Demographics and Insurance Information

Patient's Name:

____

First **Middle** **Last**

Address: ____________ **City**:____________ **State**:______ **Zip**:__________

Home Phone:____________ **Cell Phone**:____________ **Primary Contact**: ☐Home Phone ☐Cell Phone

Email Address:____________ **DOB:**____________

Gender ☐**Male** ☐**Female** **Social Security #**:____________

Race: ☐**White** ☐**Hispanic** ☐**Black or African American** ☐**Asian** ☐**Decline to Report** **Other:**____________

Ethnicity: ☐**Hispanic or Latino/a** ☐**Not Hispanic or Latino/a** ☐**Decline to Report** **Other:**____________

Parent/Guardian #1: Name:____________ **Relationship to minor**:____________

Cell Phone:____________ **Date of Birth:**____________

Parent/Guardian #2: Name:____________ **Relationship to minor:**____________

Cell Phone:____________ **Date of Birth:**____________

Preferred Pharmacy:____________ **Phone #**:____________

Whom may we call in case of an emergency? Name:____________

Relationship to patient:____________ **Primary Phone #:**____________

What if my child needs to see a provider? A parent or legal guardian must accompany patients who are minors. This accompanying adult is responsible for payment on the account.

Insurance Information

Primary Insurance Company:____________ **Insurance Phone #:**____________

Subscriber Name:____________ DOB:____________ SS#:____________

Insurance ID:____________ Group #:____________

Patient Relationship to Subscriber:____________

Secondary Insurance Company:____________ **Insurance Phone #:**____________

Subscriber Name:____________ DOB:____________ SS#:____________

Insurance ID:____________ Group #:____________

Patient Relationship to Subscriber:____________

Willow Tree Pediatrics of Lexington

PEDIATRIC MEDICAL HISTORY FORM

Patient Name: ______________________________

DOB: ______/______/________

Name of Person Completing Form: ____________________
Relation to Patient: ______________________________

Present Health Concerns: ____

MEDICATIONS: *Please list all prescription and non-prescription medications, vitamins, home remedies, birth control, herbs, etc.*

Medication Name	Dose	Frequency

<u>** If you are on 5 or more medications – please bring them with you to each appointment. **</u>

ALLERGIES: *List all reactions to medicines, foods and other agents*

Allergy	Reaction or Side Affect

REVIEW OF SYSTEMS: *Please indicate with a check (√) any **current or ongoing** problems your child has on the list below*

CONSTITUTIONAL

- ☐ Fevers/chills/sweats
- ☐ Unexplained weight loss
  Fatigue/weakness
- ☐ Excessive thirst or urination

CARDIOVASCULAR

- ☐ Chest pain/discomfort
- ☐ Leg pain with exercise
- ☐ Palpitations

GASTROINTESTINAL

- ☐ Abdominal pain
- ☐ Blood in bowel movement
- ☐ Nausea/vomiting/diarrhea

NEUROLOGICAL

- ☐ Headaches
- ☐ Dizziness/light-headedness
  Numbness
- ☐ Memory loss
- ☐ Loss of coordination

EYES

- ☐ Change in vision
- ☐ Nearsighted
- ☐ Farsighted

GENITOURINARY

- ☐ Nighttime urination
- ☐ Incontinence
- ☐ Discharge from penis

GYNECOLOGICAL

- ☐ Abnormal vaginal bleeding
- ☐ Vaginal discharge
- ☐ Vaginal odor

EARS/NOSE/THROAT/MOUTH

- ☐ Difficulty hearing/ringing in
- ☐ Hay fever/allergies
- ☐ Problems with teeth/gums

RESPIRATORY

- ☐ Cough/wheeze
- ☐ Difficulty breathing

MUSCULO-SKELETAL

- ☐ Muscle/joint pain

SKIN

- ☐ Rash or mole change(s)

PSYCHIATRIC

- ☐ Anxiety/stress
- ☐ Problems with sleep
- ☐ Depression
- ☐ ADHD

OTHER: ______________________________

____

HOSPITALIZATIONS: *Please list all prior hospitalizations and dates.*

Reason	Hospital / Clinic Name	Date

SURGERIES: *Please list any surgeries, location, and dates.*

Surgery	Hospital / Clinic Name	Date

PREGNANCY & BIRTH:

Is the patient yours by: □Birth □Adoption □Stepchild □Other: ______________________________

Were there any medical problems during pregnancy? □ Yes □ No If yes, please explain: ______________________________

