Developmental Pediatrics
Boston Children's Health Physicians
Until every child is well™

Phone: (914)304-5250
Fax: (914)345-1752

RE:_____

Dear Parent/Guardian:

Please answer the following questions as best you can, and bring this form in with you on the day of your appointment. If you have any questions about a specific piece of information being asked, you can call before your appointment as the information will be covered during the appointment. Thank you.

* * * * * * * PAST MEDICAL HISTORY QUESTIONNAIRE * * * * * * *

Child's weight at birth? _____ lbs _____ozs

Was your child born Full Term? _____Yes _____No

If not, at what week of gestation? _____ weeks, or how many _____weeks/_____months early?

What type of delivery did you have?

____Vaginal delivery (__normal/spontaneous __Pitocin induced)

____Cesarean Section - if so this was due to:_____ Repeat_____ Fetal distress

_____Failure of labor to progress Other_____

How old was the mother at the time of delivery? _____ years

What number pregnancy was this (for example 1st, 2nd, etc.)? _____

What number delivery was this (for example 1st, 2nd, etc.)? _____

Hospital child was born at _____

Were there any maternal medical problems during the pregnancy? _____Yes _____No

If yes, what was/were the problem(s)?

_____Bleeding _____Diabetes _____Infection _____Hypertension

Were any medications taken during the pregnancy?_____Yes _____No

If yes, what medication(s) and why?_____

_____

_____

Did you have a fetal sonogram? _____Yes _____No If yes, how many? _____

Result(s) of the fetal sonogram? _____Normal _____Abnormal

(If abnormal please explain)_____

Was the infant's stay in the nursery: _____Ueventful _____Complicated

Complicated, by what? _____

Please list any/all operations, hospitalizations (including Emergency Room visits), and procedures your child has had:

Where When Why

_____

_____

_____

General Pediatric care is provided by:

Name: _____

Address: _____

Are your child's immunization up to date? _____Yes_____No

Last vision exam/screening(when)_____ Normal findings? _____Yes_____No

If "No", problem was _____

Frequent ear infections? _____Yes _____No

Last hearing test/screening (when)_____ Normal findings? _____Yes _____No

If "No" problem was _____

Is your child currently taking medications? _____Yes _____No

If so, please list medications and reason for taking them: _____

_____

_____

Does the child have known allergies to foods or medications? _____Yes_____No
If yes, please list: _____ _____

_____ _____

_____ _____

Does your child have: Poor growth? _____Yes _____No

Heart Problems? _____Yes _____No

Asthma or other respiratory problems? _____Yes _____No

Stomach or bowel problems? _____Yes _____No

Urine problems? _____Yes _____No

Motor weakness or coordination problems? _____Yes _____No

Headaches? _____Yes _____No

Seizures? _____Yes _____No

Anemia or other blood disease? _____Yes _____No

If you answered "Yes" to any questions above, or if your child any

has any other health care problem not listed, please explain

_____

_____

_____Continue on back of sheet if necessary

DEVELOPMENTAL HISTORY: Please list age at which your child:

Sat up _____ Walked alone _____
Said mama/dada _____ Single words _____
Began 2-word phrases _____ Began few-word phrases _____
Speech understood by strangers_____
Please note where child attended/attends school:
3-year nursery:_____ 4-year nursery:_____
kindergarten:_____ 1st grade:_____
2nd:_____ 3rd:_____
4th:_____ 5th:_____
6th:_____ 7th:_____
8th:_____ Other:_____

Are any of the following therapies being currently provided?:

_____Physical Therapy _____Speech Therapy
_____Occupational Therapy _____Resource Room
_____Counseling _____Other:_____

Has your child ever had any evaluations such as Audiology, Psychology or Speech/Language? If you are planning to bring in any evaluations for the doctor to review, **PLEASE MAKE A PHOTOCOPY THAT YOU WILL LEAVE IN OFFICE.** Our office staff is not available to make copies for you.

For all children (when applicable): Describe peer interactions:

_____

_____

_____

_____

_____

_____

_____

Child usually goes to sleep at _____ P.M.

Child _____does _____does not sleep through the night

Child _____gets up _____is wakened at _____ A.M.

