Vineland Pediatrics, P.A.
1138 E. Chestnut Ave. Bldg. 5B
Vineland, NJ 08360
Phone: 856-692-1108

TODAY'S DATE: ______________

CHILD'S FULL NAME: ______________________ DOB: __________ AGE: __________ SEX: M/F

ADDRESS: ____

TELEPHONE: ______________________ CHILD'S SOCIAL SECURITY #: ______________________

HOSPITAL WHERE BORN: ______________________ BIRTH WEIGHT: ______________________

PREVIOUS DOCTOR: ______________________ SCHOOL NAME: ______________ GRADE: __________

	NAME	DOB	OCCUPATION/EMPLOYER	SCHOOL NAME/GRADE (CHILDREN ONLY)	HEALTH HISTORY
FATHER/GUARDIAN					
MOTHER/GUARDIAN					
OTHER CHILDREN					

Check (✓) if anyone in the immediate family has or has had: __ None Apply

☐ Tuberculosis ☐ Asthma ☐ Seizures ☐ Mental Illness ☐ Hypertension ☐ Diabetes ☐ Cancer ☐ Heart Disease

☐ Smoking ☐ Alcoholism/substance abuse ☐ other (specify)______________________

Check (✓) if the following has or had applied to this child: (Skip any item that does not apply)

☐ Child Adopted
☐ Premature
☐ Recurrent Severe abdominal pain
☐ Asthma
☐ Difficulty Breathing
☐ Bronchitis
☐ Heart Problems
☐ Seizures
☐ Bone Illness
☐ Skin Problems
☐ Hives
☐ Wheezing
☐ Anemia (past or present)

☐ Mother ill during pregnancy with this child
☐ Problems in the nursery
☐ Chronic Headaches
☐ Hearing Problems
☐ Chicken Pox
☐ Persistent Cough
☐ Kidney or Bladder infections
☐ "Slow Learner" for age
☐ Illnesses of Joints (Arthritis)
☐ Diabetes
☐ Eczema
☐ Disease of Endocrine Glands (Thyroid, etc.)

GIRLS ONLY

☐ Menstruating (having periods) ☐ Severe pain with periods

☐ Other problems with periods (specify)____

☐ Drug/Alcohol ☐ Tobacco Use ☐ Severe or Unusual Behavior Problems ☐ Treatment by Psychiatrist/Psychologist

☐ Could not say 3 words by 20 months ☐ Could not say sentences by 3 yrs ☐ Could not sit without support by 8 months

☐ Could not walk well alone by 14 months ☐ Failing School ☐ Excels ☐ Above Average ☐ Average ☐ Below Average

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____ Allergy to any drugs or medicines: If yes, please list:

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____

____ Allergy to any food or other substances: If yes, please list:

____

____

___ Taking any Medication now: If yes, please list:

____

____

____

HOSPITALIZATIONS

DATE	HOSPITAL	DOCTOR	PROBLEM

__ Any other significant illnesses or serious injuries: Please list:

____

____

____

__ Child having any problems now (If yes, describe problem stating first when it began):

____

____

____

____

____

____

____

ARCHNA JAIN, MD OLABODE OGIDAN, MD

EXCEL CARE VINELAND PEDIATRICS
1138 E. Chestnut Ave. Bldg. 5B
Vineland, NJ 08360

Immunization Consent

Patients Name (Please Print): ______________________________DOB: ______________

I have read the accompanying information about HIB, DTaP, Hepatitis A, Hepatitis B, Polio, MMR, Influenza, Varicella (chicken pox), Pneumococcal (Prevnar 13), Meningococcal (Menactra), Rotavirus, Human Papillomavirus, and Meningococcal Serogroup B (Trumenba), and Tdap. I have had a chance to ask question which were answered to my satisfaction. I believe I understand the benefits and risks for the above named vaccines.

By my consenting signature below, I request that the vaccines be administered when due, to me, or to the person named above, for whom I am authorized to make this request. Also, by my signature below I give permission to report immunization data to NJIIS.

