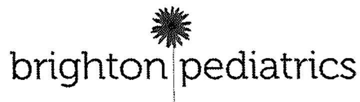


Patient Registration

Patient Last Name________________________________ **Patient First Name**_________________ **MI**_____

Sex______ **DOB**_____________ **Social Security Number**_____________

Mailing Address____

City_______________________________ **State**________________ **Zip Code**__________________

Primary Language Spoken in Home ___________________________________

	Mother	Father
Name:		
DOB:		
SS#:		
Employer:		
Cell Phone:		
Email:		
Primary Contact:	Yes/No	Yes/ No
Preferred Contact Method for Well Visit Appt Reminders:	Text Cell/Call Cell	Text Cell/Call Cell

	Primary Insurance	Secondary Insurance
Policyholder		
Relationship to Patient		
Insurance Company		
Policy #		
Group #		

Emergency Information (EXCLUDING PARENTS):

Name_____________________________________ **Relationship**____________________________________

Cell Phone ________________________ **Work Phone**_____________________ **Home Phone**___________________

Signature of Responsible Party____ **Date**__________________

brighton pediatrics

Patient's Name:

Date of Birth:

Pregnancy and Birth History

Problems during pregnancy no yes ____________
Medications no yes ____________
Smoking/Alcohol/Drugs no yes ____________
Diabetes no yes ____________
Illness during pregnancy no yes ____________
Other ____________

Delivery: Vaginal Cesarean Section
Reason for C/S ____________
Full Term Premature (# mths ____________)
Birth Weight ____________ Birth Length ____________

Problems immediately after birth:
Infection no yes ____________
Breathing Difficulty no yes ____________
Jaundice no yes ____________
Home with mother no yes ____________
Other no yes ____________

Medical History

Current Medication ____________
Medication Allergies ____________
Food Allergies ____________
Hospitalizations ____________

Previous infections/problems:
Anemia no yes ____________
Asthma no yes ____________
Bedwetting no yes ____________
Behavior problems no yes ____________
Bladder or kidney infection no yes ____________
Chicken pox no yes ____________
Constipation no yes ____________
Convulsions or seizures no yes ____________
Ear infection no yes ____________
Eczema no yes ____________
Hay fever no yes ____________
Hearing problems no yes ____________
Learning problems no yes ____________
Pneumonia no yes ____________
Sleep problems no yes ____________
Speech problems no yes ____________
Transfusion no yes ____________
Vision problems no yes ____________
Weight problems no yes ____________
Other ____________

Completed by ____________

Date:

Developmental History

Child was able to do the following at what age:
Smile ____________
Roll over ____________
Sit alone ____________
Crawl ____________
Walk alone ____________
First words ____________
Toilet trained ____________

Family History

Alcohol or drug problems no yes ____________
Allergies no yes ____________
Asthma no yes ____________
Birth defects no yes ____________
Blood diseases no yes ____________
Blindness no yes ____________
Cancer no yes ____________
Convulsions no yes ____________
Elevated cholesterol/trig no yes ____________
Deafness no yes ____________
Death in childhood (incl. SIDS) no yes ____________
Diabetes no yes ____________
Headaches/migraines no yes ____________
Heart defects (incl. congenital) no yes ____________
Heart attacks no yes ____________
At what age? ____________
Hip dislocation no yes ____________
Hypertension no yes ____________
Immun deficiency (incl. AIDS) no yes ____________
Learning problems no yes ____________
Liver disease no yes ____________
Lung disease no yes ____________
Mental retardation no yes ____________
Psychiatric disorders no yes ____________
Thyroid disease no yes ____________
TB test—positive results no yes ____________
Conditions that run in the family ____________

Social History

Exposure to passive smoke no yes ____________
Smoker in the household no yes ____________

Household Parent/Caretaker:

Name	Age	Employer

Married Divorced Separated Widowed Other ____________

Others in the home:

Name	Age	Relation to patient

Others important in child's life:

Name	Age	Relation to patient

This information has been reviewed with the parent(s):
Signature: ____________

Financial Policies

PARENTS: Please initial to indicate you understand each individual policy. If you have questions, please ask a member of our staff.

( ) **INSURANCE CARD** – You are required to present your insurance card at each visit.

( ) **COVERAGE TERMS** – Your insurance policy is a contract agreement between you and your insurance company. You are responsible for knowing the terms and conditions of your policy. It is not possible for Brighton Pediatrics to know all the different policy details on co-payments, deductibles, co-insurance and non-covered services. As a courtesy, Brighton attempts to verify eligibility and benefits, however, we are unable to obtain the exact details of payment until the claim is processed.

( ) **PREVENTATIVE CARE AND CO-PAYS** - If during a well-visit, any issue is discussed and managed outside of preventable care, your insurance company will most likely apply a co-pay for which you will be responsible.

