Developmental Pediatrics of Central Jersey
1806 Highway 35 Suite 107 Oakhurst, NJ 07755 732.660.0220

Date: _____

PATIENT INFORMATION:

Name: _____
(Last) (First) (M.I.)
Date of Birth: _____ Sex: _____ Race: _____
Address: _____
City: _____ State: _____ Zip: _____

Primary Contact Phones:
Name: _____
Cell: _____
Home: _____
Work (optional): _____

Secure Email Address: _____

Permission for Voicemail messages containing medical information (not including scheduling):

☐ Yes, I give permission for medical information to be left in voicemail.
☐ No, I do not want messages or medical information left in voicemail.

You will receive appointment reminders/confirmations via email, telephone, and text message.

PARENT(S)/LEGAL GUARDIAN(S):

Name: _____
Relationship: _____
Address (if different from above) _____
City: _____ State: _____ Zip: _____
(if different from above) Phone _____ Email _____

Name: _____
Relationship: _____
Address (if different from above) _____
City: _____ State: _____ Zip: _____
(if different from above) Phone:_____ Email _____

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EMERGENCY CONTACT INFORMATION: (if we are unable to reach you)

Name: _____
(Last) (First) (M.I)
Relationship: _____ Phone: _____

Additionally, the following person(s) have permission to **transport the patient, pick up medical documents (including prescriptions) and to provide information in my absence:**

Name: _____ Relationship: _____
Name: _____ Relationship: _____

MEDICAL INFORMATION:
Pediatrician/Practice Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

PREFERRED PHARMACY: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

REFERRAL: Were you referred to Developmental Pediatrics of Central Jersey? If so, by whom:

Name/Organization: _____
Address: _____
☐ Therapist ☐ Friend ☐ Physician ☐ Teacher/School

ADOPTION: If your child was adopted, please circle the appropriate response:

1. The adoption can be discussed freely in front of the child. ☐ Yes ☐ No
2. Please only discuss the adoption when the child is NOT present. ☐ Yes ☐ No

If you answered YES to question 2, please answer the following:

1. How old was your child at the time of adoption? _____
2. What country was your child adopted from? _____
3. Do you have birth records or information about the birth family? ☐ Yes ☐ No
4. Did you have an open adoption? ☐ Yes ☐ No
5. If yes, are you still in contact with the birth parents? ☐ Yes ☐ No

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QUESTIONNAIRE

Please help us understand your child better by completing the following form.

I. IDENTIFYING INFORMATION

Patient's Name _____

Birthdate _____/_____/_____ Sex _____

Diagnosis / Reason for Visit _____

_____

Current School Placement

Name of School: _____

Address: _____

Classification: _____ Last CST Evaluation: _____

Current Therapies Received in School:

Physical Therapy	☐ Yes ☐ No	Frequency _____
Occupational Therapy	☐ Yes ☐ No	Frequency _____
Speech Therapy	☐ Yes ☐ No	Frequency _____
Psychiatry	☐ Yes ☐ No	Frequency _____

Current Specialists and Addresses (if applicable)

Neurologist _____

Orthopedist _____

Other _____

Has your child been registered with NJ Special Health Services? ☐ Yes ☐ No

If yes, when? _____ Case Manager _____

Phone: _____ Fax or email: _____

Current Medications

NAME	DOSE	START DATE

Allergies

Medications _____

Food / Other _____

II. FAMILY INFORMATION

Mother _____ Birthdate _____

Father _____ Birthdate _____

Siblings and other household members:

Name	**Relationship**	**Age**	**Problem / Diagnosis**

Has anyone in the family (mother or father's side) had significant medical or emotional illness?

☐ Yes ☐ No If yes, please clarify: _____

_____

III. MATERNAL PREGNANCY HISTORY

Number of Pregnancies _____

Miscarriages _____ Abortions _____ Full Term _____ Premature _____

Health during pregnancy

Illness _____ Accidents _____

Medication / Vitamins taken _____

Drugs / Alcohol / Smoking _____

Any other difficulties _____

Labor and Delivery

Hospital _____

Length of Labor _____

Medications given (if any) _____

Complications during labor (if any) _____

Delivery ☐ Normal ☐ Induced ☐ C-section

Complications during delivery (if any) _____

Birthweight: _____ Length: _____ APGAR: _____

Neonatal Care

☐ Regular Nursery ☐ Intensive Care Nursery

How old was the baby when he / she came home? _____

Jaundice: ☐ Yes ☐ No

Did the baby have any of the following after delivery:

