges (copay, coinsurance and/or deductible) incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____	_____
(Child's First & Last Name)	Date of Birth
_____	_____
(Child's First & Last Name)	Date of Birth
_____	_____
(Child's First & Last Name)	Date of Birth
_____	_____
(Child's First & Last Name)	Date of Birth
_____	_____
(Child's First & Last Name)	Date of Birth

_____ _____

Signature of parent/guardian Date

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Patient & Family Medical History Form

Please fill out both sides completely. Thank you

Patients Name: _____ Date of Birth: _____/_____/_____ Today's Date: _____/_____/_____

Parent/Guardian Name: _____

Allergies/Reactions to medications, food, or vaccines:

_____

Mediations the patient is currently taking (please include both prescriptions and over the counter):

_____

Hospitalizations? – (When, Where, Why):

_____

_____

Delivery and Birth History

Mother's age at child's birth: _____

How was the patient delivered?:

☐ Vaginal ☐ Caesarean ☐ Adoption ☐ Other _____

Any problems during pregnancy?:

☐ Excessive weight gain ☐ Excessive swelling ☐ UTI ☐ Toxemia ☐ Venereal Disease

Other (please explain): _____

Medications during pregnancy?: _____

During pregnancy did mom: ☐ Smoke ☐ Drink

Other: _____

At birth, how many gestational weeks was your child? (e.g. term = 40 weeks): _____

Birth weight: _____ Birth length: _____

Problems with baby at birth?: ☐ Breathing ☐ Jaundice

Other: _____

Problems soon after birth?: _____

Feeding: ☐ Breast milk ☐ Formula ☐ Both

Feeding Problems: ☐ Colic ☐ Recurrent vomiting ☐ Recurrent diarrhea ☐ Multiple formula change →

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Child's History

Is the patient affected by any of the following (please check all that apply):

☐ ADD/ADHD	☐Depression	☐ Rashes
☐Allergies	☐ Diabetes	☐Reflux
☐ Anemia	☐ Diarrhea	☐ Seizures
☐Asthma	☐Ear infection	☐ Sickle Cell
☐Autism	☐ Eczema	☐ Urinary Problems
☐ Broken bones	☐Food allergies	☐ Vaccine Reactions
☐ Chickenpox	☐ Hearing Loss	☐ Wheezing
☐ Concussions	☐ Heart Murmur	☐ Other Issue
☐Constipation	☐ Lead exposure	

Other: _____

_____

Social History

Who does the patient live with? _____

Are parents: ☐ Married ☐ Unmarried ☐ Separated ☐ Divorced

Was the patient's house built before 1978?	☐ Yes	☐ No
Do you have access to a pool?	☐ Yes	☐ No
Are there any guns in the home?	☐ Yes	☐ No
Are there any pets in the home?	☐ Yes	☐ No
Any foreign travel within the past 5 years?	☐ Yes	☐ No

If yes, where?_____ _____

Any smokers in the home?	☐ Yes	☐ No
If so, where do they smoke?	☐ Inside	☐ Outside

Family History

Please state which of the following relatives have the conditions below (if none leave blank)

(F) Father, (M) Mother, (B) Brother, (S) Sister, (MG) Maternal Grandparent, (PG) Paternal Grandparent, (A) Aunt, (U) Uncle, (C) Cousin

Anemia/Blood disorders:	Allergies:	Alcoholism:	Arthritis:	Aids/ HIV:
Asthma:	Allergy Shots:	Cancer:	Cystic Fibrosis:	Cholesterol Problems:
Birth Defects:	Diabetes:	Eczema:	Ear Tubes:	Epilepsy/Seizures:
Drug Problems:	Early Deafness:	Heart Attack/Stroke:	Heart Disease:	High Blood Pressure:
Hereditary Problems:	Intellectually challenged:	Migraines:	Tuberculosis:	Sudden infant death:

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required by State and Federal laws, including the HIPAA Rules, to safeguard general and health-related information about you. We have created a Notice of Privacy Practices that explains how your protected health information is handled. The Notice of Privacy Practices is provided to patients (and/or their authorized representatives) when they first become our patient.

We are asking you to sign this form to show that we offered you a copy of our Notice of Privacy Practices. By signing below, you are only acknowledging that you were offered or received a copy of the Notice of Privacy Practices. You are not making any statement about the content of the Notice of Privacy Practices or about your agreement or disagreement with any portion of it.

Acknowledgment

I acknowledge that TLC Pediatrics., LLC has offered or provided me with a copy of its Notice of Privacy Practices, which describes how medical information about me may be used and disclosed, and how I can access this information.

· I understand that if I have questions or complaints I may direct my questions to the Office Manager.
· I also understand that I am entitled to receive updates upon request if TLC Pediatrics., LLC amends or changes its Notice of Privacy Practices in a material way.