( ) **OUTSTANDING BALANCES** – Brighton's policy is that all balances be kept current. Outstanding balances for any and all family members are due and are payable prior to the office visit.

( ) **BILLING POLICY** – Brighton will bill your insurance company at the time of service. When the Explanation of Benefits (EOB)/insurance payment is received, your account will be credited. If coverage is denied or there is remaining patient responsibility for any reason, you will be responsible for the payment in full when you receive a statement or at the time of your next appointment (whichever comes first.)

( ) **INSURANCE COMPANY DISPUTES** – It is your responsibility to negotiate disputed payments with your insurance company.

( ) **HMOs** – If you have an HMO plan, you may see any of our practitioners, but you will need select Dr. Dana Sless or Dr. Barry Kessler as your primary care physician (PCP) and notify your insurance company of the selection.

( ) **COLLECTION POLICY** – Brighton Pediatrics subscribes to a collection agency for any unpaid debt. In the event that your account is placed with an attorney or collection agency because of an unpaid balance, you hereby agree and promise to pay a collection fee of $50. Once your bill goes into collections, you will be responsible for any attorney fees and penalties. Brighton cannot pull an account out of collections once it is sent to collections. If your account is sent to collections, you will be discharged from the practice.

( ) **RETURNED CHECKS** – There will be a $35.00 returned check fee applied to your bill for any returned check. This is the charge we incur from our bank.

( ) **NEW BABY SERVICES** – It is the insurance subscriber's responsibility to make sure that the newborn is added to the policy in a timely manner. Brighton Pediatrics will not be responsible for charges incurred and not covered by your insurance company when a newborn has not been properly added to an insurance policy.

( ) **MISSED APPOINTMENT** – A missed appointment fee will be charged if the office is not notified in advance. The fee for a missed appointment is $25.00. This fee is not covered by insurance and will not be billed to insurance.

[ ] **COPY OF MEDICAL RECORDS** – A written request must be received prior to the release of each medical record. Brighton Pediatrics charges patients with private insurance $10.00 to provide paper copies of the patient record. This includes faxed transfer record requests. Please allow 30 days for processing from the receipt of the request and payment. Patient records can always be obtained though the Patient Portal at no charge. The patient portal can be accessed at www.brightonpediatrics.net.

[ ] **FORM COMPLETION REQUESTS** – Brighton Pediatrics charges the following fees for the completion of all forms, payable at the time of pick-up. General Universal Health Forms are available at no charge through the Patient Portal. Most daycare centers and schools (up to High School) will accept this form. The patient portal can be accessed at www.brightonpediatrics.net.

- $10.00 for all forms except WIC and Working Papers
- $20.00 for all letters requested on letterhead
- $10.00 for all utility forms (ex. Electric company)
- $5.00 for Asthma Action Plans, Allergy Plans and Seizure Plans

Patient Name: ______________________________

Patient Name: ______________________________

Patient Name: ______________________________

Patient Name: ______________________________

Parent/Guardian Name: ______________________________

Parent/Guardian Signature: ______________________________ Date: __________

Witness Signature: ______________________________ Date: __________

Office Policies

PARENTS: Please initial to indicate you understand each individual policy. If you have questions, please ask a member of our staff.

( ) **OFFICE HOURS** –We offer a 7am – 8am sick visit walk-in clinic Monday – Friday and also evening hours and Saturday mornings during the busy fall/winter season. Our hours are kept up to date on our website and on our Facebook page.

( ) **APPOINTMENTS –**

- ***Well Visits:*** All well-visits must be scheduled in advance. In order to ensure that you get a day and time that works best for you, please try to schedule your child's well visit as far in advance as possible.
- ***Sick Visits:*** Our practitioners are available each day for same-day sick visits.
- ***Late Arrivals***: Please try to arrive on time for your appointment. If you arrive more than 15 minutes late, we may need to reschedule your child's appointment.
- ***No-Shows:*** If, for any reason, you cannot make your scheduled appointment, please call us as far in advance as possible. If you do not cancel and do not show for your appointment, you will be charged a fee in accordance with our financial policy. If you do not cancel or show for two scheduled appointments, we may ask you to find another practice that can better accommodate your needs.

( ) **HIPAA NOTICE OF PRIVACY PRACTICES** – The law requires that Brighton Pediatrics inform you as to how we may use and share your protected health information and how you may exercise your health privacy rights. We are required by law to maintain the privacy of your health information; give you notice of our legal duties and privacy practices with respect to your health information; and follow the terms of our notice that are currently in effect. You will be asked to sign and acknowledge that you have received our HIPAA Notice of Privacy Practices and that you understand that your health information will be used, shared and disclosed for treatment, payment, healthcare operations, and other purposes as permitted or required by law.