Were there problems during labor and delivery? □ Yes □ No If yes, please explain: ______________________________

Were there problems such as needing oxygen, trouble breathing, jaundice (yellowness), after the patient's birth? □ Yes □ No

If yes, please explain: ______________________________

Where was the patient born? ______________________________ Method of Delivery: □ Vaginal □ Cesarean Birth

Weight/Length: ____lbs. _____oz. _____inches Was your child born prematurely? □ Yes □ No If yes how early: ______________

For Male Patients Only: Is your child circumcised? □ Yes □ No

SLEEP:

How many hours a night does the patient sleep? ______________________________

How many naps does the patient take per day and length of naps? ______________________________

Does the patient have any sleep problems? □ Yes □ No If yes, please explain: ______________________________

NUTRITION & FEEDING:

Type of feeding when the patient was a newborn: □Breastfed □Formula. If breastfed, for how long? ______________________

Has the patient had any feeding/dietary problems or restrictions? □ Yes □ No If yes, please explain: ______________________

____

Milk intake now: □ Soy Milk □ Rice Milk □ Cow's Milk (____ %) □ other, please specify: ______________________________,

# of ounces of milk per day ______________

Has the patient seen a dentist? □ Yes □ No If yes, date of last visit ________.

What is the water source at the house? □ City □ Well

DEVELOPMENT:

Were there any concerns about growth or progress made in such areas as rolling over, walking, riding a tricycle, dressing themself, or feeding themself? □ Yes □ No If yes, please explain: ______________________________

Are there any areas of concerns about language or speech development? □ Yes □ No If yes, please explain:

____

Has your child ever been to occupational, physical, or speech therapy? □ Yes □ No If yes, please explain:

____

When the patient is in the car, do they use: □ Infant Seat □ Booster Seat □ Seatbelt Only

Does the patient wear a helmet while riding a bike? □ Yes □ No

Do you have concerns about the patient's behavior at home or in groups with other children? □ Yes □ No

If yes, please explain: ______________________________

For Female Patients Only: Age at first menstrual period ______________ Any issues / concerns? ______________

SOCIAL HISTORY:

Are the patient's parents: □ Married □ Never Married □ Separated □ Divorced If divorced, for how long? ______________

Mother's Employer: ______________________ Mother's Occupation: ______________________

Father's Employer: ______________________ Father's Occupation: ______________________

Do any household members smoke? □ Yes □ No Is violence in the home a concern? □ Yes □ No

Are there guns in the home? □ Yes □ No

Would you like to speak with the physician regarding the patient's: □ Alcohol Use □ Tobacco Use □ Sexual Activity □ Aggressive Behavior

How many hours per day does the patient spend with the following: ___Watching TV ___On the Computer/iPad ___Playing Video Games

Do you have any concerns about lead exposure due to having an old home, or because of plumbing, and peeling paint? □ Yes □ No

Do you have smoke detectors in your home? □ Yes □ No

SCHOOL HISTORY:

Did/Does the patient attend school/preschool? □ Yes □ No Current grade in school? __________

Name of School Attending: ______________________

Do you have concerns with how the patient is doing in school? □ Yes □ No

Any concerns about relationships with teachers or other students? □ Yes □ No

Does your child play any sports? □ Yes □ No How many times a week? ________ How long (minutes) ________

Who lives at home with the patient?

Name	Date of Birth	Relationship

FAMILY HISTORY: *Please indicate with a check (√) who in the patient's family has had the following conditions. In the first column please indicate their living status. L = Living, D = Deceased, U = Unknown.*

	Living Status	Asthma	Diabetes	High Blood Pressure	Heart Disease	Stroke	Heart Attack	Cancer (Type)	Substance Use Problems	Depression	Other
Mother											
Father											
Siblings											
Maternal Grandmother											
Maternal Grandfather											
Paternal Grandmother											
Paternal Grandfather											

Other Family Members Information: *(please write in)*

PREVIOUS PEDIATRICIANS: *Please list the names, address and phone numbers below of previous pediatricians the child has seen from birth until current age.*

Practice / Doctor Name	Address	Phone Number

Parent / Guardian Signature

Date

Willow Tree Pediatrics of Lexington

2036 Regency Road, Suite 2
Lexington, KY 40503

CONSENT FOR TREATMENT, ASSIGNMENT OF PROVIDER BENEFITS, AND PRACTICE PRIVACY POLICIES

____ 1. **CONSENT FOR TREATMENT**

I hereby consent to examination and treatment by Willow Tree Pediatrics of Lexington, including diagnostic and/or other procedures ordered by the provider.

