



PEDIATRIC HISTORY FORM

TODAYS DATE _____

Patient Name: _____ DOB: _____

Primary Care Physician Name: _____ Phone: _____

Other Treating Physician Name: _____ Phone: _____

Pharmacy Name: _____ Phone: _____

Pharmacy Address: _____ City: _____ State: _____ Zip: _____

Reason for today's visit (New Patients ONLY) _____

Allergies: Please list any allergies your child may have to any medications .Please circle NONE if they do not have any known allergies.

_____ **NONE**

Medications: Please list all the medications your child is currently taking, dosage and frequency. For example: *Aspirin 325mg daily.*

Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Surgical History: Please list all surgeries. Include approximate dates, if possible.

Procedure: _____ Date: _____ Procedure: _____ Date: _____

Procedure: _____ Date: _____ Procedure: _____ Date: _____

****If you are unable to fit all your procedures/surgeries in the above space, please utilize the back of the page****

Past Medical History: Does your child have or had any of the following medical conditions?

Diabetes	Type 1	Type 2	NO	Kidney Disease	YES	NO	Heart Disease	YES	NO	
Asthma		YES	NO	Thyroid Disease	Hyper	Hypo	NO	Other	Yes	NO
High Blood Pressure		YES	NO	Cancer		YES	NO	If yes, please explain:		
Kidney Stones		YES	NO	If YES please specify:		_____				

When you were pregnant with this child: What was the length of pregnancy? _____

Was the pregnancy ? **NORMAL** **ABNORMAL** If abnormal, describe _____

IN-Vitro **YES** **NO**

If you had a pregnancy ultrasound, was it **NORMAL** **ABNORMAL**

Family History: Do you have a *family* history of any of the following?(grandparents, parents or siblings)

Diabetes	Type 1	Type 2	NO	Kidney Disease	YES	NO	Heart Disease	YES	NO	
Asthma		YES	NO	Thyroid Disease	Hyper	Hypo	NO	Bedwetting	YES	NO
High Blood Pressure		YES	NO	Cancer		YES	NO	Other	YES	NO
Kidney Stones		YES	NO	If YES please specify:				If yes, please explain:		
Bladder Anomolies		YES	NO	Undescended Testis		YES	NO	_____		
Genital Problems		YES	NO	Hernias		YES	NO	_____		
Recurrent UTI's		YES	NO					_____		

Review of Systems: Has your child ever experienced any of the following problems. Please circle any that apply. If none apply, please circle NONE.

Constitutional :	None	Fever	Chills	Headache	Other: _____	
Neurological :	None	Tremors	Numbness Tingling	Weakness	Other: _____	
Allergic/ Immunologic :	None	Seasonal Allergies	Drug Allergies	Other: _____		
Musculoskeletal :	None	Joint pain	Other: _____			
Gastrointestinal :	None	Abdominal pain	Nausea/ Vomiting	Other: _____		
Cardiovascular :	None	Heart Murmur	Other: _____			
Endocrine :	None	Excessive thirst	Other: _____			
Respiratory :	None	Wheezing	Shortness of breath	Frequent Cough	Other: _____	
Hematologic/ lymphatic :	None	Swollen Glands	Blood Clotting Problem	Other: _____		
Genitourinary :	None	Painful Urination	Urinary Frequency	Urinary Tract Infection	Blood in Urine	Other: _____ _____ _____

Physician Reviewed/Date: _____ Physician Reviewed/Date: _____ Physician Reviewed/Date: _____

Patient Comments: Please comment on any issues/problems not covered in the above questions.

Patient Signature: _____ Date: _____

PEDIATRIC PATIENT REGISTRATION FORM:

Patient's (child) Name: _____ Home Phone#: _____
Last First Middle
Street Address: _____ City: _____ State: _____ Zip: _____

Patient Social Security#: _____ Patient's Sex: Male Female
Patient Date of Birth: _____

Parent Information:

Mother's Name: _____ Father's Name: _____
Home address: _____ Home address: _____
Cell phone #: _____ Cell phone #: _____
Email address: _____ Email address: _____
Mother's birth date: _____ Father's birth date: _____
Employer's Name: _____ Employer's Name: _____
Employer's Address: _____ Employer's Address: _____
Work Number: _____ Work Number: _____

If parents are divorced/separated is there a court order or other financial arrangement we need to be aware of?

_____ Name of step parent: _____

Emergency Contact: _____ Phone#: _____ Relationship: _____

Pediatrician Name: _____

Address: _____ City _____ State _____ Phone # _____

Referring Doctor (if different from Pediatrician) _____

Address: _____ City _____ State _____ Phone #: _____

Pharmacy Name: _____ Town: _____ Phone #: _____

INSURANCE INFORMATION (Must be completed in full so that we may submit to your insurance for reimbursement.)

