Welcome

Thank you for selecting Newport Pediatrics as your healthcare provider! We will strive to provide you with the best possible care. To help us meet your healthcare needs, please fill out this form, front and back, completely in ink. If you have any questions or need assistance, please ask us. The information you will provide will help us service your healthcare needs more effectively and efficiently.

Patient Information

Patient's Full Name: ______________________________

Street Address: ______________________________

City: ______________ State: ______________ Zip: ______________

Telephone: Where do you prefer to receive calls? When do you prefer to be contacted?

___ Home: ______________ ___ Morning

___ Cell: ______________ ___ Afternoon

___ Work: ______________ Extension____ ___ Evening

Unless otherwise notified, text messages as well as voice messages will be provided for appointment reminders and important notices to help ensure that your child receives the care recommended by his/her primary care provider. So that we may best meet your needs, please contact us with any changes to your contact information.

Release of Information/ Consent

I hereby authorize you to release any information including the diagnosis and records of any treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners for the purpose of claims payment or provider referral. I authorize and request my insurance company to pay insurance benefits otherwise payable to me directly to the physician or physician group. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of my dependants. I also understand and agree that if my bills become 90 days past due, I will be responsible for all collection fees, legal fees, and court costs associated with my delinquent account. I realize that if my child's account is forwarded to a collection agency, he/she will be dismissed from the practice until his/her bill is paid in full.

Signature of Parent/ Guardian: ______________________________ Date: ______________

I give permission for the provider treating my child to review his/her prescription history. I realize that there may be prescriptions present in the history that were written by other providers.

Signature of Parent/ Guardian______________________________ Date______________

Patient's Primary Care Provider (PCP): ______________________________

(PCP would be defined as the caregiver who would provide the majority of treatment for your child.)

Patient's Birthdate: ______________ Circle one: Male Female Transgender

Patient's Social Security number: (Required if a referral to a specialist is made)______________

Patient's School or Employer:

Contact Information

In the event of an emergency, if unable to reach parent, please contact:

Name: ______________________________ Relationship to Patient: ______________

Do you give permission for this person to receive health information about your child? ___Yes ___No

Contact Address:______________________________

Home Phone: ______________ Work Phone:

Responsible Party

Place a check on the line beside the person responsible for payment after all insurance policies have been billed.

__ Mother's Name:______________________________ Date of Birth:______________

SS#:______________________________ Phone#:______________

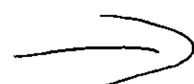
Address:______________________________ City:______________ State:___ Zip:_____

Mother's Employer:______________________________ Work#:______________

__ Father's Name:______________________________ Date of Birth:______________

SS#:______________________________ Phone#:______________

Address:______________________________ City:______________ State:____ Zip:_____



Father's Employer:_______________________________ Work#:_______________

__ Guardian's Name: _______________________________ Date of Birth: _______________

SS#:_______________________________ Phone#:_______________

Address:_______________________________ City:__________ State:____ Zip:_____

Guardian's Employer:_______________________________ Work #:_______________

With whom does child live? _______________________________

Insurance Information

Please check all that apply.

__ I have no insurance to cover my child's medical expenses and realize that I must pay for his/her office visit today. A minimum of $50 is required up front with the expectation that the remainder of the visit to be paid in full prior to my child being seen again.

Signature of Parent/ Guardian:_______________________________ Date:__________

If you have insurance on your child through your employer and also have TennCare, your employer's insurance will be primary.
You have to turn in this information in order for TennCare to pay.

__ Primary Insurance

Name of Insurance: _______________________________ ID#: _______________

Copay Amt:_______________________________ Group#_______________

Name on Insurance Card:_______________________________

Relationship to Patient:_______________________________

__ Secondary Insurance

Name of Insurance: _______________________________ ID#: _______________

Copay Amt:_______________________________ Group#_______________

Name on Insurance Card:_______________________________

Relationship to Patient:_______________________________

Additional Information

Email Address:_______________________________

Would you like to view patient information online via our patient portal? ___ Yes ___No

This would include your visit summary and test results from today. Having your email address allows us to provide you with appointment reminders and other important notices in this manner as well.