X______________________________ ______________________
Print Parent/Guardian Name Relationship to Patient

X______________________________ ______________________
Signature of Parent/Guardian Name Date

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BILLING AUTHORIZATION

Patients Name: ______________________________DOB:_________________ Social Security #: _________________

MEDICAL INSURANCE POLICIES

	PRIMARY INSURANCE	SECONDARY INSURANCE
INSURANCE COMPANY NAME		
SUBSCRIBER NAME		
SUBSCRIBER DATE OF BIRTH		
POLICY ID #		
GROUP ID #		
COPAY		

AUTHORIZED PERSON'S SIGNATURE REQUIRED:

I certify that the above information is complete and accurate.
I authorize the release of any medical or other information necessary to process insurance claims.
I authorize payment of medical benefits to Vineland Pediatrics, P.A. for any services they provide.
I accept financial responsibility for services or charges not covered by insurance including copayments, coinsurance, and deductibles.

It is my responsibility to furnish this office with changes in insurance information or full payment may be require by me.

Signed: ______________________________________ Date: ____________________

Relationship to Patient: ________________________

Acknowledgement of Receipt of Privacy Practice Notice
I certify that I have received a copy of Vineland Pediatrics, P.A. Notice of Privacy Practices

Signed: ____________________________________ Date: _____________________

Relationship to Patient: _____________________

INSURANCE EXCLUSIONS

4/1/14

The following services may not be covered by your insurance policy.

- Exams, tests (e.g. PPD), vaccines, etc., for such things as sports, camp, employment, school, travel, marriage, life insurance.
- Screenings such as Hearing, Vision, MCHAT, etc.
- Obesity/ Weight reduction services
- ADHD, school/ learning problems, behavior problems, developmental delay
- Supplies (e.g. Ace bandages, splints, etc.)
- Medical reports/ services for 3rd parties (e.g. life insurance, employment, litigation, etc.)
- Some plans have limitations on how frequently they will cover check-ups, such as no more than once every 1-year (365 days) or 2-years (730 days) from the last check-up, or the number of well-child check-ups in the first one or two years of life. Some plans do not cover checkups for certain ages such as between 7 and 19 years of age.
- Work-related conditions must be billed to Workman's Compensation Insurance before any medical policy. The insurance information must be presented when checking in for that visit. If not provided, payment for our service is expected directly from guarantor.
- Auto Accident-related services must be billed to auto insurance before any medical policy and is usually applied to deductible. The deductible is not generally covered by the patient's medical policy* and therefore payable by the patient/guarantor. Auto insurance info including Claim number, address to send claims, and signed assignment of benefits form if applicable must be presented when checking in for the visit. If the information is not provided, payment for our service is expected directly from the patient/guarantor. *If you have a question about this please call your medical insurance company.
- Some immunizations may not be covered by your policy. If your policy does not cover ANY immunizations, tell us at check-in and also when taken back to the exam room.

This list is not all-inclusive and serves as a general guide. Every insurance policy is different. Refer to your insurance policy for your complete list of exclusions.

If you have specific questions about your plan, please call your insurance company before your visit.

PATIENT NAME: ______________________________

I have been informed by Excel Care Vineland Pediatrics that there are services that may not be covered by my child's medical insurance. I accept financial responsibility for the non-covered services.

______________________________ (Signature)   ______________ (Date)

______________________________ (Printed Name)   ______________ (Relationship to Patient)

If other than patient or parent: Address ______________________________

____

Phone ______________________________

Archna Jain, MD Olabode Ogidan, MD

MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Excel Care Vineland Pediatrics. When you schedule an appointment with Excel Care Vineland Pediatrics we set aside enough time to provide you with the highest quality care. Should you need to cancel or rescheduled 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 below:

1. Effective July 1, 2018 any patient who fails to No Show or cancels/reschedules an appointment and has not contacted our office with at least 24 hour notice will be considered a NO SHOW and charged a $15.00 fee.
2. Any patient who fails to No Show or Cancels/Reschedules an appointment with less than 24 hour notice a second time will be charged another $15.00 fee.
3. If a third No Show or Cancels/Reschedule with less than 24 hour notice should occur the patient will be charged another $15.00 fee and sent to Collection.
4. If a fourth No Show or Cancels/Reschedule with less than 24 hour notice you may be discharged from the practice.
5. The fee is charged to the patient, not the insurance company, and is **DUE AT THE TIME OF THE PATIENT'S NEXT OFFICE VISIT.**
6. There is a $15.00 fee every time you No Show or Cancel/Reschedule with less than 24 hour notice.
7. As a courtesy, when time allow, we make reminder calls for appointment. 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 Office Manager.

Excel Care Vineland Pediatrics: (856) 692-1108

I have read and understand the Medical Appointment Cancellation/No Show Policy

______________________________	______________________________
Signature of Parent/Legal Guardian	Relationship to Patient
______________________________	______________________________
Patient Name	Date