____ 2. **ASSIGNMENT OF BENEFITS**

I authorize direct payment of benefits provided under any health care plan or medical expense policy due to me or payable on my behalf to Willow Tree Pediatrics of Lexington. I further authorize release of information required by any third party payor regarding this claim. I permit a copy of this authorization to be used in place of the original. I acknowledge that any or all of the expenses not paid by my third party payor, as defined under my plan benefit contract, are my responsibility.

____ 3. **PRIVACY PRACTICES ACKNOWLEDGEMENT**

I acknowledge that Willow Tree Pediatrics of Lexington has provided me with a written copy of their Notice of Privacy Practices, if so requested. I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions, which explains how my medical information will be used and disclosed.

____ 4. **PAYMENT**

I accept financial responsibility for payments for all services and products received. All copayments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. You may pay by cash, check or credit card. I also understand there will be an additional $50.00 processing fee for collection accounts and bounced checks for each date of service. I have also been made aware that Willow Tree Pediatrics of Lexington does not take credit card payments over the phone.

____ 5. **PATIENT AUTHORIZATION**

I authorize Willow Tree Pediatrics of Lexington to send copies of my records to other providers as needed for continuity of care. I agree and understand that a copy of my medical records including AIDS, HIV, behavioral health records, psychiatric care, and treatment for alcohol/drug use will be included as part of my health information. I also agree that Willow Tree Pediatrics of Lexington can release my records to accrediting or regulatory agencies, if those agencies request my records and if the law allows these agencies to see my records.

____ 6. **TEXT MESSAGING CONSENT**

By signing below, I authorize Willow Tree Pediatrics of Lexington to contact me by automated SMS text messages for appointment reminders. I understand that

message/data rates may apply to messages sent by Willow Tree Pediatrics of Lexington under my cell phone plan. I know that I am under no obligation to authorize Willow Tree Pediatrics of Lexington to send me text messages. I may opt-out of receiving these communications at any time by calling the office at (859) 286-9046. Please allow 5-7 business days for processing. I understand that text messaging is not a secure format of communication. There is some risk that individually identifiable health information and other sensitive or confidential information contained in such text may be misdirected, disclosed to, or intercepted by unauthorized third parties. Information included in text messages may include your first name, date/time of appointments, name of provider, and provider phone number, or other other pertinent information. By signing below, I indicate that I am the primary user for the mobile phone listed on the registration form. I accept the risk explained above and consent to receive text messages via automated technology from Willow Tree Pediatrics of Lexington to the phone number I have provided.

____ 7. **AUTHORIZATION TO COMMUNICATE HEALTH INFORMATION**

I authorize Willow Tree Pediatrics of Lexington to leave messages on my answering machine, voicemail, or with individuals who answer the phone numbers provided on the patient registration form. Willow Tree Pediatrics of Lexington will share private health information with authorized individuals.

____ 8. **WELL CHILD VISITS**

To ensure the best possible care for your child, we ask that you attend all scheduled well-child visits in accordance with the American Academy of Pediatrics' recommended schedule. These visits are essential for immunization counseling, disease detection, growth and development monitoring, and establishing a strong relationship between your family and our healthcare provider. In the event that you choose to miss **1** scheduled visit, we will provide written notification of our need to dismiss you from our practice at Willow Tree Pediatrics of Lexington.

Please initial each statement and sign below. By signing below, I attest I have read the above and authorize Willow Tree Pediatrics of Lexington, to treat, bill, and share my medical information as discussed above.

______________________________	______________________________
Signature of Patient/Parent or Guardian(if minor)	**Name of Patient/Parent or Guardian (if minor)**
______________________________	______________________________
Date	**Relationship to Patient (if minor)**

MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Willow Tree Pediatrics of Lexington. When you schedule an appointment with Willow Tree Pediatrics of Lexington we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy effective June 8, 2023, below:

- Any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours notice** will be considered a **No Show**.

- Any established patient who fails to show or cancels/reschedules an appointment with no 24 hour notice a **second** time will be considered a **No Show.**

- If a **third** No Show or cancellation/reschedule with no 24 hour notice should occur the patient may be dismissed from Willow Tree Pediatrics of Lexington.

- Any **new patient** who fails to show for their **initial visit** will not be rescheduled.

- Any established patient who **fails to show twice AND does not contact our office** to communicate they will not be at the appointment (this is a **NO SHOW, NO CALL**) will be dismissed from Willow Tree Pediatrics of Lexington.