Patient's Race:_______________________ Ethnicity: ___ Hispanic ___ Non-Hispanic

Patient's Language(s) Spoken/Written:_______________________________

Do you need help with language services? ___ Yes ___ No

Which pharmacy do you prefer to use?_______________________ City:_______________

Contact

I, ____________________, give the following people permission to bring my child to this office for medical treatment. I realize that this person **must be aware of my child's medical history and should be able to answer necessary medical questions. I also realize that I will need to provide this person with my child's current address, telephone number, current insurance information, and applicable payment for the service in order for him/her to be seen. I realize that identification of the person bringing in my child may be requested, and if he/she is not on this list, my child may not receive treatment. I am giving this person the right to have access to my child's health information.**

Name: ____________________ Relationship:____________________ Phone:__________

Name: ____________________ Relationship:____________________ Phone:__________

Name: ____________________ Relationship:____________________ Phone:__________

Name: ____________________ Relationship:____________________ Phone:__________

Implemented 08-01-18 Revised __________

Newport Pediatrics,P.C.
1829 Crowe Lane
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Patient Consent for Physician to use or Disclose Health Care Information for Treatment, Payment and Health Care Operations

Patient Name: ______________________________ Date of Birth:__________
SSN:____________________________________

I understand that my/ my child's health information is private and confidential. I understand that Newport Pediatrics, P.C. works very hard to protect my/ my child's privacy and preserve the confidentiality of my/ my child's personal health information.

I understand that signing this document means that Newport Pediatrics, P.C. may use and disclose my/ my child's personal health information to help provide health care to me/ my child, to handle billing and payment, and to take care of other health care operations. Failure to sign this consent may result in the provider declining to treat me/ my child.

Newport Pediatrics, P.C. has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices used to protect their patients' privacy. I understand that I have the right to read the "Notice" before signing this agreement.

Newport Pediatrics, P.C. may update this "Notice of Privacy Practices". If I ask, Newport Pediatrics, P.C. will provide me with the most current "Notice of Privacy Practices".

Under the terms of this consent, I can ask Newport Pediatrics, P.C. to restrict how my/ my child's personal health information is used or disclosed to carry out treatment, payment, or health care operations. I understand that Newport Pediatrics, P.C. does not have to agree to my request. If Newport Pediatrics, P.C. does agree to my request, I understand that Newport Pediatrics, P.C. would follow the agreed limits.

I understand that I have the right to cancel this consent in writing, at any time. If I do cancel the consent, I understand that Newport Pediatrics, P.C. may have already used or disclosed information about me/ my child and canceling this consent would not effect the information already used or disclosed.

I may cancel this consent at any time by doing one of the following:

1. Signing and dating a form that Newport Pediatrics, P.C. can give me called "Revocation of Consent for Use and Disclosure of Health Care Information"; or

2. Writing, signing, and dating a letter to Newport Pediatrics, P.C. If I write a letter, it must say that I want to revoke my consent to authorize the use and disclosure of the patient's personal health information for treatment, payment, and health care operations.

I understand if I cancel this consent, Newport Pediatrics, P.C. does not have to provide any further health care services to me/ my child.

My signature below indicates that I have been given the chance to review a current copy of Newport Pediatrics, P.C.'s "Notice of Privacy Practices".

Parent or Legal Guardian's Signature: ____________________________ Date:_________

Relationship to Patient: ____

Newport Pediatrics, P.C.
1829 Crowe Lane
Newport, TN 37821

Birth History/Past Medical History

Patient Name:______________________________ Date of Birth:______________ Date:______________

Please fill in the circle completely – <u>DO NOT PUT X's OVER THE CIRCLES</u> or you will have to redo the form.