Turn blue ☐ Yes ☐ No

Have difficulty breathing ☐ Yes ☐ No

Need a respirator ☐ Yes ☐ No How long? _____

Have a seizure ☐ Yes ☐ No Medications _____

Have bleeding in the brain ☐ Yes ☐ No

Have surgery ☐ Yes ☐ No What type? _____

Details on any of the above _____

IV. MEDICAL / DEVELOPMENTAL HISTORY

Previous medical / therapy evaluations (Please list type of evaluation, facility, and clinician or physician)

_____
_____
_____

Previous therapy / treatment (Please list type of evaluation, facility, and clinician or physician)

_____
_____
_____

Operations / hospitalizations (Please list dates, facility, and type of operation)

_____
_____
_____

Serious illnesses / injuries / loss of consciousness (Please list dates and types)

_____
_____
_____

V. DEVELOPMENTAL MILESTONES

Please indicate at what age your child accomplished each of the following. If you do not remember the age please check (✓) if your child had difficulty achieving.

Motor Skills	Age / Difficulty	Speech and Feeding	Age / Difficulty
Held head up		Smiled	
Sat up without support		Babbled	
Crawled on the floor		Played games: ☐ peek-a-boo, ☐ patti-cake, ☐ other	
Stood alone		Words / Phrases	
Transferred from hand to hand		Simple sentences	
Held bottle		Baby Food	
Built blocks		Table food	
Used ☐ spoon, ☐ fork, ☐ cup		Drank from cup	
Did ☐buttons, ☐ tied shoes		Pointed to body parts	
Toilet trained		Recognized colors	
Dry at night		Recognized shapes	
		Recognized numbers	
		Recognized letters	

VI. PRESENT DEVELOPMENT

Medical problems: (ear infections, seizures, allergies, etc.)

_____

_____

Vision: ☐ Good ☐ Poor Formally tested? ☐ Yes ☐ No Glasses: ☐ Yes ☐ No

Hearing: ☐ Good ☐ Poor Formally tested? ☐ Yes ☐ No If yes, when? _____

Teeth: ☐ Good ☐ Poor Formally tested? ☐ Yes ☐ No If yes, when? _____

Feeding difficulties: ☐ Yes ☐ No **Sleeping difficulties:** ☐ Yes ☐ No

Toilet difficulties: ☐ Yes ☐ No **Walking pattern:** ☐ Normal ☐ Abnormal

Coordination: ☐ Good ☐ Fair ☐ Poor

Describe details of any of the above

_____

_____

Wears splints / braces: ☐ Yes ☐ No If yes, what kind? _____

Special equipment: ☐ wheelchair ☐ walker ☐ stander ☐ bath chair

☐ other_____

Talking Pattern (examples of speech): _____

_____

BEHAVIOR / PERSONALITY: Please check all that apply

Activity Level:

☐ Quiet ☐ Average ☐ Overactive ☐ Hyperactive ☐ Cooperative

☐ Self Confident ☐ Pays attention ☐ Follows directions ☐ Understands what is said

☐ Generally happy ☐ Frustrates easily

☐ Other_____

How does your child interact with:

Peers _____

Siblings _____

Mother _____

Father _____

Other Adults _____

Favorite activities: _____

_____

_____

Dislikes: _____

Fears: _____

How do you discipline your child? _____

_____

What areas of behavior are harder for you to deal with? _____

_____

Does your child have difficulty separating from you? ☐ Yes ☐ No

What else would like us to know about your child? _____

_____

_____

_____ _____

Signature of Patient or Legal Guardian **Date**

_____

Print Name of Patient or Legal Guardian

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PATIENT BILL OF RIGHTS

Welcome to our office. Please be advised that we are legally obligated to provide you with this list of your rights. Please read the following carefully. Feel free to ask questions if there is something you do not fully understand. After you have fully read this list of rights, please acknowledge that we have provided you with this important information by signing below.

