Crown Colony Pediatrics

We would like to welcome you to Crown Colony Pediatrics.

500 CONGRESS STREET
SUITE 1F
QUINCY, MA 02169

(617) 471-3411

NEW PATIENT REGISTRATION

CHILD'S NAME: _____ DATE OF BIRTH: _____

PRENATAL HISTORY

Total # Pregnancies_____ # Live Births____ # Living Children____ # Still Births____ # Miscarriages____

Were you sick during this pregnancy? Yes ☐ No ☐

What hospital was the baby born at? _____

During this pregnancy did you have:

Baby's birth weight _____

German Measles Yes ☐ No ☐

Unexplained rash Yes ☐ No ☐

Anemia Yes ☐ No ☐

Sexually Transm'd Disease Yes ☐ No ☐

Protein in urine test Yes ☐ No ☐

Kidney Infections Yes ☐ No ☐

Injuries/Accident Yes ☐ No ☐

Bleeding/Spotting Yes ☐ No ☐

Excessive weight gain Yes ☐ No ☐

High blood pressure Yes ☐ No ☐

Diabetes Yes ☐ No ☐

RH problem Yes ☐ No ☐

X-Ray Yes ☐ No ☐

Did you smoke/drink alcohol/or use drugs Yes ☐ No ☐

Take vitamins and/or iron Yes ☐ No ☐

Was child born ☐ early ☐ on time ☐ overdue

Length of labor ☐ under 2 hours ☐ over 12 hours

Difficulty at delivery Yes ☐ No ☐

Breech ☐ Cesarean ☐

Other problems _____

Anesthesia Yes ☐ No ☐

Awake at birth Yes ☐ No ☐

Did baby fail to cry immediately Yes ☐ No ☐

Was baby in special nursery Yes ☐ No ☐

Was baby in hospital longer than mom Yes ☐ No ☐

Other _____

When did you seek prenatal care ☐ 1st trimester

☐ 2nd trimester ☐ 3rd trimester ☐ not at all

During this pregnancy were you ever hospitalized?

Yes ☐ No ☐

If yes, reason _____

Other medications (Please List):

_____

_____

_____

Other

_____

-See over-

FAMILY HISTORY: INDICATE IF ANY OF THE FOLLOWING ARE IN THE FAMILY. CHILD'S GRANDPARENTS, AUNTS, UNCLES, BROTHERS OR SISTERS

	DISEASE PROBLEM	RELATIONSHIP		DISEASE PROBLEM	RELATIONSHIP
YES ☐ NO ☐	HYPERTENSION		YES ☐ NO ☐	ASTHMA/HAY FEVER,ECZEMA	
YES ☐ NO ☐	HEART DISEASE		YES ☐ NO ☐	MENTAL ILLNESS	
YES ☐ NO ☐	KIDNEY TROUBLE		YES ☐ NO ☐	BIRTH DEFECTS	
YES ☐ NO ☐	TUBERCULOSIS		YES ☐ NO ☐	MENTAL RETARDATION	
YES ☐ NO ☐	DIABETES		YES ☐ NO ☐	SCHOOL PROBLEMS	
YES ☐ NO ☐	CANCER/TUMORS		YES ☐ NO ☐	POOR VISION, HEARING, SPEECH	
YES ☐ NO ☐	CONVULSIONS/EPILEPSY		YES ☐ NO ☐	ALCOHOL DEPENDENCY	
YES ☐ NO ☐	BLEEDING PROBLEMS		YES ☐ NO ☐	DRUG DEPENDENCY	
YES ☐ NO ☐	ANEMA/SICKLE CELL		YES ☐ NO ☐	OTHER INHERITED DISEASE	

SOCIAL HISTORY FAMILY CONSTELLATION

YEARS AT PRESENT ADDRESS _____ SINGLE PARENT VS TWO PARENTS _____

LIVING WITH SOMEONE OTHER THAN NATURAL PARENT_____

FAMILY CONSTELLATION

NAME	RELATIONSHIP AGE	OCCUPATION	PLACE OF EMPLOYMENT	LIVING IN HOME YES/NO
	MOTHER			YES ☐ NO ☐
	FATHER			YES ☐ NO ☐
				YES ☐ NO ☐
				YES ☐ NO ☐
				YES ☐ NO ☐
				YES ☐ NO ☐
				YES ☐ NO ☐
				YES ☐ NO ☐
				YES ☐ NO ☐

