Colonia Office
795 Inman Ave
Colonia, NJ 07067
Ph: (732) 396-0700
Fax: (732) 396-0701

Plainfield Office
120 W 7th St. Ste 203
Plainfield, NJ 07060
Ph: (908) 757-8687
Fax: (908) 481-4891

Initial Patient Information

Name of person filling the form: _____ Date: _____

Relationship to Patient: _____

Patient information

Full name: _____
FIRST LAST MI

Address: _____

_____
CITY STATE ZIP

Sex: ☐ Male ☐ Female

Date of Birth: _____
MM/DD/YYYY

Demographics

Language(s) _____

Race/Ethnicity _____

Hispanic/Latino ☐ Yes ☐ No

Guarantor information

Relation: ☐ Mother ☐ Father ☐ Guardian

Full name: _____
FIRST LAST MI

Address: _____
STREET APT

_____
CITY STATE ZIP

Date of Birth: _____ **Email[1]:** _____

Employer: _____ (H) Phone: _____

(C) Phone: _____ (O) Phone: _____

[1] Your email address will be used to create your Patient Portal: a secure website that allows access to personal health information using a secure username and password.

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Initial Patient Information

Emergency Contact(s)

Name:		Name:	
Address (apt):		Address (apt):	
City/State/Zip:		City/State/Zip:	
Relationship to Patient:		Relationship to Patient:	
Home Phone:		Home Phone:	
Cell Phone:		Cell Phone:	

Primary Insurance

Insurer:	
Insured's Name	
Address Line 1:	
Address Line 2:	
Relationship to Patient:	
Effective Date:	
Policy #	
Group #	

Secondary Insurance

Insurer:	
Insured's Name	
Address Line 1:	
Address Line 2:	
Relationship to Patient:	
Effective Date:	
Policy #	
Group #	

Pharmacy Information

Name:			
Town:		Phone Number:	

Consent for Treatment / Release of Information / Assignment of Benefits

I consent to the treatment necessary for the care of the patient indicated on this form. Authorization is hereby granted to release information as may be necessary to process and complete my claim. I hereby authorize payment of medical benefits to be paid directly to the attending physician for services rendered.

Signature: _____ Date: _____

Consent for New Jersey Immunization Information System

I have received information about the NJIIS and understand that the purpose of this program is to help remind me when my child's immunizations are due and to keep a central record of my child's immunization history.
I understand that the medical information in the NJIIS may be shared with authorized health care providers, schools, licensed child care centers, colleges, public health agencies, health insurance companies, and others as permitted by New Jersey law at N.J.S.A 26:4-131 et seq. And rules at N.J.A.C 8:57-3.
I understand that i can get a copy of my child's record from my primary health care provider, my local health department, or the New Jersey department of health (NJDOH).

Signature: _____ Date: _____

Initial History Questionnaire

Name

ID NUMBER

FORM COMPLETED BY | DATE COMPLETED

BIRTH DATE | AGE M F

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names, ages, and where they live. _____

What is the child's living situation if not with both biological parents?
☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody
☐ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

Birth History ☐ Don't know birth history

Birth weight _____ Was the baby born at term? _____ OR _____ weeks

Were there any prenatal or neonatal complications?
☐ Yes ☐ No Explain _____

Was a NICU stay required? ☐ Yes ☐ No Explain _____

During pregnancy, did mother
Use tobacco ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No
Use drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins
What _____ When _____

Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, why?

Was initial feeding ☐ Formula ☐ Breast milk How long breastfed? _____

Did your baby go home with mother from the hospital?
☐ Yes ☐ No Explain _____

General DK = don't know

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ DK Explain _____

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ DK Explain _____

Has your child had any surgery? ☐ Yes ☐ No ☐ DK Explain _____

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ DK Explain _____

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ DK Explain _____

Do you feel your family has enough to eat? ☐ Yes ☐ No ☐ DK Explain _____

Biological Family History DK = don't know

Have any family members had the following?

