SG Pediatrics

26850 PROVIDENCE PKWY || SUITE 320 || NOVI, MI-48374 || PH: (248) 662-4091 || ANSWERING SERVICES: (248) 858-6889

PATIENT INFORMATION

PATIENT NAME: _____ _____ _____ MALE/FEMALE

LAST FIRST MIDDLE

AGE: _____ DATE OF BIRTH (DOB): _____ EMAIL: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

PHONE: _____ CELL: _____

RACE: AMERICAN INDIAN / ASIAN / NATIVE HAWAIIAN / BLACK / AFRICAN AMERICAN / WHITE / HISPANIC / OTHER / REFUSE TO REPORT

ETHNICITY: HISPANIC OR LATINO / NOT HISPANIC OR LATINO / REFUSE TO REPORT

LANGUAGE: ENGLISH / INDIAN / SPANISH / RUSSIAN / OTHER _____

PARENT(S) OR GUARDIAN(S) INFORMATION

PARENT /GUARDIAN NAME: _____ MALE/FEMALE DOB: _____

RELATIONSHIP TO PATIENT: MOTHER / FATHER / GRANDPARENT / FOSTER PARENT / OTHER _____

ADDRESS: _____ CITY/STATE/ZIP: _____

PHONE #: _____ CELL: _____

EMPLOYER: _____ OCCUPATION: _____

WORK ADDRESS: _____ PHONE: _____

PARENT /GUARDIAN NAME: _____ MALE/FEMALE DOB: _____

RELATIONSHIP TO PATIENT: MOTHER / FATHER / GRANDPARENT / FOSTER PARENT / OTHER _____

ADDRESS: _____ CITY/STATE/ZIP: _____

PHONE #: _____ CELL: _____

EMPLOYER: _____ OCCUPATION: _____

WORK ADDRESS: _____ PHONE: _____

IN CASE OF EMERGENCY PLEASE PROVIDE THE NAME OF A RELATIVE OR FRIEND AT A DIFFERENT ADDRESS:

NAME: _____ PHONE: _____

ADDRESS: _____ RELATIONSHIP TO PT: _____

AUTHORIZATION TO LEAVE MESSAGES REGARDING PATIENT INFORMATION AND PATIENT PORAL

I hereby authorize SG PEDIATRICS, PLLC to send messages regarding testing results via patient portal and schedule appointments to the following

PHONE NUMBER: _____ HOME/CELL INITIALS: _____

EMAIL: _____

PREFERRED PHARMACY: _____ PHONE NO.: _____

HOW DID YOU HEAR ABOUT US? : _____

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PATIENT'S NAME _____ DOB: _____

DRUG ALLERGIES _____ WHO REFERRED? _____

PREVIOUS PHYSICIAN _____ CITY _____ MAJOR COMPLAINTS LAST 6 MONTHS:

ALLERGIES (DRUGS, FOOD, OTHER) _____ _____

_____ _____

FAMILY HISTORY PLEASE MENTION ANY ILLNESS THAT ANY BLOOD RELATIVE HAS HAD (PARENTS, SIBLINGS, GRANDPARENTS, UNCLES AUNTS OR COUSINS OF THE PATIENT). NA FOR NOT APPLICABLE

ARE YOUR CHILD'S IMMUNIZATIONS UP TO RELATIVE DATE? _____ DID YOU BRING ENTIRE HEALTH RECORDS? _____

CONDITION_____ RELATIVE _____ DESCRIPTION _____ OPERATIONS? _____

ALLERGIES (hay fever, etc.,) _____ ACCIDENTS? _____

BIRTH DEFECTS _____ HOSPITALIZATIONS? _____

BLOOD DISORDERS (anemia, bleeding) _____ _____

BONE or JOINT DISEASE (arthritis) _____ SERIOUS ILLNESS or PROBLEMS? _____

CANCERS OR TUMORS _____ _____

CYSTIC FIBROSIS _____ CHRONIC DISEASES (under treatment) __

DIABETES (before age 40) _____ _____

EARLY CHILDHOOD DEATHS _____ CURRENT MEDICATION _____

EYE or EAR DISORDER _____ _____

HEART TROUBLE _____ BEHAVIORAL HISTORY

HEART ATTACK (before age 60) _____ DEVELOPMENAL PROBLEMS _____

HIGH BLOOD PRESSURE _____ FEEDING PROBLEMS _____

KIDNEY DISORDER (urinary disorders) _____ ADHD _____

LUNG DISEASE (asthma, bronchitis) _____ DISCIPLINE PROBLEMS _____

MENTAL RETARDATION _____

PSYCHIATRIC PROBLEMS _____ BIRTH HISTORY

HISTORY OF DRUG ABUSE _____ DELIVERY TYPE: Vaginal / C-Section

SEIZURES _____ BIRTH WEIGHT _____

TUBERCULOSIS _____ COMPLICATIONS _____

SEE HIGH RISK QUESTIONNAIRE NSE REVIEWING HISTORY _____ _____

SIGNATURE OF PERSON COMPLETING FORM _____

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Patient Name: _____

Acknowledgement

I have read the above HIPAA Privacy policies. As indicated above, I know my rights as a patient and also know and agree to the policies and procedures set in place by SG Pediatrics of Novi.