PRIMARY LANGUAGE OF FAMILY _____ RACE _____ ETHNICITY _____

WOULD YOU LIKE TO TALK TO ONE OF THE PHYSICIANS ABOUT: ☐ OTHER FAMILY NEEDS FOR HEALTH CARE

☐ BIRTH CONTROL ☐ FAMILY FINANCE ☐ HOUSING ☐ FAMILY PROBLEMS ☐ MARTIAL PROBLEMS

☐ DAY CARE ☐ SCHOOL OTHER _____

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HEALTH NEEDS ASSESSMENT

Patient Name:		Patient Date of Birth:	
Your Name:		Relationship to Patient:	
Preferred Language:			

		Please circle
	In the last 12 months, did you or your family ever eat less than you felt you should because there wasn't enough money for food?	Yes / No
	Are you worried that in the next 2 months you may not have stable housing?	Yes / No
	Think about the place you live. Do you have problems with any of the following? Pests (mice or roaches), mold, no/not working smoke detectors, water leaks, no windows guards.	Yes / No
	In the last 12 months, has the electric, gas, oil, or water company threatened to shut off your services in your home?	Yes / No
	In the last 12 months, have you or your family ever had to go without heal care because you didn't have a way to get there?	Yes / No
	Are you or your family worried about feeling safe in your home?	Yes / No
	Do you feel that you need more support from other people or programs to help you care for yourself or your family?	Yes / No
	Do you need help understanding your or your child's healthcare needs (diagnosis, medications, plan, etc.)?	Yes / No
	In the last 12 months, was there a time when your child needed to see a doctor or get medications or supplies but could not because of cost?	Yes / No
	Did you or your child miss school or work because of a health problem that could have been avoided?	Yes / No

	If you checked YES to any boxes above, would you like to receive assistance with any of these needs?	Yes / No
Comments:		

PATIENT DEMOGRAPHIC FORM

CHILDREN IN HOUSEHOLD	DATE OF BIRTH	GRADE LEVEL

PARENT/GUARDIAN'S INFORMATION

Name:	Name
Relationship:	Relationship:
Date of Birth:	Date of Birth:
Address	Address:
Email:	Email:
Primary Phone: ☐ Cell ☐ Home Work Phone:	Primary Phone: ☐ Cell ☐ Home Work Phone:
Emergency Contact (cannot be parent)	
Name:	Relationship to Patient:
Primary Phone: ☐ Cell ☐ Home	Secondary Phone: ☐ Cell ☐ Home
Insurance:	Named Insured:
Insurance ID:	

- I HEREBY AUTHORIZE NEGATIVE LAB/XRAY RESULTS TO BE REPORTED TO ME VIA EMAIL/MY CHART
- I UNDERSTAND THAT CROWN COLONY PEDIATRICS BELIEVES STRONGLY IN THE SAFETY AND EFFICACY OF IMMUNIZATIONS AND MY CHILD WILL RECEIVE IMMUNIZATIONS AS RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS. CROWN COLONY PEDIATRICS DOES NOT ACCEPT OR KEEP PATIENTS/FAMILIES WHO REFUSE TO VACCINATE
- I HAVE RECEIVED CROWN COLONY PEDIATRICS IMMUNIZATION SCHEDULE
- I HEREBY AUTHORIZE BILLING VIA ELECTRONIC SUBMISSION AND PAYMENT DIRECTLY TO THE OFFICE FOR PROFESSIONAL SERVICES RENDERED AND I SHALL BE RESPONSIBLE FOR ANY UNPAID BALANCE TO THIS OFFICE. CO-PAYMENTS ARE DUE AT THE TIME OF YOUR VISIT. THE OFFICE RESERVES THE RIGHT TO ADD BILLING CHARGES TO ACCOUNTS AFTER SIXTY DAYS AND ANY ACCOUNTS FORWARDED TO COLLECTION SERVICES WILL BE SUBJECTED TO AN ADDITIONAL 1/3 CHARGE ADDED TO THE ACCOUNT. I AUTHORIZE THE ATTENDING PHYSICIAN TO RELEASE INFORMATION CONCERNING THE EXAMINATION AND TREATMENT OF MY CHILD (FOR INSURANCE PURPOSES ONLY)
- I AM GRANTING PERMISSION FOR CROWN COLONY PEDIATRICS TO VIEW MY CHILD'S PRESCRIPTION HISTORY FROM EXTERNAL SOURCES
- I HAVE RECEIVED YOUR NOTICE OF PRIVACY PRACTICES AND/OR I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT
- I AGREE THAT TELEPHONE MESSAGES REGARDING MY APPOINTMENTS, PRESCRIPTION REFILLS, LAB RESULTS, AND ALL OTHER PROTECTED HEALTH INFORMATION (PHI) MAY BE LEFT FOR ME ON VOICEMAIL SYSTEMS AND ANSWERING MACHINES AT THE TELEPHONE NUMBERS I PROVIDED TO YOU
- I UNDERSTAND AND AGREE THAT **ONLY A PARENT OR LEGAL GUARDIAN CAN ACCOMPANY MY CHILD TO THEIR PHYSICALS/ANNUAL WELL VISITS**