( ) **REFERRALS** – Please allow up to four days for the completion of Referrals.

( ) **VACCINATIONS** – Brighton requires that each child is vaccinated according to the schedule recommended by the American Academy of Pediatrics. You will always be provided with the appropriate Vaccine Information Statement (VIS) when a vaccine is given.

( ) **AUTHORIZATION TO TREAT MINORS** – Brighton will be unable to treat any minor (under the age of 18) without a parent or legal guardian present unless proper written consent is provided (see attached form).

( ) **CONTACT INFORMATION** – Please inform us as soon as possible of any changes in your contact information (ex.phone number or home address).

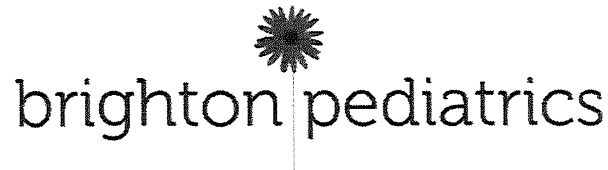
Patient Name: ______________________ Patient Name: ______________________

Patient Name: ______________________ Patient Name: ______________________

Parent/Guardian Name: ______________________________

Parent/Guardian Signature: ______________________________ Date: __________

Witness Signature: ______________________________ Date: __________



Primary Contact Number and Authorization to Release Lab Results

In order to more efficiently convey lab, test results and other communication, Brighton Pediatrics is requesting that you provide a secure telephone number/s, which our staff may call and leave messages regarding your child. This will help prevent the delay of pertinent information relating to your child (patient). If you have not heard from Brighton Pediatrics regarding your child's lab work in the expected time, please do not hesitate to contact the office.

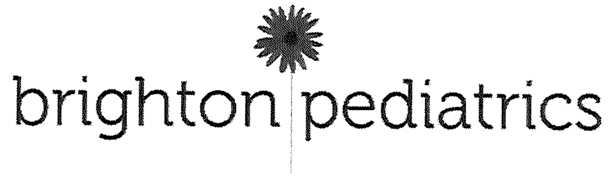
Phone #____ (Primary)

Phone #____ (Secondary)

I, (parent/guardian)________________________________, give Brighton Pediatrics permission to leave messages on my child (patient), ___________________________, on the above telephone lines.

Parent/Guardian Signature ________________________________ Date__________________

Relationship to Patient____



CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I, the undersigned patient, hereby consent to the use or disclosure of individually identifiable health information by Brighton Pediatrics in order to carry out treatment, payment, or health care operations. I have received and reviewed this facility's Notice of Privacy Policy prior to signing this form and hereby acknowledge and understand my rights as indicated therein.

I understand that this facility reserves the right to change the terms of its Notice of Privacy Policy at any time. If the facility does change the terms of its Notice of Privacy Policy, I may obtain a copy of the revised Notice of Privacy Policy by requesting same in writing.

At all times, I retain the right to revoke this consent. Such revocation must be submitted to the facility in writing. The revocation shall be effective except to the extent the facility has already taken action in reliance on this Consent Form.

I understand that this facility may refuse to provide treatment if I or my authorized representative does not sign this Consent Form, except to the extent that the facility is otherwise required by law to provide treatment to individuals. If I or my authorized representative signs this Consent Form and then revokes consent, the facility has the right to refuse to provide further treatment to patient as of the time of the revocation, except as otherwise required by law.

I have read and understand this information. I have received a copy of this form and this facility's Notice of Privacy Policy. I am the patient or I am authorized to act on behalf of the patient to sign this document verifying consent to the above stated terms.

Signature of Parent/Authorized Representative ______________________________

Printed Name of Parent/Authorized Representative ____________________________

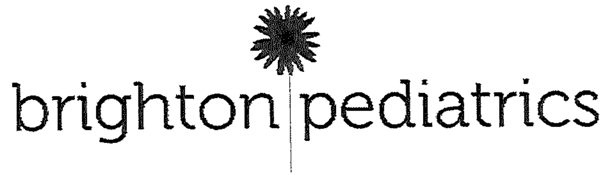
Date ______________________

Name of Child/Children____________________________________

____

____

Please complete both sides ⟹



AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION

I, the undersigned patient, hereby authorize the disclosure of individually identifiable health information by Brighton Pediatrics for the purpose of providing information to my school and/or employer. The facility may use or disclose such protected health information for one (1) year from the date indicated herein. I understand that I may refuse to sign this Authorization if I so choose, but I understand such refusal will result in this facility's inability to provide any personal health information, including records and/or notes, on my behalf to my school and/or employer.