Primary Insurance: _____

Policyholder's name (insured's name): _____ Date of Birth: _____
Sex: Male Female Social Security #: _____ Employer: _____

Patient's relationship to insured (please circle): Child Other/ Dependent

Group Number: _____ Policy Number: _____

Secondary Insurance:

Policyholder's name (insured's name): _____ Date of Birth: _____
Sex: Male Female Social Security #: _____ Employer: _____

Patient's relationship to insured (please circle): Child Other/ Dependent

Group Number: _____ Policy Number: _____

I request that payment of authorized Medicare, Medicaid, and/or commercial insurance benefits be made to Garden State Urology for any service furnished to me by GSU's physicians. I authorize Garden State Urology to release medical information which may be required by my insurance carrier to determine payment for services rendered. I further understand that I am responsible to pay certain amounts due the physician. These amounts could include annual deductibles, co-payments, charges denied as not covered by Medicare or my insurance program, and charges denied for services determined as not medically necessary. I further understand that if GSU incurs any fees associated with collecting reimbursement on my account, I will be responsible for paying those fees.

Signature: _____

Date: _____



By signing below, I acknowledge that I have received a copy of my physician's Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by this practice, and how I may obtain access to and control this information. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of this practice, its physicians and staff.

Print Name of Patient or Patient's Personal Representative

Signature of Patient or Patient's Personal Representative

Description of Personal Representative's Authority

Date

If you have any questions about this notice or would like further information, please contact the Privacy Officer at Garden State Urology, LLC, Jeanmarie Falco.

For office use only: If the patient does not sign this acknowledgement and consent form, record here the good faith efforts made to obtain this acknowledgement and consent.

Consent to Discuss Health Care

Patient Name: _____

Today's Date: _____ Date of Birth: _____

I authorize _____
to discuss my health care information with the individuals listed below.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I give permission to leave my health care information at the following telephone number(s).

Home: _____ Cellular: _____

Work: _____ Other: _____

Signature of Patient, Parent or Legal Guardian

Printed Name

**Morris Urology,
a division of Garden State Urology, LLC**

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AUTHORIZATION / REFERRAL POLICY

Many insurance companies have strict guidelines and policies with respect to authorizations and referrals for radiology and lab procedures. Because these policies change on a regular basis, it is the responsibility of the patient to know what information is needed and what guidelines must be met according to his or her insurance company's policies in order to have a radiology or lab procedure. In addition, it is your responsibility to have an understanding of your responsibilities under your insurance contract in respect to referral and pre-authorization requirements as well as your deductible, co-pay and coverage limits.

I understand that I, the patient, am responsible for any payment related to any procedure for which I did not properly obtain a referral, or any procedure that I did not have properly authorized or pre-certified. I also understand that obtaining a proper referral, authorization or precertification is not a guaranty of payment by the insurance company and I am financially responsible for payment of all services not covered by my insurance company.

PRINT PATIENT'S NAME

SIGNATURE

DATE



PATIENT NAME: _____ DATE OF BIRTH: _____

ACKNOWLEDGEMENT FORM FOR THE FINANCIAL INFORMATION DOCUMENT

Attached is Garden State Urology Financial Information Document. This document explains the following information:

- In-network financial responsibility
- Out-of-network financial responsibility
- Self Pay / no insurance
- Medicaid/Charity Care
- Collections
- Precertification/authorization

Please take a few moments to read the document and save it with your medical records for future reference.

If you have any questions or concerns after reading the document, please ask to speak to a Financial Counselor.

In order to document for our records that you received this document we require all patients/guarantors to sign below acknowledging receipt of the document.

I acknowledge receipt of Garden State Urology's Financial Information Sheet that explains the information as outlined above.

Patient/Guarantor Signature _____ Date: _____

For patients with Blue Shield or Horizon Insurance who are seeing an out of network physician:

Unfortunately, these insurance carriers will not send payment directly to an out of network physician. All payments/ explanations of benefits are sent to the patient/guardian.

When you receive an explanation of benefit/payment for a service rendered by Garden State Urology contact the Billing Department IMMEDIATELY.

DO NOT WAIT until you receive a statement or phone call from us.

Internal Use Only:

If patient or patient's representative refuses to sign acknowledgement of receipt of the Payment Summary Sheet, please document the date and time the notice was presented to patient and sign below.

Date: _____ Time: _____ Employee Name: _____

G:\GSU BILLING POLICIES\GSU Financial acknowledgment form.doc