Lincoln Pediatric Group, LLC
Family Registration

Date _____ Physician _____

LIST BIOLOGICAL/ADOPTIVE PARENTS:

MOTHER _____ Marital Status: ○ Single ○ Married ○ Divorced

Birth Date _____ Address _____ City _____ State ____ Zip _____

Cell Phone (____) _____ Work Phone (____) _____ Home Phone (____) _____

Employer _____ Email _____

FATHER _____ Marital Status: ○ Single ○ Married ○ Divorced

Birth Date _____ Address _____ City _____ State ____ Zip _____

Cell Phone (____) _____ Work Phone (____) _____ Home Phone (____) _____

Employer _____ Email _____

LIST ALL CHILDREN:

	BIRTH DATE	*SEX*	*LIVES WITH:*	*RELATIONSHIP:*
Name _____				○ Biological ○ Non-biological
Name _____				○ Biological ○ Non-biological
Name _____				○ Biological ○ Non-biological
Name _____				○ Biological ○ Non-biological

List any deceased children: Name _____ Cause of death _____

IF ANY CHILDREN HAVE A PARENT OTHER THAN THE ONE(S) LISTED ABOVE, PLEASE ADD:

Name _____ Child's Name _____

Birth Date _____ Address _____ City _____ State ____ Zip _____

Cell Phone (____) _____ Work Phone (____) _____ Home Phone (____) _____

Employer _____ Email _____

EMERGENCY CONTACT OTHER THAN PARENTS:

Name _____ Relationship _____ Phone (____) _____

WHO REFERRED YOU TO OUR OFFICE? _____

CHECK ANY OF THE FOLLOWING CONDITIONS WHICH OCCUR IN ANY RELATIVE AND STATE THE RELATIONSHIP TO THE CHILD *(PLEASE SPECIFY MATERNAL OR PATERNAL)*:

○ **No changes since last form completed**

DISEASE	*MATERNAL*	*PATERNAL*	*RELATIONSHIP TO CHILD:*
○ Asthma	○	○	
○ Hay Fever/Allergies	○	○	
○ Eczema	○	○	
○ Lead Poisoning	○	○	
○ Blood or Bleeding Disease	○	○	
○ Epilepsy/Convulsions	○	○	
○ Kidney Disease	○	○	
○ Developmental Disabilities	○	○	
○ Nervous Condition	○	○	
○ Diabetes	○	○	
○ Cancer	○	○	
○ Depression	○	○	

DISEASE	*MATERNAL*	*PATERNAL*	*RELATIONSHIP TO CHILD:*
○ Tuberculosis	○	○	
○ Stillborn Babies	○	○	
○ Miscarriage	○	○	
○ Other Inherited Disease	○	○	
○ Hearing Loss/Deafness	○	○	
○ Thyroid Disease	○	○	
○ High Blood Pressure	○	○	
○ Birth Defects	○	○	
○ Heart Disease	○	○	
○ High Cholesterol	○	○	
○ Alcoholism	○	○	
○ None of the above	○	○	

Does anyone smoke in the home? ○ Yes ○ No

I hereby authorize The Lincoln Pediatric Group to release any information acquired in the course of examination to my insurance carrier. This authorization shall remain valid until written notice is given by me revoking said authorization. I further authorize payments directly to the physician. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Signature _____ Date _____

Print Name _____

(OVER)

Explanation of Preventative Service Charges

Thank you for entrusting your child's health to our office. Lincoln Pediatric Group recommends regular well visits (also known as preventive exams or "physicals") per the American Academy of Pediatrics (AAP) guidelines. We are providing this document to help you understand the different services which may be provided during a well visit and the charges associated with those services.

Screenings and procedures: During well visits, we perform AAP recommended screenings and procedures appropriate to your child's age which help us uncover conditions which may cause health problems in the future. Some insurance plans cover these services and some do not. Because there are so many different insurance companies and plans, we do not know in advance what will and will not be covered. It is your responsibility to understand what services are covered by your insurance plan. The most common services performed during a well visit are listed below:

Age	Screening/Procedure Performed	Code We Bill
2 week – 6 month	Postpartum Depression Screen	96161
12 month-18 month	Fluoride application	99188
18 month, 24 month	MCHAT autism screening	96110
3 year	Autorefractor vision screening	99177
3 year – 18 year	Hearing screen	92551
Ages 9 & Up	PHQ-9 Depression Screening	96127

These services are the standard of care in pediatrics and they are billed with your well visit to your insurance company. Your insurance company may apply the cost of these services to your deductible or bill you for the entire amount depending on your insurance plan. Please be advised that you will be responsible for any balance not covered by insurance.

Additional charges for problem-oriented services: If, during your child's well visit, a significant and separate problem (such as asthma, ADHD, anxiety, wart removal, etc.) must be evaluated and/or managed, an additional problem-oriented service may be charged. Your insurance company requires us to report this additional problem-oriented service using a separate code and this additional charge may result in a co-pay/deductible/co-insurance depending on your insurance plan. If you need further explanation or have questions about fees which may be charged during a well visit, please ask to speak with a member of our business office.

Acknowledgement of Well Visit Billing Procedures: I acknowledge that during my well visit there may be additional services performed in addition to the well visit. In this case, I understand that additional charges may be submitted to my insurance company and that a co-pay/deductible/co-insurance may be applied by my insurance company. Alternatively, I understand I may choose to return for a separate visit to obtain these services at which time the co-pay/deductible/co-insurance would still apply.

Parent/guardian signature: _____

Date: _____

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