VILLAGE
Pediatrics & Rheumatology

Joan G. Calkins, MD
17 Long Ave. Suite 110
Hamburg, New York 14075
Tel: **716.646.5188**
Fax: **716.646.5190**

PATIENT INFORMATION FORM

Patient's Name _____ Male ☐ Female ☐ DOB _____
(First) (M. I.) (Last)

Home Address _____

City _____ State _____ Zip Code _____

Mother _____ DOB _____

Maiden Name _____

Father _____ DOB _____

Mother's Cell # _____ Mother's Work # _____

Father's Cell # _____ Father's Work # _____

NAMES OF OTHER CHILDREN SEEN HERE

NAME	DOB	INSURANCE SUFFIX

Emergency Contact Name _____

Relationship to Patient _____ Phone # _____

Referred By (Rheumatology only) _____

PCP Name _____ PCP Phone # _____

VILLAGE
Pediatrics & Rheumatology

PATIENT DEMOGRAPHICS

Race ☐ White ☐ Black/African America ☐ American Indian/Alaska Native ☐ Asian
☐ Native Hawaiian/Other Pacific Islander ☐ Other ☐ Patient Declined

Ethnicity ☐ Spanish/Hispanic Origin ☐ Not of Spanish/Hispanic Origin ☐ Patient Declined

Language ☐ English ☐ Spanish ☐ Declined ☐ Other _____

PRIMARY INSURANCE INFORMATION

Policyholder's Name _____ Male ☐ Female ☐

Policyholder's Address (if different than patient)

_____

Phone # (if different) _____ Work # _____

Employer _____

Insurance Company _____ ID # _____

Relationship to Patient _____ Co-Pay $ _____ (Sick) $ _____ (Well)

Marital Status (Circle) ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legal Status

Primary Pharmacy _____ (Name) Location _____ (Street, Town)

SECONDARY INSURANCE INFORMATION

Policyholder's Name _____ Male ☐ Female ☐

Policyholder's Address (if different than patient)

_____

Phone # (if different) _____ Work # _____

Employer _____

Insurance Company _____ ID # _____

Relationship to Patient _____ Co-Pay $ _____ (Sick) $ _____ (Well)

Marital Status (Circle) ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legal Status

Case Manager _____ Phone # _____

Social Worker _____ Phone # _____

VILLAGE
Pediatrics & Rheumatology

AUTHORIZATION FOR INSURANCE BILLING

I hereby authorize Joan G. Calkins, MD to apply for benefits on my behalf for covered services. I request that payment from my insurance company be made directly to Dr. Calkins. I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original.

Patient Name _____ **Date** _____

Signature _____

RECORD RELEASE AUTHORIZATION

I hereby authorize you to release to Joan G. Calkins, MD, at the above address, any and all information, including diagnosis and records of any treatment or examination rendered. I permit a copy of this authorization to be used in place of the original.

Patient Name _____ **Date** _____

Signature _____

Dr. Calkins occasionally has students working with her. If you prefer that the students not assist with your child please let a staff member know. Thank you for your understanding and help in this matter. Our students appreciate the opportunity to learn from you!

How did you learn about our Practice?

_____

_____

_____

_____

_____

VILLAGE
Pediatrics & Rheumatology

Joan G. Calkins, MD
17 Long Ave. Suite 110
Hamburg, New York 14075
Tel: **716.646.5188**
Fax: **716.646.5190**

Record Release

Please release the following children's records to:

Village Pediatrics & Rheumatology
Joan G. Calkins, M.D.
17 Long Avenue, Suite 110
Hamburg, N.Y. 14075

	Name	**Date of Birth**
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

Please send the entire medical record ☐

Please send a summary of the above named records ☐

_____ _____

Parent or Guardian Signature Date

Previous Practice

Name _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

VILLAGE
Pediatrics & Rheumatology

Joan G. Calkins, MD
17 Long Ave. Suite 110
Hamburg, New York 14075
Tel: **716.646.5188**
Fax: **716.646.5190**

Family History

Patient Name _____ **DOB** _____

	No	Yes	Relationship (Parent, Grand Parent, etc)
Diabetes	☐	☐	_____
Heart Disease	☐	☐	_____
High Blood Pressure	☐	☐	_____
High Cholesterol	☐	☐	_____
Cystic Fibrosis	☐	☐	_____
Bleeding Disorders	☐	☐	_____
Genetic Disorders	☐	☐	_____
Allergies	☐	☐	_____
Asthma	☐	☐	_____
Seizures	☐	☐	_____
Intellectual & Development Disabilities	☐	☐	_____
Arthritis	☐	☐	_____
Cancer	☐	☐	_____
ADD/ADHD	☐	☐	_____
Learning Disability	☐	☐	_____
Depression	☐	☐	_____
Addiction	☐	☐	_____
Other	☐	☐	_____

