PEDIATRIC ASTHMA AND PULMONARY ASSOCIATES OF N.Y., P.C.

REGISTRATION INFORMATION

Patient's Name _____ Birth Date _____

Address_____ Sex: M / F

City _____ Zip _____ Allergies _____

Home phone _____(Mother's Cell) _____(Father's Cell)_____

Email address of parents: _____

PEDIATRICIAN: _____

Address _____ Phone _____

Referred By: ( ) Pediatrician_____ Other ( )_____

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Patient's Mother Name _____

Social Security # _____ Date of Birth _____

Occupation _____ Employer _____

Employers Address _____ Phone _____

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Patient's Father Name _____

Social Security # _____ Date of Birth _____

Occupation _____ Employer _____

Employers Address _____ Phone _____

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Person Responsible for Payment _____ Relation to Patient _____

Insurance Carrier _____

Address _____

Policy Holder _____ ID # _____

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Pharmacy Name and Address: _____

Telephone Number: _____ Fax Number: _____

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In order to submit a claim for payment to us for services covered under your policy we must have your authorization to release medical information to your insurance carrier. I hereby authorize release of information to file a claim with my insurance company and *ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO*: ***Pediatric Asthma and Pulmonary Associates of NY, P.C.***

I understand that it is my responsibility to provide this office with current and accurate information regarding my insurance coverage and referrals when necessary form my primary physician. I understand that failure to do so could result in non-payment by my insurance carrier and that any such balances are my responsibility. Furthermore, I understand and agree that I am responsible for any unpaid balance. As we expect all payments within 4 weeks of the date of visit, we ask that you follow-up closely with your insurance company to expedite payment.

Signature of Parent/Guardian _____ Date _____

PEDIATRIC ASTHMA AND PULMONARY ASSOCIATES OF N.Y., P.C.

Janis I. Schaeffer, MD, FCCP, FAAP
Jason Price, M.D.

NAME: _____

Review of Systems Questionnaire

Please circle any of the symptoms that you are currently or have recently experienced:

Constitutional Symptoms
Fevers
Weight loss
Changes in appetite and/or energy level

Eyes
Redness, Swelling
Itchy
Discharge

Ears/Nose/Throat
Pain
Nasal discharge/congestion
Hearing loss
Sore throat
Snoring

Cardiovascular
History of murmur or heart disorder
Exercise intolerance
Change in color of extremities and/or lips

Respiratory
Coughing
Wheezing
Difficulty breathing

Gastrointestinal
Nausea/vomiting/diarrhea
Excessive gas
Belly pain
Feeding problems (choking/gagging/coughing)

Skin
Rashes, itching
Bruising
Swelling

Neurological
Headaches
Seizures
Behavioral problems
Low tone
Developmental delay

Endocrine
Poor growth
Abnormal blood sugars
Excessive thirst, urination

Immunologic
Repeat skin, ear, sinus infections
Frequent pneumonia

Musculoskeletal
Joint pains/swelling
Recurrent fractures

☐ My child/I have none of the above