For children 4 years and older:

Would you say that this child displays a lack of attention such as often:

1. "On the go" or "driven by a motor":	1. Yes____ No____
2. Difficulty engaging in quiet activities:	2. Yes____ No____
3. Fidgeting/squirming:	3. Yes____ No____
4. Has difficulty staying seated:	4. Yes____ No____
5. Restlessness:	5. Yes____ No____
6. Runs about and excessively and Inappropriately:	6. Yes____ No____
7. Talks excessively:	7. Yes____ No____
8. Blurts out answers before questions completed:	8. Yes____ No____
9. Has difficulty awaiting turn:	9. Yes____ No____
10. Interrupts or intrudes on others:	10. Yes____ No____
11. Avoids tasks which require sustained mental effort:	11. Yes____ No____
12. Has difficulty organizing tasks and activities:	12. Yes____ No____
13. Has difficulty sustaining attention in tasks or play activities:	13. Yes____ No____
14. Does not seem to listen:	14. Yes____ No____
15. Is easily distracted:	15. Yes____ No____
16. Is forgetful in daily activities:	16. Yes____ No____
17. Loses necessary items such as school books and materials:	17. Yes____ No____
18. Fails to give close attention to detail or makes careless mistakes:	18. Yes____ No____
19. Has difficulty following through on instructions from others:	19. Yes____ No____

FAMILY COMPOSITION:
Mother's age _____ Highest grade completed _____
Father's age _____ Highest grade completed _____
Please list all other brothers and sisters of child:

. Name_____ ____age ____male ____female
. Name_____ ____age ____male ____female
. Name_____ ____age ____male ____female
. Name_____ ____age ____male ____female
. Name_____ ____age ____male ____female
. Name_____ ____age ____male ____female

Do any other members of the family have developmental disabilities?
_____Yes _____No If yes, please explain below

_____

_____

_____

Rev. 5/5/16

PEDIATRIC SYMPTOM CHECKLIST (PSC) FOR AGES 4 TO 16

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your chil

Please mark under the heading that best describes your child:

		NEVER	SOMETIME	OFTEN
1. Complains of aches and pains	1			
2. Spends more time alone	2			
3. Tires easily, has little energy	3			
4. Fidgety . Unable to sit still	4			
5. Has trouble with teacher	5			
6. Less interested in school	6			
7. Acts as if driven by motor	7			
8. Daydreams too much	8			
9. Distracted easily	9			
10. Is afraid of new situations	10			
11. Feels sad, unhappy	11			
12. Is irritable, angry	12			
13. Feels hopeless	13			
14. Has trouble concentrating	14			
15. Less interested in friends	15			
16. Fights with other children	16			
17. Absent from school	17			
18. School grades dropping	18			
19. Is down on him or herself	19			
20. Visits the doctor with doctor finding nothing wrong	20			
21. Has trouble sleeping	21			
22. Worries a lot	22			
23. Wants to be with you more than before	23			
24. Feels he or she is bad	24			
25. Takes unnecessary risks	25			
26. Gets hurt frequently	26			
27. Seems to be having less fun	27			
28. Acts younger than children his or her age	28			
29. Does not listen to rules	29			
30. Does not show feelings	30			
31. Does not understand other people's feelings	31			
32. Teases others	32			
33. Blames others for his or her troubles	33			
34. Takes things that do not belong to him or her	34			
35. Refuses to share	35			

Total score _____

Does your child have any emotional or behavioral problems for which she/he needs help? ( )N ( )Y

Are there any services that you would like your child to receive for these problems? ( )N ( )Y

If yes, what services? _____

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PATIENT FINANCIAL POLICY

Thank you for choosing Boston Children's Health Physicians as your (your child's) health care provider. Please be assured that your child's health care is of the utmost importance to us.

Thank you for taking the time to review our policies. Your clear understanding of our Financial Policy is important to our professional relationship with you. Please feel free to ask any questions or share any special concerns that you may have.

Co-Payments
We are required to collect your co-payment at the time of visit. There will be a $15 surcharge applied to your balance if your co-pay is not paid at time of visit. BCHP accepts cash, check or credit cards.

Some insurance plans charge multiple co-pays for services provided on the same day. If you have any of those services you may be billed for additional co-payments after the visit.