By Signing below, you agree to the above statements:

Signature of Parent/Guardian: _____ Date: _____

Parents please complete items 1-4

Patient Eligibility Screening Record
Vaccines for Children Program

1. Initial Screening Date: (_ _ / _ _ / _ _ _ _) Today's Date
   M M D D Y Y Y Y

2. Child's Name: _____ __
   Last Name First MI

3. Child's Date of Birth: (_ _ / _ _ / _ _ _ _)
   M M D D Y Y Y Y

4. Parent/Guardian/Individual of Record: _____ __
   Last Name First MI

5. Is your facility a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC)?

   X Yes ☐ No

6. Primary Provider's Name: Crown Colony Pediatrics, P.C.
   500 Congress St. Suite 1F Quincy, MA 02169 (617) 471-3411

7. Does this patient qualify for immunization through the VFC program because he/she (check only one box):
   a) Yes, is enrolled in Medicaid □
   b) Yes, does not have health insurance □
   c) Yes, is an American Indian or Alaska Native □
   d) Yes, is underinsured (has health insurance that does not pay for vaccinations)* □
   f) No, this child does not qualify for immunizations through the VFC program because he/she does not meet the eligibility criteria. □

Current Eligibility Status					
Date	Is enrolled in Medicaid	Does not have health insurance	Is an American Indian or Alaska Native	Is underinsured (has health insurance that does not pay for vaccinations)*	Does not meet eligibility criteria

A record of all children 18 years of age or younger who receive immunizations must be kept in the health care provider's office. The record may be completed by the parent, guardian, individual of record, or by the health care provider. **VFC eligibility screening and documentation of eligibility status must take place with each immunization visit to ensure the child's eligibility status has not changed.** While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine.

** To be supported with VFC purchased vaccine, underinsured children must be vaccinated through a FQHC or RHC or under a deputized agreement with an approved provider.*

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Authorization to Release Patient's Medical Records to Crown Colony Pediatrics

Patient's Name: _____ Date of Birth: _____/_____/_____

Parent/Guardian Name: _____

Address: _____

_____

City: _____ State: _____ Zip Code: _____

Phone: _____ ☐ Cell ☐ Home Email: _____

I HEREBY AUTHORIZE _____
TO RELEASE FULL CONTENT OF MEDICAL RECORDS, INCLUDING ALL TEST RESULTS AND RECORDS RECEIVED FROM PRIOR PHYSICIANS TO CROWN COLONY PEDIATRICS.

Patient/Parent/Guardian Signature _____ Date: _____

THE MEDICAL RECORD MAY CONTAIN INFORMATION ABOUT DRUG ABUSE, ALCOHOLISM, VENERAL DISEASE, ABORTION, OR MENTAL HEALTH TREATMENT. SEPARATE CONSENT MUST BE GIVEN BEFORE THIS INFORMATION IS RELEASED.

I CONSENT TO HAVE THIS INFORMATION DISCLOSED.

Patient/Parent/Guardian Signature _____ Date: _____

THIS MEDICAL RECORD MAY CONTAIN INFORMATION CONCERING HIV TESTING AND/OR AIDS DIAGNOSIS OR TREATMENT. SEPARATE CONSENT IS REQUIRED TO HAVE THIS INFORMATION RELEASED.