_____ _____
Signature of patient or patient's representative Date

_____ _____
Printed name of patient/patient's representative Relationship to patient

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OFFICE POLICIES

Today's Date: _____

Dear Parent or Guardian,

At T.L.C. Pediatrics, we are committed to providing comprehensive quality care for your child in a family-friendly environment. In order to accomplish this we need to work together. Please review & sign the following policies that have been developed to provide the highest possible care for your child:

Vaccinating:
I ***agree*** to have my child fully vaccinated while under the care of TLC Pediatrics. Immunizations have had an enormous impact on improving the health of children in the United States. Vaccination is one of the best ways parents can protect infants, children, and teens from 16 potentially harmful diseases. (Should you have any questions, you may ask to speak to our Office Manager)

After-hours service and phone calls:
Our office offers after-hours services in case of an emergency. Call 203-855-7551 or 855-303-1969 and the on-call doctor will be paged. The doctor will then call you to determine the next step. Our phone system requires you to leave detailed specific information. Please speak slowly and clearly. Repeat the contact phone number twice so we are able to accurately return your call.

Payment at the time of service:
Our office requires payment for the office visit or co-pay be paid at the time of visit.

Appointment confirmations, No shows and late arrivals:
Not showing up for an appointment prevents us from scheduling other patients. Arriving late for an office visit causes the provider to fall behind in his or her schedule and delays the visit for other patients who arrive on time. In consideration of our other patients, a client who is late may be asked to reschedule their appointment. Additionally, a missed appointment will result in a $50.00 cancellation fee.
In addition we require a 1 hour notice of cancellations or rescheduling for ALL other appointments (sick visits, nurse visits, vaccine administration, weight check etc.)

The above noted fees will NOT be billed to your insurance, they are your responsibility. Our office confirms appointments the day prior to your appointment. This is provided as a courtesy to our families, it is your responsibility to remember your appointment. If an appointment if missed 3 times you will be asked to transfer care to another practice.

Daycare, Camp, school, sports forms and immunization records:
Forms that need to be filled out by the doctor can be left at our office for completion and then picked up in one week. If a self-addressed, stamped envelope is provided we will mail the form to you or the facility. Some forms can also be faxed to the facility if we are provided with the fax number. Parents—please read the requirements for physicals on camp and sports forms. Some forms specify that the child have a physical exam every 12 months. If you need a form filled out, and it indicates the need for a physical exam within the last year, we cannot sign the form unless your child has had a complete physical exam within that time period. Note: if you need a form filled out ASAP, we are happy to accommodate with a minimum 24 hour completion time. →

Well care physicals and sick appointments:

Well care physicals consists of a complete physical exam. A well care psychical exam is required every 12 months for most day cares and facilities, camps, junior high and high school sports. The AAP recommends yearly well care physicals from 3yrs -21 yrs. Visits are more frequent under the age of 3yrs (see attached well care physical schedule)

Sick appointments are given a time slot much less than physicals. This time is set up for the doctor to examine the patient and diagnose the illness. If your child has multiple symptoms, problems, or concerns, please let the receptionist know when you make the appointment so the visit can be extended. We want to make sure the doctor has enough time to address all of your concerns without feeling rushed.

Our schedule is not set for walk-in appointments. Please call ahead (at 9am) to establish an appointment time. Please keep in mind that the doctor cannot schedule appointments from home, if you wish to schedule a same day appointment please call the office at 9am.

Medication refill:

For routine medication refills, please contact your pharmacy first. They will contact us directly for refill requests. When leaving a message for medication refills, the nurses need the name of the child (with spelling), the prescription medicine and the name of the pharmacy we should call. Prescription refills will be called in the same day requested and available for pick up after 5pm. If an ADD/ADHD medication refill is needed, a 24/48 hour advance notice is needed. Medication recheck visits for ADD/ADHD are performed every 6 months. Yearly well care visits are recommended and this fulfills a medication recheck visit.

I have read and understood the office policies and procedures of TLC Pediatrics., LLC.

Parent/Guardian Name (Print): _____

Signature of Parent/Guardian: _____ Date: _____

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Policy for Missed Appointments

I, _____, parent, or legal guardian of:

List child(s) Name and Date of Birth:

_____ _____
(Child's First & Last Name) Date of Birth

_____ _____
(Child's First & Last Name) Date of Birth

_____ _____
(Child's First & Last Name) Date of Birth

_____ _____
(Child's First & Last Name) Date of Birth

_____ _____
(Child's First & Last Name) Date of Birth

have been informed by TLC Pediatrics., LLC, that the office requires a 24 hour cancellation notice for all Well Child Check ups and a 1 hour cancellation for all other appointments such as sick visits, nurse visits, vaccine administration, weight check, etc. I understand that there may be a $50 fee after the first "waived" no-show.

I understand that three missed appointments in the family will result in discharge from the practice.

_____ _____
Signature of parent/guardian Date

_____
Print full name

Revised December 2016