No Show/Late Cancel Policy
A $40 surcharge will be applied to your balance if you (your dependent) do not arrive for an appointment and do not cancel prior to the late cancel period. Please consult with your physician's office for specific information about the late cancel period.

Insurance
We will require a copy of your (or your dependent's) insurance card for our files. Please also inform us of any change in your insurance coverage.

Participating Plans
BCHP participates in most insurance plans. In order to properly bill your insurance company we require all insurance information including primary and secondary insurance, as well as any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. It is the insurance company that makes the final determination of your eligibility and benefits. You are responsible for any co-insurance, deductibles or non-covered services not paid by your insurance.

Non-Participating Plans
If we are out of network for your insurance and your insurance pays you directly, payment is due at time of visit unless other arrangements have been made prior to the visit.

Referrals
If your insurance company requires a referral, it is your responsibility to obtain it prior to the visit and have it at the time of the visit. If you do not have the referral you will be required to sign a financial waiver making you responsible for your bill if the referral is not obtained in time to have the visit covered by the insurance company.

Self-Pay
Payment is expected at the time of visit unless other arrangements have been made with the office manager prior to the visit.

PATIENT FINANCIAL RESPONSIBILITY

I acknowledge full responsibility for services rendered by Boston Children's Health Physicians, LLP. I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance. I understand that co-pays are due at time of check-in; otherwise a $15 surcharge will be added to my bill in addition to the applicable co-pay charge.

I authorize BCHP to release information to Medicare/other insurance carriers responsible for my or my dependent's care. I request that payment of authorized Medicare/other insurance company benefits be made either to me or on my behalf to BCHP for any services rendered.

Name of Patient

Date of Birth

Signature of Parent or Authorized Person

Print name of Parent or Authorized Person

Date

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CREDIT CARD ON FILE POLICY

We ask that all patients maintain a valid credit card on file with us. **Any patient balances that are present 30 days after you have received a statement will be billed on your credit card.** Please be assured if there are financial circumstances that preclude you from settling your account, we are more than willing to work with you, but you must communicate this with our billing staff so arrangements can be made.

Your credit card information will be stored in an encrypted merchant services account. Orangetown Pediatrics (and BCHP) only has access to the last 4 digits of your account number. Nothing is stored on site.

According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances. Patient balances are billed immediately upon receipt of your insurance plan's explanation of benefits. Your remittance is due within 30 days of receipt of your bill. For your convenience, we accept debit cards and credit cards.

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

(Please Print Name)_____ authorizes Orangetown Pediatrics/BCHP to charge my credit/debit card for the following reasons: Office Visits, Deductibles, Coinsurance, Copayments, Non-covered services, Cancellations and No show Fees.

X_____ Date: ____/____/____

Parent/Guardian Signature

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DIRECTIONS TO:
503 Grasslands Road, Suite 200
Valhalla, NY 10595
(914)304-5250 - PHONE
(914)345-1752 - FAX

IF YOU ARE USING A GPS, PLEASE USE 505 GRASSLANDS ROAD

TACONIC PARWAY SOUTH:
to Sprain Brook Parkway South to Exit 26- Sprain Brook Parkway South to Eastview Exit/Route 100 C. Turn left onto NY 100 C / Grasslands Road. Continue to follow Grasslands Road/ Rt. 100 C to 503, approximately ¼ mile on the right.

SAW MILL RIVER PARKWAY SOUTH:
to Exit 26- Sprain Brook Parkway South to Eastview Exit/ Route 100 C. Turn left onto NY 100 C/ Grasslands Road. Continue to follow Grasslands Road/rt. 100 C. to 503, approximately ¼ miles on the right.

SAW MILL RIVER PARKWAY NORTH:
to Exit 21 East. Take the ramp on the right for Route 119 East toward Elmsford. Turn right onto Route 119/East Main Street/Tarrytown- White Plains Road. Turn left onto Route 9A. Take the ramp on the right and follow signs for Route 100 C. Turn right onto Grasslands Road/ Route 100 C.