Birth History

Did baby have problems at birth?	O Yes	O No
Did mother have an illness or problems during pregnancy?	O Yes	O No
Did mother drink alcohol during pregnancy?	O Yes	O No
Did mother use drugs or meds during pregnancy?	O Yes	O No
Did mother smoke during pregnancy?	O Yes	O No
Was baby normal vaginal delivery?	O Yes	O No
Was baby C-section?	O Yes	O No
Was baby full term?	O Yes	O No
Was baby early?	O Yes	O No
Was baby late?	O Yes	O No
Did baby go home with mother from hospital?	O Yes	O No

Past Medical History

Chicken Pox?	O Yes	O No
Frequent ear infections?	O Yes	O No
Problems with his/her ears or hearing?	O Yes	O No
Nasal allergies?	O Yes	O No
Problems with his/her yes or vision?	O Yes	O No
Asthma, bronchitis, or pneumonia?	O Yes	O No
Heart problems or murmur?	O Yes	O No
Anemia or bleeding problem?	O Yes	O No
A blood transfusion?	O Yes	O No
Frequent abdominal pain?	O Yes	O No
Constipation requiring doctor visits?	O Yes	O No
Bladder or kidney infection?	O Yes	O No
Bed-wetting (after 5 years old)?	O Yes	O No
Has she started her menstrual period?	O Yes	O No
Are there problems with her menstrual periods?	O Yes	O No
Frequent headaches?	O Yes	O No
Convulsions, seizures, or other neurological problems?	O Yes	O No
Diabetes?	O Yes	O No
Thyroid or other endocrine problems?	O Yes	O No
Other significant problem?	O Yes	O No
Any alcohol use?	O Yes	O No
Any drug use?	O Yes	O No
Any tobacco use?	O Yes	O No
Is the patient sexually active?	O Yes	O No

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Jennifer L. Sauceman, M. D. - Courtney Burgin, FNP-BC

First, we would like to thank you for choosing our providers and practice for your child's medical care needs. We have recently noticed an increase in emergency room usage in the past several months. Due to the current pandemic, it is important to avoid emergency rooms, hospitals, and urgent care clinics if possible, as this is where very sick and serious patients will be. **We encourage you to go to the emergency department for emergencies/life-threatening situations only.**

A few other reasons we should be your first choice for medical care is continuity of care, cost of care, and the fact we specialize in pediatric care. Our office has access to all your child's medical records, making it easier to provide appropriate and individualized care. The cost of care is less for you and your medical insurance provider if you see us rather than going to emergency department. While the providers at the emergency department and urgent care clinics are great at what they do, more than likely they do not specialize in pediatrics. Adult and pediatric medical issues, needs, and treatments are not the same. At Newport Pediatrics, our providers studied and do continuing education specifically for pediatric patients.

We have recently made a few changes to be more accessible to our patients. We are now offering the option of tele-health visits, so there is a possibility your child will not have to come into the office to receive medical care. That decision of course is left up to the provider to decide if that option is appropriate. Our new office hours are 8:00 AM to 5:00 PM on Monday, Wednesday, and Friday. On Tuesday and Thursday, we are extending our hours and will be open from 8:00 AM until 7:00 PM. We are also answering phones and seeing patients through the lunch hours. On Saturday, we are open from 8:30 AM until 12:00 PM. We are aware that medical needs will come up outside of our office hours, so for our patient's convenience, we have an on-call provider available to address questions or concerns. To speak with someone after hours you just need to call into the office at 423-623-0653 and select the appropriate option. If you do not receive a call back within 30 minutes, please call back.

My signature below indicates I have read and understand the above information. I understand that I may contact Newport Pediatrics for all **non-emergent** medical questions or concerns. I also understand that if at any time my child's life is in danger or I feel like they are having a life-threatening issue, I should go to the nearest emergency room or call 911.

Patient Name: ______________________________________ DOB: ___________________

Parent/Guardian's signature: ____________________________________ Date: _____________