Childhood hearing loss	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Asthma	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tuberculosis	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Heart disease (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
High cholesterol/takes cholesterol medication	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Anemia	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bleeding disorder	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Dental decay	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Cancer (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

(Biological Family History continued on back side.)

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Biological Family History *(Continued from front side.)* DK = don't know

Liver disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Kidney disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Diabetes (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bed-wetting (after 10 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Obesity	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Epilepsy or convulsions	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Alcohol abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Drug abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Mental illness/depression	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Developmental disability	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tobacco use	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

Additional family history _____

Past History DK = don't know

Does your child have, or has your child ever had,

Chickenpox	☐ Yes	☐ No	☐ DK	When _____
Frequent ear infections	☐ Yes	☐ No	☐ DK	Explain _____
Problems with ears or hearing	☐ Yes	☐ No	☐ DK	Explain _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Explain _____
Problems with eyes or vision	☐ Yes	☐ No	☐ DK	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	☐ DK	Explain _____
Any heart problem or heart murmur	☐ Yes	☐ No	☐ DK	Explain _____
Anemia or bleeding problem	☐ Yes	☐ No	☐ DK	Explain _____
Blood transfusion	☐ Yes	☐ No	☐ DK	Explain _____
HIV	☐ Yes	☐ No	☐ DK	Explain _____
Organ transplant	☐ Yes	☐ No	☐ DK	Explain _____
Malignancy/bone marrow transplant	☐ Yes	☐ No	☐ DK	Explain _____
Chemotherapy	☐ Yes	☐ No	☐ DK	Explain _____
Frequent abdominal pain	☐ Yes	☐ No	☐ DK	Explain _____
Constipation requiring doctor visits	☐ Yes	☐ No	☐ DK	Explain _____
Recurrent urinary tract infections and problems	☐ Yes	☐ No	☐ DK	Explain _____
Congenital cataracts/retinoblastoma	☐ Yes	☐ No	☐ DK	Explain _____
Metabolic/Genetic disorders	☐ Yes	☐ No	☐ DK	Explain _____
Cancer	☐ Yes	☐ No	☐ DK	Explain _____
Kidney disease or urologic malformations	☐ Yes	☐ No	☐ DK	Explain _____
Bed-wetting (after 5 years old)	☐ Yes	☐ No	☐ DK	Explain _____
Sleep problems; snoring	☐ Yes	☐ No	☐ DK	Explain _____
Chronic or recurrent skin problems (eg, acne, eczema)	☐ Yes	☐ No	☐ DK	Explain _____
Frequent headaches	☐ Yes	☐ No	☐ DK	Explain _____
Convulsions or other neurologic problems	☐ Yes	☐ No	☐ DK	Explain _____
Obesity	☐ Yes	☐ No	☐ DK	Explain _____
Diabetes	☐ Yes	☐ No	☐ DK	Explain _____
Thyroid or other endocrine problems	☐ Yes	☐ No	☐ DK	Explain _____
High blood pressure	☐ Yes	☐ No	☐ DK	Explain _____
History of serious injuries/fractures/concussions	☐ Yes	☐ No	☐ DK	Explain _____
Use of alcohol or drugs	☐ Yes	☐ No	☐ DK	Explain _____
Tobacco use	☐ Yes	☐ No	☐ DK	Explain _____
ADHD/anxiety/mood problems/depression	☐ Yes	☐ No	☐ DK	Explain _____
Developmental delay	☐ Yes	☐ No	☐ DK	Explain _____
Dental decay	☐ Yes	☐ No	☐ DK	Explain _____
History of family violence	☐ Yes	☐ No	☐ DK	Explain _____
Sexually transmitted infections	☐ Yes	☐ No	☐ DK	Explain _____
Pregnancy	☐ Yes	☐ No	☐ DK	Explain _____
(For girls) Problems with her periods	☐ Yes	☐ No	☐ DK	Explain _____

Has had first period ☐ Yes ☐ No Age of first period _____

Any other significant problem _____

This American Academy of Pediatrics Initial History Questionnaire is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 3rd Edition.