At all times, I retain the right to revoke this Authorization, except if the Authorization was obtained as a condition of obtaining insurance coverage. Such revocation must be submitted to this facility in writing. The revocation shall be effective except to the extent that the facility has already used or disclosed information in reliance on the Authorization.

I have been informed and understand that information used or disclosed pursuant to this Authorization may be subject to disclosure by the recipient of such information, and, at that point, the information may no longer be protected under this agreement.

I have read and understand this information. I have received a copy of this form and I am the patient or I am authorized to act on behalf of the patient to sign this document verifying authorization for the use or disclosure of the protected health information under the above stated terms.

Signature of Parent/Authorized Representative ______________________________

Printed Name of Parent/Authorized Representative ______________________________

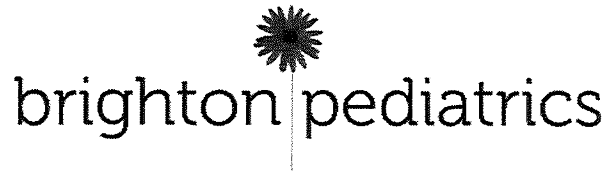
Date ______________________

Name of Child/Children ______________________________

____

____

Please complete both sides ➡



Child Medical Consent Form

Patient Name (Child):_______________________________ **DOB:**_____________

I specifically understand and acknowledge that only a parent, legal guardian or authorized adult may accompany a child for a medical appointment. In the event that I am unavailable to accompany my child during their appointment, I hereby consent the individual listed below to act as a Temporary Guardian and accompany my child to Brighton Pediatrics for medical services. I authorize the Temporary Guardian to make medical decisions regarding my child, in my absence. I understand that I am financially responsible for all charges incurred for services rendered in my absence. I am hereby requesting that a copy of this consent form be placed in my child's medical record.

Parent Name:_____________________ **Phone number:**______________________

Home Address:_______________________________________

____

____

Sole Custody:☐ Joint Custody: ☐ Other(Indicate in Custody Notes): ☐

Custody Notes:

____

____

____

____

Temporary Guardian Effective Date(s):____________________ to _______________________

Or check if permanent ☐

Temporary Guardian Name:_________________________ **Phone:**______________________

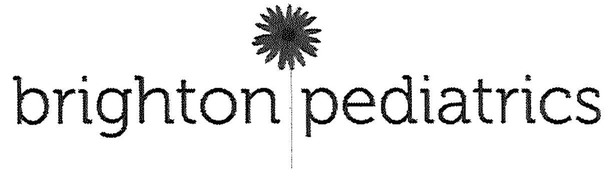
Consent to make the following medical decisions regarding:

☐ Sick visits ☐ Well visits

☐Vaccines ☐Administering Medications ☐Other___________________

Parent/Guardian Signature ____________________________

Date ______________



Authorization for Release of Medical Records

Attention: ____

Address: ____

____

Phone: ______________________ Fax: __________________

Please release a complete copy of my child's medical records to:

Brighton Pediatrics
3069 English Creek Avenue
Suite 302
Egg Harbor Township, NJ 08234
Phone: (609) 383-3800
Fax: (609) 383-3839

Patient's Complete Name: ____________________________________

Date of Birth: ____________________________________

Please mail/fax these records for an appointment on: ________________

Parent/Guardian Name: ______________________________________

Parent/Guardian Signature: ___________________________________

Witnessed By____

Date: ____

New Jersey Department of Health
Vaccine Preventable Disease Program
P.O. Box 369, Trenton, NJ 08625-0369
609-826-4860 (Fax 609-826-4866)
www.njiis.nj.gov

NEW JERSEY IMMUNIZATION INFORMATION SYSTEM (NJIIS)
CONSENT TO PARTICIPATE

- RETAIN A COPY OF THIS FORM IN THE MEDICAL RECORD -

REGISTRANT INFORMATION	***PARENT/GUARDIAN INFORMATION (if NJIIS Registrant is a minor)***
Registrant Name *(Print)*	Name *(Print)*
Date of Birth	Address
Country of Birth	City, State, Zip Code
Name of Primary Health Care Provider **Brighton Pediatrics**	Relationship to Registrant

I have received information about the New Jersey Immunization Information System (NJIIS) and understand that the purpose of this program is to help remind me when my/my child's immunizations are due and to keep a central record of my/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/my child's record from my primary health care provider, my local health department, or the New Jersey Department of Health (NJDOH). The NJDOH may be contacted at the website or telephone number listed above.

There is no cost to participate in this program.

☐ Yes, I would like to participate in this program.

☐ No, I do not want to participate in this program.

Signature of Registrant (or Parent/Guardian, IF Registrant under 18 Years of Age)	Date

Name of NJIIS Enrollment Site	Registry ID Number	Medical Record Number

- RETAIN A COPY OF THIS FORM IN THE MEDICAL RECORD -