HERE WE GROW
PEDIATRICS

Patient Information

If all of your children have the same insurance, home address, and primary contacts you may use one form per family, if any of this information differs between patients, please request a new form per patient from our front office staff.

Child #1 Patients Name: Race: Preferred Language:	DOB: Primary Care Physician:	Male: ◯ Female ◯
Child #2 Patients Name: Race: Preferred Language:	DOB: Primary Care Physician:	Male: ◯ Female ◯
Child #3 Patients Name: Race: Preferred Language:	DOB: Primary Care Physician:	Male: ◯ Female ◯
Child #4 Patients Name: Race: Preferred Language:	DOB: Primary Care Physician:	Male: ◯ Female ◯
Child #5 Patients Name: Race: Preferred Language:	DOB: Primary Care Physician:	Male: ◯ Female ◯
If you have more than 5 children as patients at our practice, please download another patient information form or request an additional patient information form from our front desk.		
Home Address Street name: State:	Zip Code:	City:
Your families preferred pharmacy: (if pharmacy info differs between children, please notify our front desk staff) Pharmacy Name: Pharmacy Address:		

Primary Contact #1

First and Last Name: Primary Phone Number:
Relationship to Patient(s): Primary Email Address:
Would you like us to register this information and create an account for you in our patient portal?
Please choose whichever applies Yes ◯ No ◯ Already Registered ◯

Primary Contact #2

First and Last Name: Primary Phone Number:
Relationship to Patient(s): Primary Email Address:
Would you like us to register this information and create an account for you in our patient portal?
Please choose whichever applies Yes ◯ No ◯ Already Registered ◯

Other notes or information your physician/physician's office should be aware of for your family (example: Any non traditional household dynamics or guardianship) Information such as this will help our office treat you and your family with the care and sensitivity you deserve. (for any instances regarding legal name changes, or changes in custody please provide our office with the proper legal documentation):

How did you hear about Here We Grow? (referred by friend/family, google, hwgpediatrics.com, social media, previous patient of one of our physicians etc..):

If your family was previously cared for by one of our physicians, and you are willing, please use this space to share any information about your experience, positive or negative. As a new office, we appreciate any and all feedback so we can grow into the best pediatric office possible.

For Newborns:
Do you already have any other children(siblings) being seen in our office? If so, please list their name(s) and dob(s): _____
What hospital was your newborn delivered at? _____
Did your newborn have to stay in the hospital's NICU? If so, for what reasons, and how long after birth?: _____

Family History: Do biological mom or dad have any diagnosed health problems, or disorders?

Patient History: if you have more than one child, please fill out patient history per child.

Patient Name:
Birth Gestation (weeks pregnant): Birth Weight: Complications during pregnancy or birth:
Any problems with developmental, motor skills, or speech and language?

Current Medical Problems? Please list:

Is your child being treated by any specialists? If so, please provide the specialists name, practice name, and for what reasons your child is seeing them.

Concerns with patient:

Drug Allergies: Food Allergies:

Patient History: if you have more than one child, please fill out patient history per child if necessary.

Patient Name:
Birth Gestation (weeks pregnant): Birth Weight: Complications during pregnancy or birth:
Any problems with developmental, motor skills, or speech and language?

Current Medical Problems? Please list:

Is your child being treated by any specialists? If so, please provide the specialists name, practice name, and for what reasons your child is seeing them.

Concerns with patient:

Drug Allergies: Food Allergies:

If you have more than 2 children you are needing to provide patient history for, please download another patient information form or request an additional patient history form from our front desk.

INSURANCE INFORMATION:

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party to this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company we require that you disclose 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. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

Please confirm PRIOR to appointments if your insurance requires an up to date PCP be assigned to the patients account. All PCP changes have to be done prior to services rendered, and we will be unable to provide services or see patients until it is accurately updated. You are responsible for updating your child's PCP with their insurance.

Primary Insurance:
Company: Insured Name & DOB (Primary Holder):

ID/Certificate #: Group/Policy #: Effective Date:

Address associated with insurance:
Is the subscribers address the same as the patients? Yes ◯ No ◯

City: State: Zip Code: Social Security #:

Secondary Insurance: (Our office does not file secondary insurance for primary copays. Primary copay is due at time of service.)

Company: Insured Name & DOB (Primary Holder):

ID/Certificate #: Group/Policy #: Effective Date:

Address associated with insurance:
Is the subscribers address the same as the patients? Yes ◯ No ◯

City: State: Zip Code: Social Security #:

Please make sure to give your insurance card to the employee that checks you in at our front desk at your first appointment, and at any appointments after a change or update to your insurance. I understand that if the above insurance information is not true or if the child(ren) are not eligible under the terms of my medical subscriber health insurance agreement that I am liable for all charges for services rendered. I further authorize the physician(s) providing service to release for insurance purposes any information acquired in the course of my child(rens) examination and treatment

Date Signed: Signature of Responsible Party:

_____ _____