Martha Jefferson Medical Group

Pediatric Form

Instructions: Please print and complete this form on both sides and bring it with you to your first appointment.

Patient Information

Patient (Last, First, Middle)		SSN
Street Address		
City State Zip		
Home Phone	Work Phone	Cell Phone
OK to leave message on □ home □ work □ cell phone ? (check all that apply)		
Sex □ Male □ Female Date of Birth Marital Status M S W D		
Patient's Employer		
Street address		
City State Zip		

Who is responsible for paying the bill? (if different from above)

Name (Last, First, Middle)		SSN
Street Address		
City State Zip		
Home Phone	Work Phone	Cell Phone
Sex □ Male □ Female Date of Birth		
Relationship to Patient □Spouse□ Self □ Parent □ Other □ Employer		
Employer Name		
Street Address		
City State Zip		

Insurance Information (Please provide a copy of your insurance card(s)

Who is the **subscriber** of the insurance? If it is the same as the patient, skip this section.

Name (Last, First, Middle)		SSN
Street Address		
City State Zip		
Home Phone	Work Phone	Cell Phone
Sex □ Male □ Female Relationship to Patient □ Spouse □ Parent □ Other Date of Birth		

Emergency Contact Information

Relationship to Patient □ Spouse □ Parent □ Other		
Street Address		
City State Zip		
Home Phone	Work Phone	Cell Phone

Minor Information—Who is authorized to bring a minor child (under age 18) in for treatment?

Name: ____

Who has legal custody of the minor? If different from above, please provide your custody agreement.

Relationship to Patient □ Spouse □ Parent □ Other _______________________		
Street Address		
City State Zip		
Home Phone	Work Phone	Cell Phone

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Patient Name:	Patient Date of Birth:

Release of Information—To whom can we release information about the patient?

Name Relationship to patient
Name Relationship to Patient
Name Relationship to Patient

Deemed Consent for Designated Blood Borne Pathogens
Consent to Medical Care, and Release of Information

Virginia law requires health care providers to notify you that the Hepatitis B and C or HIV (Aids) Virus testing on a sample of your blood may be done if a health care worker is exposed to your blood or body fluids. This following notice is to advise you that this is in effect at this facility:

As a health care provider under the Virginia Acts of Assembly Section 32.1-45.1, whenever any health care worker associated with or working for Martha Jefferson Medical Group is directly exposed to body fluids of a patient in a manner which, according to the guidelines of the Center for Disease Control, may transmit human immunodeficiency virus or Hepatitis B and C, Martha Jefferson Medical Group will proceed to test the patient through his or her physician and to the health care worker(s) who was/were exposed.

When a person is tested, we automatically test for Hepatitis B and C for the safety of all concerned, Martha Jefferson Medical Group policy protects you as a patient, should you be exposed.

I voluntarily consent to medical care at Martha Jefferson Medical Group which may include examinations, tests, photographs and treatments by doctors and staff. No promises have been made to me as to the results of treatments or examinations.

I certify that the information I have reported in regard to my insurance coverage is correct. I hereby authorize the release of pertinent information to my insurance company or CMS and any other doctors involved with my case. I authorize insurance benefits to be paid directly to this office, realizing that I am responsible to pay for any non-covered services. I understand that if my account becomes delinquent and is assigned to a collection agency, I agree to pay all costs of collections, including agency and attorney fees.

I have read, understand, and agree to all terms specified in the Financial Policy. I acknowledge that I have received or been offered a copy of Martha Jefferson Medical Group's Notice of Privacy Practices.

Patient's relationship to signer: □ Patient □ Spouse □ Parent □Child □ Other __________________________
□ Patient is unable to sign or acknowledge

____ ________________________
Sign Date

____ ________________________
Sign Date

____ ________________________
Sign Date

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Financial Policy

Martha Jefferson Medical Group (MJMG) is committed to providing each patient with the best possible medical care. If a patient has special needs, we are here to assist in any way we can. The following information is provided to avoid any misunderstanding concerning payment for the professional services rendered by our practice.

For your convenience, we accept all of the following methods of payment:

1.) Cash
2.) Check (returned checks are subject to a $35.00 fee)
3.) Visa
4.) Master Card
5.) Discover
6.) Debit Card
7.) Travelers Check (with photo identification)

Full payment is due at the time of service unless we participate with your insurance company. Any required co-pays or deductibles owed by you will be collected at the time of service (a $10.00 statement processing fee will be assessed to an account if payment is not made at time of service). If you are unable to pay your account balance in full, please ask the receptionist for payment options. You will be responsible to pay any billed amounts upon receipt of a statement from our billing office, unless other arrangements have been made. If your insurance plan determines a service not to be covered, we will bill you for that charge.

If we do not have a contract with your insurance carrier, we cannot accept assignment to be reimbursed by your carrier. In this case, charges would be due and payable by you at the time of service. As a courtesy we will however, bill your insurance plan on your behalf for any service we provide.

MJMG requests 24 hours advance cancellation notice for all appointments. If a patient does not contact the office in advance, a $25.00 “No Show” fee may be charged for each appointment missed, depending on the circumstance of the cancellation. If a patient misses more than three (3) appointments in one year, MJMG reserves the right to discharge the patient, and ask the patient to seek medical care with another provider.

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Health History Form

Instructions: Please print this form and complete it before arriving for your child's appointment.

Name:	Date of birth:
Form Completed by:	Relationship:

Birth History (if age 10 or older, skip to Past Medical History)

Please check the appropriate column	Yes	No
Was the child born close to the due date?		
If not, how many weeks early or late? Please explain:		
Birth Weight: ________________		
Was the delivery vaginal?		
Was the delivery C-Section?		
Were there any complications during the delivery?		
If yes, please describe:		
Did the child leave the hospital with the mother?		
Was the child breast fed?		
Length of time breast fed:		
Were there problems with jaundice (yellow skin)?		
Were there feeding difficulties?		
Was there infection at birth?		

Past Medical History

Please check the appropriate column	Yes	No
Has the child ever been hospitalized?		
If yes, for what reasons (include age at time of illness):		
Has the child ever had surgery?		
If yes, what type of operation and the age:		
Has the child ever had a serious accident, injury or broken bones?		
If yes, please describe:		
Has the child ever had any of the following problems? Mark all that apply		
Ear infection	Allergies/Hay Fever	Chicken Pox
Asthma or wheezing	Skin conditions	Developmental problems
Acid reflux	Heart murmur	Seizure
Current Medications including vitamins and herbal supplements:		
Allergies to medicines:		
Allergies to foods or other:		

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Pediatric Form
Health History Form

Patient Name:	Patient Date of Birth:

Family History:

Please note anyone in the child's family with the following conditions. Please list relationship to child		
Allergies/Hay Fever	Seizure	Stroke
Asthma or wheezing	Overweight	Psychiatric illnesses
Blood disorders	High Cholesterol	Alcohol/Drug Problem
Diabetes	High Blood Pressure	Heart Disease/Heart Attack
Cancer	Other:	

Social History:

Please check the appropriate column	Yes	No
Who lives at home with the child? Name, age, relationship		
Where and with whom does the child spend the day?		
Are there any smokers in the house?		
Does the child have a bike?		
Does the child wear a bike helmet?		
Does your home have a swimming pool?		
Do you have any pets?		
If yes, what type:		
Is there any other information you'd like to share with your doctor?		