As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect. We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Administrative Assistant. You may contact Willow Tree Pediatrics of Lexington during regular business hours at the number below.

Willow Tree Pediatrics of Lexington (859) 286-9046

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

_______________________________ _______________________________

Signature (Parent/Legal Guardian) Relationship to Patient

_______________________________ _______________________________

Printed Name Date

Willow Tree Pediatrics of Lexington
2036 Regency Road, Suite 2
Lexington, KY 40503
PHONE: (859)286-9046
EMAIL: info@willowtreepediatrics.co
FAX: (859)276-3726

Updated 9/23

Our Vaccine Friendly Policy

Willow Tree Pediatrics is a vaccine-friendly environment and believes that parents should be free to select the best "medical home" for their children, regardless of one's philosophy on vaccination.

We do not receive any government funding or grants for vaccines. Therefore, we do not keep all vaccines in our practice. If our provider orders a vaccine that is not routinely stocked, then you will be referred to Kroger Little Clinic to make a vaccine appointment. You will book your appointment online and take a vaccine order with you to the appointment.

Some parents choose to vaccinate their kids consistent with the recommendations of the American Academy of Pediatrics and we have parents fit in this category. However, some of our parents choose not to vaccinate their children, others want to partially vaccinate or follow alternative vaccination schedules, and still others just want help figuring out what will be best for their child. If you fit into any of these categories, you may have had a hard time finding a pediatric provider in Fayette County. Many doctors abandon patients for simply requesting an alternative vaccine schedule or even for asking too many questions. We deeply respect each individual parent's right to choose how to proceed with vaccinating their children without the threat of having their choice of pediatric home being threatened.

If you decide to do anything less than the recommended schedule, we will respect your wishes but you acknowledge your decision and its risks are solely your responsibility and that we are not accountable for any adversity should your child suffer from a disease for which there is a vaccination.
I have read and acknowledge this statement.

______________________________	______________________
PATIENT'S NAME	DATE OF BIRTH
______________________________	______________________
PARENT'S/GUARDIAN'S SIGNATURE	TODAY'S DATE

Willow Tree Pediatrics of Lexington
2036 Regency Road, Suite 2
Lexington, KY 40503

Patient Portal Agreement

By accessing and using the portal, you are indicating your acceptance and confirm that you have read, understood, and agree to be bound by the terms and conditions of this Agreement and the related Notice of Privacy Practices. If you do not accept these terms and conditions, your immediate remedy is to not access or continue to use the portal.

In this agreement, you understand that the portal is not meant to be used in case of an emergency. For all matters requiring urgent care, which you believe may negatively impact your health or well-being, you understand that you must call 911 or proceed to the nearest emergency department.

This Patient Portal is provided as a courtesy to our patients. You will receive an email to login and gain access to your child's account after your first visit. However, if abuse or negligent usage of the Patient Portal persists, we reserve the right, at our discretion, to terminate Patient Portal offering, suspend user access and modify services available through the Patient Portal.

In the patient portal, there are many features you can utilize, such as viewing medical records, such as lab results, direct messaging, accessing immunization records, and seeing upcoming appointments.

If needed, you can message our medical assistant(s) directly through the portal with any questions you may have in regards to your children's care. Messaging the medical assistant with questions through the portal is our preferred choice of communication. Patient-initiated digital communications provided by the provider fall under online digital evaluation services, or e-visits. **Therefore, messaging our provider directly for medical advice will be billed to your insurance which often requires a copay**. With direct messaging, I understand that it can take 24-48 hours to receive a response.

By signing this form, I certify that I have read this form and/or has this form explained to me. I fully understand its contents and I have been given an opportunity to ask any questions and that those questions have been answered to my satisfaction.

______________________________	______________________________
Name of Patient/Parent or Guardian (if minor)	Signature of Patient/Parent or Guardian (if minor)
______________________________	______________________________
Today's Date	Relationship to Patient (if minor)

Willow Tree Pediatrics of Lexington

Medical Records Agreement

By transferring to Willow Tree Pediatrics of Lexington, I agree to initiate a records request from ALL previous pediatricians my child has seen within **90 days** of transferring care.
I understand it is my full responsibility to obtain records within 90 days of my child's first visit. Failure to obtain medical records may result in dismissal from our practice.

______________________________	______________
Patient Name	Date of Birth

______________________________	______________
Parent / Guardian Signature	Date

______________________________	______________
Willow Tree Pediatrics of Lexington Employee Signature	Date