Welcome to Gogue Pediatrics! We look forward to being a part of your child's health care from infancy into adulthood. Please provide us with some information below:

Patient's Name:_____(Male/Female) DOB:_____

Mother's Name:_____DOB:_____

Father's Name:_____DOB:_____

Home Ph:_____Cell Ph :_____Work Ph: _____

Insurance Name: _____ ID#:_____

Policy Holder Name: _____ D.O.B.: _____

Employer Name:_____ Employer Address:_____

PHARMACY*:*
Name*:*_____Address*:*_____

Phone Number*:*_____

Would you like to Enable Patient Portal:___Yes ___No

Email address:_____

Home Address:_____

City:_____State:_____Zip:_____

Emergency Contact Name:_____Relation:_____Emergency Contact Phone #:_____

How did you hear about us?_____

I give permission to Gogue Pediatrics to contact me via text messages, phone calls, and emails regarding future appointments, financial responsibility, and all other communications in regards to your child.

Patient/Guardian Name:_____

Signature:_____Date:_____

PATIENT INFORMATION

Birthing Hospital?:_____

Delivery:

- ❑ C-section
- ❑ Vaginal

Birth Weight of baby: _____

Please list any complications during birth?:_____

Did your baby stay in the NICU?:

- ❑ Yes (*reason*):_____
- ❑ No

Please list all siblings name and D.O.B below:

First _____ Last_____ D.O.B: _____

First _____ Last_____ D.O.B: _____

First _____ Last_____ D.O.B: _____

First _____ Last_____ D.O.B: _____

First _____ Last_____ D.O.B: _____

Past Medical History:

Has your child had the following?

Check box and Explain, please include the year of diagnosis for all items that apply.

- ❑ Major concerns from family for child's health _____
- ❑ Abdominal pain frequently _____
- ❑ Anemia _____
- ❑ Asthma _____
- ❑ Bladder or kidney infection _____
- ❑ Bleeding Problem _____
- ❑ Bronchiolitis _____
- ❑ Bronchitis _____
- ❑ Constipation _____
- ❑ Diabetes _____
- ❑ Ear infections _____
- ❑ Emotional Problem _____
- ❑ Eye problem _____
- ❑ Headaches frequently _____
- ❑ Hearing loss _____
- ❑ Heart murmur _____
- ❑ Heart problem _____
- ❑ Hospitalization _____
- ❑ Injuries or accidents _____
- ❑ Pneumonia _____
- ❑ Pregnancy or newborn period problems _____
- ❑ Seizures _____
- ❑ Serious illness or medical condition _____
- ❑ Skin problem _____
- ❑ Thyroid or other endocrine problems _____
- ❑ Vision problem _____
- ❑ Other significant problems_____

Drug/Food Allergies:_____

Family History:

Check if any family members had the following. Please include relationship to child and age at onset.

- ❑ Alcohol or Drug abuse _____
- ❑ Allergies _____
- ❑ Anemia _____
- ❑ Asthma _____
- ❑ Bleeding Disorder _____
- ❑ Cancer _____
- ❑ Diabetes_____
- ❑ Early/Sudden death _____
- ❑ Epilepsy/Convulsions_____
- ❑ Crohns/Ulcerative Colitis_____
- ❑ Hearing loss/Deafness_____
- ❑ Heart Disease_____
- ❑ High Blood Pressure_____
- ❑ High Cholesterol_____
- ❑ Immune Problems_____
- ❑ Kidney Disease_____
- ❑ Liver Disease_____
- ❑ Mental Illness/Depression_____
- ❑ Skin Problems_____
- ❑ Other Significant History_____

Social History:

- Who does your child live with? _____
- Primary Language(s) Spoken at Home _____
- Smokers in the household _____
- Significant issues in family or household _____

Surgery: _____

Medications:_____

Financial Responsibility

Parents or guardians seeking care will accept financial responsibility for payment. Parents and guardians will be held responsible for understanding coverage limitations and for dollar amounts not covered by insurance.

I agree to pay for any and all medical services I receive from this practice that my insurance company refuses to pay, for whatever reason. This office will file a claim on my behalf; however, if my insurance company refuses to pay, for whatever reason, I will pay for the same amount upon written/verbal notice of their refusal. I further agree and understand that this office can only code and file a claim for my child's visit with a diagnosis that was encountered and documented in the medical record. Thus, to ask this office to **change** a diagnosis solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and fraudulent. I authorize the release of any medical information necessary to process any claims, either to myself or any parties who request this information. Policy subject to change. Updates will be posted on our website.

Newborns

- ***You have 30 days from the patient's date of birth to add your child to your current insurance policy, otherwise, you will be financially responsible for any and all services rendered.***

Patient/Guardian Name:_____

Signature:_____Date:_____

General Consent for Treatment

I have voluntarily presented for medical care and consent to such medical care and treatment including any diagnostic procedures and tests that the physician(s), his or her associates, assistants and other healthcare providers determine to be necessary. In the course of treatment, I understand and acknowledge that no warranty or guarantee has been or will be made as to the result or cure of treatment. I have the legal right to consent to medical treatment because I am the patient or I am the parent/guardian of the patient. All references to “I”, "patient", "me" and

"my" in this document means: (name of patient)_____.

Patient /Legal
Guardian Signature:_____Date:_____

Delegation of Consent

Patient:_____DOB:_____

I hereby authorize (when I am unavailable to give consent) to the following individual(s):

Name:_____Relationship to Patient:_____

Name:_____Relationship to Patient:_____

to consent to any and all medical care and attention for this child which is deemed necessary and appropriate by a healthcare provider licensed in the state of Michigan. This consent includes, but is not limited to, medical and surgical intervention and elective as well as emergency care. This delegation shall be valid until I withdraw delegation of consent.

Signature of Parent/Guardian/Patient (if 18 years or older)_____

Relationship to
Patient_____Date_____

(HIPAA)
Notice of Privacy Practices Patient Acknowledgement

Patient's Name: _____ D.O.B: _____

I have received and understand the practice's Notice of Privacy Practices. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by this practice. If changes to the policy occur, this practice will provide me with a revised Notice of Privacy Practices upon request.

Signature Parent/Guardian: _____Date:_____

(PCMH)
Patient Centered Medical Home

Patient Centered Medical Home is a care team, led by a primary care physician which focuses on each patient's health goals and needs, and coordinates that patient's care across all health settings.

Signature Parent/Guardian:_____Date:_____