VILLAGE
Pediatrics & Rheumatology

Joan G. Calkins, MD
17 Long Ave. Suite 110
Hamburg, New York 14075
Tel: **716.646.5188**
Fax: **716.646.5190**

Authorization & Acknowledgement of Practices Financial & Privacy Policies

In general, the HIPAA Privacy Rule (Health Insurance Portability & Accountability Act of 1996- a federal law) gives individuals the right to request a restriction of uses and disclosures of their Protected Heath Information (PHI). It also provides the right to request confidential communications between an individual and his/her physician's office. In order to protect your privacy and in keeping with the Federal Privacy Law, all of your medical information, PHI, is kept strictly confidential. We will use this PHI for Treatment, Payment, Operation (TPO) of our medical practice. We will be required to get an authorization in writing from you if we intend to use your PHI for any other purposes.

AUTHORIZATION

I authorize the release of any PHI necessary to determine liability for payment & to obtain reimbursement on any claim.

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled, including, but not limited to, Medicaid, Medicaire, private insurances, and other health managment organizaton to the practice named on this form.

The assignments of benefits will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

I also give permisssion to the providers & nurses of Village Pediatrics & Rheumatology, LLC to treat, perform any diagnostic procedures, and to administer vaccines in the medical care of my child(ren).

I authorize Dr. Joan Calkins, and the practice staff to leave medical information pertaining to my care by the following methods; and I will assume the responsibility of notifying the office whenever this information changes.

Please indicate below how you would like our office to handle communicaitons with you.

APPOINTMENT INFORMATION:

- Home Phone (Include auto call)? ☐
- Mobile Phone (Include auto call)? ☐
- Mobile Text (Include auto call)? ☐
- Work Phone? ☐
- With Another Person? ☐
- Send via Mail? ☐

MEDICAL INFORMATION:

- Home Phone (Include auto call)? ☐
- Mobile Phone (Include auto call)? ☐
- Work Phone? ☐
- With Another Person? ☐
- Send via Mail? ☐

CONTACTS: OK to contact (Name, Relationship, Phone Number)

_____ _____ _____

_____ _____ _____

_____ _____ _____

I agree to the insurance assignments & financial responsibilities as indicated by Village Pediatrics & Rheumatology, LLC. I am also aware of my rights and practice's responsibilities with respect to Private Health Information (PHI) as outlined in Village Pediatrics & Rheumatology's Notice of Privacy Practices.

_____ _____ _____

Patient Name (Please Print) | Signature (Patient or Parent if Minor) | Date

VILLAGE
Pediatrics & Rheumatology

Joan G. Calkins, MD
17 Long Ave. Suite 110
Hamburg, New York 14075
Tel: **716.646.5188**
Fax: **716.646.5190**

Vaccine Policy Statement

Patient Name _____ **DOB** _____

We at Village Pediatrics strongly support the NYS and American Academy of Pediatrics recommended vaccine schedule for infants, children and adolescents.

We recognize the confusion and questions some parents may have about vaccines. The very success of the vaccine program contributes to some of the questions; we do not see many of the childhood diseases we once saw because the vaccines are so effective. This may lead parents to have a false sense of security that their child is not at risk. But the diseases still exist and can infect a child who is not vaccinated.

There is also a large amount of misinformation in the press and on the internet about vaccines. There is no control over what is printed or placed on an individual's blog or Facebook. Because information is in print does not make it true. Conversely, because information is not in print does not make it false.

What is true is that years of scientific investigation that have gone into vaccine research. Vaccines are safe and necessary. If a child is not vaccinated, that child is clearly at risk and that child can put other children at risk. There is an obligation parents of unvaccinated children have to the other children in the community, this includes our office and waiting room.

If you plan to refuse all vaccines for your child or children, we recommend you seek another pediatrics practice that holds your similar views. We will continue to work with families who are willing to work with us but choose to follow alternative vaccine schedules. Vaccines are safe, effective and save lives. We will answer any questions you have about vaccines. We appreciate that this is an important decision parents are making for their child or children and will offer guidance and support.

Joan G Calkins, M.D.

I have read and understand the above stated policy.

_____ Date_____

Additional Patient Names

_____ **DOB** _____

_____ **DOB** _____

_____ **DOB** _____

_____ **DOB** _____