TAPPAN ZEE BRIDGE TOWARD WESTCHESTER TO I287 EAST:
to Exit 4. Make a left onto Knollwood Rd. Follow Knollwood Rd., and then make a left onto Grasslands Road/ 100 C. Go down to the light, make a u-turn, go back up on Grasslands Rd. and look for 503.

SPRAIN BROOK PARKWAY NORTH:
to Exit toward Rt. 100 C. South/ Rt. 100/Eastview. Make a right onto Grasslands Rd.

I95 (NEW ENGLAND THRUWAY) NORTH:
to 287 West. Stay in right land and take next exit, Exit 3- Sprain Brook Parkway North. Stay in left lane (Taconic Pkwy North) and take first exit Eastview Ave. Turn right at exit and make immediate right at 503 Grasslands.

I95 (NEW ENGLAND THRUWAY) SOUTH:
to 287 West. Stay in right lane and take next exit, Exit 3- Spain Brook Parkway North. Stay in left lane (Taconic Pkwy North) and take first exit Eastview Ave. Turn right at exit and make immediate right at 503 Grasslands.

MERRITT PARKWAY SOUTH:
Becomes Hutchinson River Parkway South, take the Westchester Ave. Exit, Exit 26 West toward I-287 West. Stay in right lane and take next exit, Exit 3- Sprain Brook Parkway North. Stay in left lane (Taconic Pkwy North) and take first exit Eastview Ave. Turn Right at exit and make immediate right at 503 Grasslands

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DIRECTIONS TO:
100 Crystal Run Road, Suite 110
Middletown, NY 10941
(845)692-8968 – PH
(845)692-5790 - FAX

FROM WESTCHESTER, ROCKLAND AND SOUTHERN ORANGE COUNTY, NY:
New York State Thruway North (I87) to Exit 16 (Route 17/ Harriman). Follow signs for Route 17 West to Exit 122 (Crystal Run Crossing). Off exit make a right at first traffic light, then left at next traffic light onto Crystal Run Road. Go to 2nd traffic light (past Holiday Inn) and make a right onto service road (Notice cement sign for 100 Crystal Run Road). then see NOTE below.

FROM SULLIVAN COUNTY AND POINTS NORTH:
Take Route 17 East to exit 122. Follow exit ramp to traffic light and make a left onto Crystal Run Road. Go to 3rd traffic light and make a right onto service road (Notice cement sign for 100 Crystal Run Road) then see NOTE below

FROM INTERSTATE 84 EAST/WEST:
Take Exit 4E. Follow exit ramp to traffic light. Make left onto Crystal Run Road. Go to 3rd traffic light and make a right onto service road (Notice cement sign for 100 Crystal Run Road) Then see NOTE below.

NOTE:
Follow service road until you come to last building marked "100." Make a right into parking lot and drive to 2nd entrance. Go into entrance and go to first door on right, Suite 110.

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DIRECTIONS TO:
130 Grand Street
Croton-on-Hudson, NY 10520
(914) 271-4727 - PH
(914)271-5639 - FAX

FROM THE SOUTH:
Sprain Brook Parkway North becomes the Taconic Parkway North. Take the 9A North exit. Follow 9A into Croton-on-Hudson to the exit that says Route 9A/Route 129. At the end of the exit, make the first right onto Grand Street. Follow Grand Street Approximately 0.6 Miles. The Office is on the right hand side of the street next to **ROBBINS PHARMACY**. There is a parking lot in the back of our Building.

FROM THE NORTH:
Taconic Parkway South to the Underhill Avenue exit, make a right turn onto Underhill Avenue. Follow for approximately ¼ of a mile and then make a right onto Route 129. Follow Route 129, after entering Croton-On-Hudson, there will be a fork in the road. Stay to the right onto Grant Street, the office will be on your left. **Parking In The Back**.

FROM THE BEAR MOUNTAIN BRIDGE:
Go over the Bear Mountain Bridge and make a right. Follow this road until you enter the traffic circle, follow signs for Route 9 South. Take Route 9 South until you reach the 2nd Croton-on-Hudson Exit, which is Route 9A/Route 129. At the end of the exit, make a left turn. At the traffic light, make a left turn onto Riverside Avenue. Make the first right onto Grand Street. The office is 0.6 miles on the right hand side of the street. **Parking In The Back.**