Children's Mercy - Preferred Pediatrics, INC.
241 NW McNary Ct.
Lee's Summit, MO 64086
(816) 347-0064
Fax: (816) 347-0593

Noel Graham, MD, FAAP
Jyoti Panicker, MD
Sherri Quick, RN, MSN, CPNP
Adrienne Menghini, RN, CPNP

Patient Demographics

Today's Date: _____

Child's Name: _____ ☐ Male ☐ Female
(Last) (First) (MI)

Child's Address: _____
(Street) (Apt.)

_____
(City) (State) (Zip Code)

Phone: _____ Date of Birth: _____ SSN#: _____

Primary Physician: _____

Father's Name: _____ Date of Birth: _____ SSN#: _____

Employer: _____ Work Ph #: _____ Cell Ph #: _____

Email Address: _____

Mother's Name: _____ Date of Birth: _____ SSN#: _____

Employer: _____ Work Ph #: _____ Cell Ph #: _____

Email Address: _____

Parents Are: ☐ Married ☐ Separated ☐ Divorced ☐ Unmarried

If parents are not married, who has legal custody of child? _____

Emergency Contact if a parent is not available: _____
(Name) (Phone #)

Type of Insurance: ☐ Commercial ☐ Medicaid ☐ Self Pay (None)

Who Carries Insurance on Child(ren): _____

If parents are not married, who is responsible for the balance?

Name: _____

Address: _____

Phone: _____

If you have two insurances (Primary and Secondary) you will need to fill out two insurance forms.
Withholding insurance information is fraud and is subject to prosecution.

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Race/Ethnicity Form

Patient Name: _____

Patient Date of Birth: _____

Race:

☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American
☐ Hawaiian/Pacific Islander ☐ White

Ethnicity:

☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Preferred Language:

☐ English ☐ Spanish ☐ French ☐ German ☐ Other: _____

The majority of prescriptions in our office are sent electronically. Please provide at least one pharmacy and it's address and/or phone number that you would like to have your prescriptions sent to.

Pharmacy: _____

Address and/or Phone Number: _____

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Office Policies & Consent to Treat

YOUR INFORMATION: Please provide your most current information such as phone/cell numbers, address, etc. Also, please bring your insurance card to each visit to ensure accurate filing and payment from your insurance carrier.

TECH POLICY: Please refrain from using your cell phone when your child is in the exam room and being seen for their appointment and also when checking in and/or out of the office. You are not allowed to photograph, video, or voice record any part of the patient visit without the consent of the provider, violation will result in patient termination with our office.

Patient consent to allow electric communication of health records, as necessary, to any health professionals approved by Preferred Pediatrics. This includes sending and receiving medical information through the patient portal. Follow My Health, as well as secure messaging to patients.

APPOINTMENT POLICY: Patients with scheduled appointments are seen between 9:00am and 4:30pm Monday through Friday. If you have an appointment scheduled for a child, and would like an additional child to be seen, please call our office in advance of coming to the office. We will do our best to accommodate you. Please provide a 24 hour notice if an appointment needs to be canceled.

TREATING MINORS WITHOUT A PARENT OR LEGAL GUARDIAN: Preferred Pediatrics patient requires a dated and signed "authorization for medical treatment of a minor" form when is being accompanied for their appointment by a person other than the birth parent or legal guardian. This includes stepparents, grandparents, day care providers, nanny, baby-sitter, etc. Non-emergency care may be denied without this form.

PAYMENT/RESPONSIBLE PARTY: Please pay the co pay your insurance requires and any outstanding balance or a payment towards that balance at the time of your visit. **Please contact your insurance company to verify the benefits available including well baby care, laboratory, and vaccinations.** It's the responsibility of the guarantor to pay any outstanding charges not covered by their insurance benefit. The billing office can discuss possible pay arrangements with you if needed. In cases where there is a divorce, the parent bringing the child into the office at time of visit will be responsible for payment and will need to collect from the responsible party on their own. With regard to phone-calls requesting to speak directly to the doctor, a charge may be incurred if certain criteria are met such as complexity and length of the call.

PRESCRIPTION REFILL/FORM COMPLETED/REFERRAL REQUEST: Please allow at least 24 to 48 hours for all forms to be completed. Daycare forms, FMLA forms, and all of forms will have fees please see form fee schedule. Insurance referrals and prescription refill request will be 24-to-48 hour process. Please note that in compliance with Missouri Law, some medication prescriptions must be picked up at our offices. These prescriptions will not be sent directly to your pharmacy and you will be notified in advance if this is the case, please be prepared to show identification if

requested when picking up these items.

CONSENT TO TREAT: I, the undersigned patient, parent, or legal guardian is responsible for consenting on patient's behalf, hereby requested and consent to the children listed below, to be examined and treated by the medical, nursing and other healthcare personnel who may participate in the patient's care. I hereby authorize the clinicians of Preferred Pediatrics, to administer vaccinations (see policy) and all other medical procedures to the children below.

PLEASE SIGN BELOW TO VERIFY THAT YOU HAVE READ AND UNDERSTAND OUR OFFICE POLICIES AND CONSENT TO TREAT

Signature of Patient, Parent or Legal Guardian: _____

Printed name of person signing and relationship to patients: _____

Child/Children(s) Name(s): _____

Date: _____

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Receipt of Notice of Privacy Practices
Written Acknowledgment Form

Please check one:

☐ I have **received** a copy of Preferred Pediatrics Notice of Privacy Practices.

☐ I **decline** to accept a copy of Preferred Pediatrics Notice of Privacy Practices.

Patient Name: _____

Signature of Guardian: _____

Date: _____

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Patient Portal Sign-up

Sign-up for our patient portal. In the patient portal you will have access to your child's vaccine record, health history, request a refill on active medications, send messages to a nurse, and request appointments for non-ill visits.

Parent Name: _____

Parent Email: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

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