IT IS OUR LEGAL DUTY and OBLIGATION TO…

- Treat you with consideration and respect in a safe setting free from all forms of abuse and harassment. Your privacy will be protected.
- Keep all communications and records about your care confidential. In general, you have the right to see all the information in your health records.
- Provide clearly written and spoken information in words you can understand.
- Provide all the information you need to make an informed decision about your care including information about your options, risks and benefits, possible outcomes, possible side effects, who is providing your care and all possible costs.
- Respect your decision to refuse care. To allow you to leave the office even if the physician advises against it.
- Provide you with the freedom from restraints and seclusion of any form that is not medically necessary.
- Provide you with all available information about possible research participation and obtain your informed consent.
- Give you the opportunity to examine and receive an explanation of your bill regardless of source of payment.
- Allow you to express a concern or complaint and receive a prompt response. You also have the right to file a formal grievance if you are not satisfied with the resolution of your complaint.

I have read and fully understand this Patient Bill of Rights.

_____ _____

Signature of Patient or Legal Guardian **Date**

_____

Print Name of Patient or Legal Guardian

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CONSENT FOR TREATMENT

Developmental Pediatrics of Central Jersey (DPCJ) is authorized to initiate Evaluative/Diagnostic/Therapeutic procedures on the above-named patient to clarify issues pertinent to the health, development, or adjustment of the patient.

_____ _____

Signature of Patient or Legal Guardian **Date**

_____

Print Name of Patient or Legal Guardian

FINANCIAL POLICY

I understand that Developmental Pediatrics of Central Jersey is a fee-for-service practice and does not accept insurance payment. All payments are made by cash, check, or charge **for the full amount at the time of service.** DPCJ will provide an itemized statement for the patient/family to submit to an insurance company for reimbursement, should you choose to do so.

I have read and understand the above stated policy.

_____ _____

Signature of Patient or Legal Guardian **Date**

_____

Print Name of Patient or Legal Guardian

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APPOINTMENT CONFIRMATION AND CANCELLATION POLICY

I understand that when I schedule an appointment at Developmental Pediatrics of Central Jersey (DPCJ) this time is reserved for my child only. Appointment times may be blocked for up to 2 hours. DPCJ sends reminder calls, emails, and texts staring approximately one week prior to the appointment. **If I do not confirm my appointment, DPCJ reserves the right to release my appointment to another patient.**

At least 24 hours advance notice is required to cancel my appointment for any reason. DPCJ understands that illness is unpredictable. **If no prior notification is received (no-show) I may be charged the full fee.** If I cancel an appointment with less than 24 hours' notice, I will be billed 50% for that appointment.

I have read and understand the above stated policy.

_____ _____

Signature of Patient or Legal Guardian **Date**

_____

Print Name of Patient or Legal Guardian

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health and Insurance Portability and Accountability Act (HIPPA), I have certain rights to privacy regarding my protected health information.

I acknowledge that I have received and read the Notice of Privacy Practices. I understand that DPCJ has the right to change the Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations.

_____ _____

Signature of Patient or Legal Guardian **Date**

_____

Print Name of Patient or Legal Guardian

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____

Parent / Legal Guardian (print): _____

Developmental Pediatrics of Central Jersey is authorized to RELEASE records TO:

1. Name of Individual/Organization: _____
Relationship to Patient (if applicable): _____
Address: _____
City: _____ State: _____Zip: _____
Phone: _____ Fax: _____

2. Name of Individual/Organization: _____
Relationship to Patient (if applicable): _____
Address: _____
City: _____ State: _____Zip: _____
Phone: _____ Fax: _____

Developmental Pediatrics of Central Jersey is authorized to OBTAIN information FROM:

1. Name of Individual/Organization: _____
Relationship to Patient (if applicable): _____
Address: _____
City: _____ State: _____Zip: _____
Phone: _____ Fax: _____

2. Name of Individual/Organization: _____
Relationship to Patient (if applicable): _____
Address: _____
City: _____ State: _____Zip: _____
Phone: _____ Fax: _____

3. Name of Individual/Organization: _____
Relationship to Patient (if applicable): _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION (cont.)

The type of information to be disclosed:

☐ All Medical Information (Lab Results, X-Ray and/or other Diagnostic tests, Medications, Immunizations, etc.)

☐ Consultation Reports (medical, psychological and/or speech-language evaluation)

☐ Only Dates of Service: From _____/_____/_____ To _____/_____/_____

I understand that this information may include information relating to AIDs or HIV, treatment of drug or alcohol abuse, or mental / behavioral health / psychiatric care. This consent is valid indefinitely or until revoked in writing. I understand that authorization is voluntary and is not required to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rule.

I authorize the use or disclosure of the above-named individual's health information as discussed above.

_____ _____

Signature of Patient or Legal Guardian **Date**

_____

Print Name of Patient or Legal Guardian