I CONSENT TO HAVE THIS INFORMATION DISCLOSED.

Patient/Parent/Guardian Signature _____ Date: _____

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Permission Authorization for Sick Visits

Date: _____

To: Crown Colony Pediatrics

In the event that I am unable to bring my child into the office for a Sick visit, I hereby give my

permission for my child: _____ DOB: _____

To be brought in for treatment by:

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

If you have any questions, please call me at _____ OR _____

_____
Signature of Parent or Guardian

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SEPARATION AND DIVORCE POLICY

Crown Colony Pediatrics is dedicated to the health and well-being of our patients. Since our patients are young children and adolescents, we rely on parents/guardians to support us in their care. Separation and divorce can present our practice with unique challenges; therefore, it is important for us to articulate our practice philosophy to avoid misunderstandings.

1. In general, we ask that parents/guardians NOT place our office in the middle of family disagreements. If parents/guardians become disruptive to our organization or there is non-compliance with this policy, we reserve the right to terminate the patient/doctor relationship so care can be transferred to another practice.
2. Either parent or legal guardian can schedule an appointment for their child, be present for a visit, have access to the child(ren)'s MyChart portal, and/or obtain copies of medical records unless a COURT ORDER has been presented to our office RESTRICTING a parent/guardian's rights. If you have a court order, please provide a copy to our office immediately upon receiving. If the court order changes at any point, it is your responsibility to provide us with an updated copy. We will assume the last copy we have on file is the current agreement/order.
3. We are contractually obligated to collect copays at the time of a visit. Therefore, the parent/guardian that brings the child in for an appointment is responsible for the copays or insurance deductibles at the time of service, even if the other parent/guardian is responsible for medical insurance. We will NOT mediate financial disputes between parents. Any disputes about reimbursement for medical expenses need to be settled between parents/guardians.
4. A parent/guardian must accompany a child to WELL VISITS. If a stepparent should bring your child in for these visits, we must have a "Consent for Treatment" on file with that adult's name within the past year. In circumstances when it is unclear whether the attending adult has the right to consent or treat, we may call you for a on-time authorization, or we reserve the right to require the well visit to be rescheduled to a time a parent/guardian can be present.
5. Additionally, we will NOT:
    a. Call the non-accompanying parent/guardian for consent prior to treatment or inform the other parent/guardian whenever visits are scheduled.
    b. Restrict either parent/guardian's involvement in your child(ren)'s care unless authorized by law.
    c. Tolerate appointment scheduling/cancelling (or no show) patterns of behavior between parents.
    d. Call the non-accompanying parent/guardian following visits. It is the responsibility of the accompanying parent to communicate with the other parent/guardian about the patient's care and any relevant information regarding follow up care for the child.

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VACCINE POLICY

Crown Colony Pediatrics does not accept patients who do not vaccinate.

We follow the recommendations of the American Academy of Pediatrics with regards to scheduling well child visits and immunizations. If you have any reservations regarding immunizations, you should speak to one of the doctors before scheduling an appointment.

We believe strongly in the effectiveness of vaccines to prevent serious illness and to save lives.

We believe strongly in the safety of our vaccines.

We believe strongly, based on all available literature, evidence and current studies, that vaccines do not cause autism or other developmental disabilities. Vaccinating children may be the single most important health promoting intervention we perform as health care providers. When you choose not to vaccinate, you are putting your child and our other families and children at risk.

For more information on vaccinations please refer to the American Academy of Pediatrics and Center for Disease Control websites.

www.aap.org

www.cdc.gov

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NO SHOW/LATE CANCELATION POLICY

Crown Colony Pediatrics defines a “no show” as any appointment you do not cancel at least 24 hours in advance when you are not able to keep it. Canceling in advance allows us the opportunity to give that appointment slot to someone else who needs it. We feel that continuity of care is very important, thus please find our detailed “no show” policy below:

Initial No Show:

Patients who no show for the first time will be sent a postcard reminder

Second No Show:

Patients who no show for a second time will be sent a letter reminding them of the policy and a warning that if they no show a third time, they may be asked to find a new medical practice.

Third/Final No Show:

Patients who no show for a third time may be asked to leave the practice and find a new pediatrician. We will see the patient for 4 weeks for urgent care and follow-up visits only and will be happy to work with the patient to get them the medical records needed so they can transition smoothly to a new practice.