HE0328

9-223/0109

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Fax: (908) 757-8685

Information Release Form

Name: _____ Date: _____

Relationship to Patient: _____

Patient information

Full name: _____
FIRST LAST MI

Address: _____

_____
CITY STATE ZIP

Birthday: _____
MM DD YYYY

Release medical information from:

_____

_____

_____

Information Requested

All Records ☐
Immunization Records ☐
Progress Notes ☐
Other ☐ _____

Signature: _____ Date: _____

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VACCINE POLICY ACKNOWLEDGEMENT

Patient's Name:_____ Date of Birth:_____

Parent/Guardian Name:_____

EFFECTIVE 01Jan2020 OUR NEW VACCINE POLICY WILL BE AS FOLLOWS

All patients must receive all recommended vaccines according to the Centers for Disease Control/American Academy of Pediatrics vaccine schedule unless there is a medical contraindication. Parents/Guardians/Patients will have 30-days after being informed of this policy verbally and in writing to find another health care provider.

New Patients

- We will not accept new patients whose parents choose not to vaccinate their children.
- Parents of newborns who refuse the Vitamin K shot upon birth will not be accepted into our practice and can be seen and followed up by the hospital pediatric service.

Established Patients

- Established patients who are unvaccinated and whose parents continue to refuse vaccines will be required to find another pediatric health care provider after discussion at their next visit or by phone call from our office. This will allow them to find a new pediatric provider before **30-days after notice.**
- Parents/guardians, of established patients who have a newborn, will be given until the 4 month checkup to initiate vaccines. If vaccines are not initiated at that time, patients will be required to find another pediatric health care provider.

Alternative Vaccine Schedules

- We **do not recommend** alternative vaccine schedules.
- For parents who chose alternative schedules, the recommended vaccines will be discussed, and the parents will decide on a schedule, with the goal that children will be fully vaccinated.
- A vaccine may not be delayed more than 6 months from its recommended time to be given, unless there is a medical contraindication.
- Parents who choose alternative schedules must **always** inform health care providers that their child is **not fully immunized** when calling for medical advice or being seen in all settings. **Under-immunized children may require isolation, immediate attention, or tests that might not be necessary if a child is fully-vaccinated.**

Optional Vaccines

- Although we strongly encourage all vaccines to be given as scheduled, we will allow the following vaccines to remain **optional but highly recommended**: Hepatitis A, Human Papilloma Virus (HPV), Influenza, Meningococcal B, and Rotavirus

_____ I have read the above policy and agree to comply with the recommended vaccine schedules published by the Centers for Disease Control and the American Academy of Pediatrics.

_____ I have had the opportunity to discuss the recommended vaccines with _____ and I understand the risks and benefits of the recommended vaccines.

_____ _____

Parent/Guardian Signature Date

120 W. 7th STREET
PLAINFIELD, NJ 07060
908 757 8687

795 INMAN AVENUE
COLONIA, NJ 07067
732 396 0700

Telemedicine Services
Terms of Use
Effective 03/17/2020

Welcome to Kids Care Pediatrics Telemedicine services. We are excited to provide you with this service.

Please do not use this site for emergency medical needs. If you experience a medical emergency, call 911 immediately!

Privacy
You acknowledge that you are consenting to receiving care via telemedicine/telehealth. The scope of care will be at the sole discretion of Kids Care Pediatrics provider who is treating you, with no guarantee of diagnosis, treatment or prescription. Kids Care Pediatrics Provider will determine whether or not the condition being diagnosed and/or treated is appropriate for a telehealth encounter. You understand and agree that your interaction is not intended to take the place of any face-to-face appointments, when possible.

Informed consent for services performed via telehealth/telemedicine
The delivery of healthcare through services using communication tools such as a cell/telephone, live two-way audio and video, remote patient monitoring, or other electronic means, is called "telemedicine". Telemedicine involves the use of electronic communications to enable healthcare providers who are remote from patients to provide care and services. The information gathered/accessed may be used for diagnosis, treatment, follow-up, therapy or education and may include information from existing medical history or records.