_____

(Parent/Legal Guardian Signature)

_____

(Date)

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PLEASE BE ADVISED THAT IF ANYONE OTHER THAN THE PARENTS WILL BE BRINGING YOUR CHILD TO THE DOCTOR FOR EXAMINATION, IMMUNIZATIONS OR LAB TEST, THEY MUST BE LISTED BELOW THAT THEY HAVE YOUR PERMISSION TO DO SO.

NAME _____ RELATIONSHIP _____ PHONE # _____

1. _____
2. _____
3. _____
4. _____

_____ _____

SIGNATURE OF PARENT / GUARDIAN Date

Insurance and Parent/Guardian Information

Primary Insurance Company _____ Policy Number _____

Group Number _____

Subscriber Name _____ Subscriber SS# _____

Subscriber Birthdate _____ Subscriber Employer _____

Secondary Insurance

Insurance Company _____ Policy Number _____

Group Number _____

Subscriber Name _____

Consent For Treatment & Insurance Authorization

In order to submit a claim for services covered under your policy, we must have authorization to release all medical information to your insurance carrier. Your signature authorizes the release of any medical information necessary to process your claim and request payment of benefits to the insured party who accepts assignment. I understand that I am responsible for the payment for any services that are not covered or rejected by my insurance company. If there is a co-pay or deductible, I am responsible for paying this on the day the services are rendered. I request and authorize care as my child's physician and his/her designees and assistants may deem necessary or advisable. This includes, but is not limited to, routine diagnostic and laboratory procedures, administration of drugs and routine medical, nursing and hospital care.

Signature _____ Date _____

SG Pediatrics Patient Portal Authorization

SG Pediatrics, Novi, provides this new feature Patient Portal exclusively to our established patients. The Patient Portal is designed to enhance patient physician communication.

The information on the Patient Portal is maintained by SG Pediatrics, Novi, in partnership with eclinicals, our EHR software vendor and provider.

In the event of an emergency dial 911.

Do not use the Patient Portal.

What is the Patient Portal?

The Patient Portal is a web based system that allows for secure communication and transfer of medical information between SG Pediatrics and the patient. Due to patient privacy laws, we do not accept any communication through traditional emails.

The Patient Portal does provide the following services:

- Use the messaging function to communicate with the staff and the doctor
- View lab and diagnostic tests, growth charts and immunizations
- Review medications, allergies and your medical history
- Request medication refills, referrals and appointments
- Will receive automatic appointment reminders to your email provided

The Patient Portal is not intended to provide any triage and treatment. We will respond within 24hrs or at most within 3 business days. If you do not receive any communication within 3 business days please call our office at 248-662-4091.

Please provide us with and keep up to date, the email address to which you would like us to send notifications via the Patient Portal. We strive to keep all of the information in your records correct and complete. If you identify any discrepancy on your record, you agree to notify us immediately.

Privacy and Security:

All messages sent to you will be encrypted and the data is on HIPAA compliant VPN. Your email address is confidential and protected information. We are focused on providing highest level of service and health care. However, if abuse or negligent usage of Patient Portal persists, we reserve right at our own

discretion to terminate Patient Portal offering, suspend user access, or modify services offered through the Patient Portal.

Only parents and guardians of our patients who are at least 18yrs of age are eligible to access the Patient Portal.

My signature below acknowledges that I have read and understand the information contained in this consent form and that I consent to electronic communications through the Patient Portal with the staff of SG Pediatrics. I understand that such electronic portal communications may contain medical information about my child and concern matters regarding my child's health care. I understand that Patient Portal communications are subject to inherent risks of inadvertent and unintentional disclosure. I agree to hold harmless SG Pediatrics, its physicians, staff and affiliates from any and all claims, cause of action, losses, injuries, liabilities and expenses arising out of or relating to any electronic mail technical or administrative failures and unauthorized disclosures. You may revoke this consent and discontinue use of the Patient Portal by providing SG Pediatrics written notice.

_____ _____

Signature or Parent/Guardian Date

_____

Printed Name

_____

E- mail Address