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AGE	VACCINE	PROCEDURES	GUIDANCE	SCREENING TOOLS
1-2 Weeks	Hep B **IF NOT GIVEN AT THE HOSPITAL**	WT, HT, HC	Info Sheet 1-2 Weeks Temperature Taking, Hep B Info Sheet	PEDS PHQ- 2 (MATERNAL)
1 Month		WT, HT, HC		PEDS PHQ- 2 (MATERNAL)
2 Months	Vaxelis (Dtap, IPV, HIB, Hep B) PCV20 Rotateq	WT, HT, HC	Info Sheet 2 Months Tylenol/Temperature, Taking VIS	PEDS PHQ- 2 (MATERNAL)
4 Months	Vaxelis (Dtap, IPV, HIB, Hep B) PCV20 Rotateq	WT, HT, HC	Info Sheet 4 Months Solid Foods, VIS	PEDS PHQ- 2 (MATERNAL)
6 Months	Vaxelis (Dtap, IPV, HIB, Hep B) PCV20 Rotateq	WT, HT, HC	Info Sheet 6 Months VIS	PEDS PHQ- 2 (MATERNAL)
9 Months		WT, HT, HC TB Risk Screening	Info Sheet 9 Months Choking Info, Poison Control, VIS	PEDS
12 Months (Must be after 1 year Birthday)	MMR Varivax Hep A	HGB, PB (lead), Spot Vision TB Risk Screening	Info Sheet 12 Months, VIS	PEDS
15 Months	Pentacel (DTAP, IPV, HIB) PCV20	WT, HT, HC TB Risk Screening	Info Sheet 15 Months, VIS	PEDS
18 Months	Hep A **Hep A MUST BE MINIMUM OF 6 MONTHS AFTER Hep A #1** **12 MONTHS**	WT, HT, HC TB Risk Screening	Info Sheet 18 Months, VIS	M-CHAT
2 Years		WT, HT, HC, HGB, PB, Spot Vision TB Risk Screening	Info Sheet 2 Years Toilet Training	M-CHAT
3 Years		WT, HT, BP, HGB, Pulse, PB (Lead) Spot Vision TB Risk Screening	Safety Information	PEDS
4 Years	Quadracel (DTAP, IPV, MMRV)	WT, HT, BP, HGB, Pulse PB (lead) if at risk* Spot Vision/Hearing *lives in high risk community or previous high lead TB Risk Screening		PEDS
5 Years		WT, HT, BP, Pulse Spot Vision/ Hearing TB Risk Screening		PEDS

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6-8 Years		WT, HT, BP, Pulse Near Vision (LEA symbols) Passing20/32 or better & stereopsis Hearing at 6,8 TB Risk Screening		PSC-17
9-10 Years	HPV #1 at 9 HPV #2 at 10	WT, HT, BP, Pulse Vision only at 9 Vision/Hearing at 10 TB Risk Screening		PSC-17
11 Years	Tdap MenQuadfi *HPV #2 (*if #1 not given at 9)	WT, HT, BP, Pulse Vision Cholesterol Screening TB Risk Screening		PSC-17 Y PSC - Parent
12-15 Years	Check if HPV Complete	WT, HT, BP, Pulse TB Risk Screening	BSE/TSE Exam Aid Info Age Appropriate Info Sheets VIS	PSC-17 Y PSC - Parent
16 Years	MenQuadfi Booster	WT, HT, BP, Pulse (HGB, females only) Cholesterol Screening TB Risk Screening	BSE/TSE Exam Aid Info Age Appropriate Info Sheets VIS	PSC-17 Y PSC - Parent
17 Years	Meningococcal B #1	WT, HT, BP, Pulse TB Risk Screening	BSE/TSE Exam Aid Info Age Appropriate Info Sheets VIS	PSC-17 Y PSC - Parent
18 Years	Meningococcal B #2	WT, HT, BP, Pulse TB Risk Screening	BSE/TSE Exam Aid Info Age Appropriate Info Sheets VIS	PHQ-4 HIPAA Consent Form (Aging Out of Practice Information)
ASTHMATIC				ACT FORM
HEAD INJURY/CONCUSSION				PCSS FORM
ANXIETY/ DEPRESSION				GAD-7 PHQ-9

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