The communication systems used will incorporate network and software security protocols to protect your confidentiality and will include measures to secure the data against intentionally/unintentional corruptions or access. It is your responsibility to be in a secure/private location where your telehealth encounter can occur. Do not use telehealth services in a public location, or on a public computer.

As with office-based face-to-face visits, a visit summary will be made available to you if you request. This summary can be kept for your records or shared with another healthcare provider of your choosing (e.g., specialist or other provider).

Benefits of Telemedicine

- Improved and increased access to care remotely.
- More efficient medical evaluation and management.
- Convenient.

Possible Risks of Telemedicine

As with any medical visit, office based or otherwise, there are potential risks associated. The risks may include:

- Delays in medical evaluation and consultation or treatment due to deficiencies or failure of technology;
- In very rare instances, unanticipated breach in security protocols – poor security controls;
- In rare cases, a lack of access to complete or comprehensive medical records, resulting in adverse drug interaction, allergic reactions or other negative outcomes;
    - Patient must disclose comprehensive/complete medical and medication history.

How to Receive Follow up Care

If at any time during the telehealth visit:

- You experience a health emergency and feel you need immediate care, please inform the healthcare provider, it may be necessary to call 911 and you may be directed to the nearest hospital/emergency room.
- You or your healthcare provider experience telecommunication or equipment failure that prohibits the completion of visit, please contact the office directly to be connected to afterhours call line and the healthcare provider.

By agreeing to these *Terms of Use* and by accepting *Online Telemedicine/Telehealth Services* you agree and understand the following:

1. The laws that protect privacy and confidentiality of medical information also apply to telemedicine/telehealth and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. That you have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. That telemedicine involves electronic communications of my personal health information.
4. You may expect the anticipated benefits from the use of telehealth in your care but results from care/treatment cannot be guaranteed or assured.
5. My healthcare provider has the right to discontinue at any time if he/she feels it is necessary or that an in-person visit is necessary. (i.e. can't meet standard of care)
6. Your health information may be shared with other individuals for treatment, payment and healthcare purposes.
    a. Psychotherapy notes are maintained by the telemedicine healthcare clinician, but not shared with others. Only billing codes and visit summaries with be shared with others and you.
    b. If you obtain psychotherapy services, you understand that your therapist has the right to limit the information provided to you, if in the therapist professional judgement sharing the information with you would be harmful to you.
7. Your healthcare information may be shared in the following circumstances:
    c. A valid court order is issued for medical records
    d. Reporting suspected abuse, neglect or domestic violence
    e. Preventing or reducing serious threats to anyone's' health or safety

Charges for Services

You understand and agree that you are responsible for all charges related to your telehealth visit. You will pay for all services provided and agree that the charges are valid and appropriate.
This can be done:

1. Providing you credit card on file charging your regular office co-pay.
2. If you don't have a credit card on file, you must provide credit card information.

Process for telemedicine

1. Use the link provided by the office.
2. Enter your Child's Full Name
3. Allow access to your camera and microphone on your device
4. Then wait for the Doctor to connect with you

Patient Consent to the Use of Telemedicine

Having read and understood the information provided above regarding telemedicine and understand the risk and benefits of telemedicine, I agree to Terms of Use, and give my informed consent to Kids Care Pediatrics to participate in a telemedicine healthcare visit in the course of my diagnosis and treatment.

Patient Name		Date
Patient or Parent/Guardian Name	If Parent/Guardian; Relationship to Patient	Signature

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Acknowledgement of Receipt of Notice of Privacy Practices

Name: _____ Date: _____

Relationship to Patient: _____

I acknowledge that I was provided a copy of the Notice of Privacy Practices for Kids Care Pediatrics.

Patient Name (Print): _____

Name of person signing acknowledgment (Print): _____

Relationship to Patient: _____

Request a copy of the notice of privacy practices? ☐ Yes ☐ No

Signature: _____ Date: _____

For Office Use

If patient/representative requested a copy of Notice of Privacy Practices: Date copy was provided: _____

If no acknowledgement could be obtained, state the reasons why and the efforts taken to try to obtain the acknowledgement:

_____

_____

_____

_____

_____

Name: _____ Date: _____