WUCA - Nash Pediatrics, LLC

Alison C. Nash, MD
Dianne Schmidt, CPNP
Andrea Mouldon, CPNP

Registration Packet

Requirements for Registration:
1. Complete the enclosed forms (please fill in all the blanks)
2. A copy of the immunization/shot records
3. A copy of your insurance card(s) (front and back)

When we have received the above information and verify the insurance we will be able to schedule an appointment for your child.

Revised April 2016

WUCA - Nash Pediatrics, LLC
3737 N. Kingshighway Blvd., Suite 209-210
St. Louis, MO 63115
Office phone: 314-261-5250
Office Fax: 314-261-4567
After Hours: 314-362-2128

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Dianne Schmidt, CPNP
Andrea Mouldon, CPNP

Welcome to Nash Pediatrics!

We are happy to have you in our practice. There is one pediatrician and two pediatric nurse practitioners who will care for your child(ren). The names are listed above.

Office hours are:
Monday, Tuesday, Wednesday, Thursday | 8 a.m. - 11:30 a.m.; 1 p.m. - 4:30 p.m.
Friday | 8 a.m. - 11:30 a.m.
First Tuesday of each month | closed

Our goal is to provide quality care to our patients by listening to their needs and the needs of their families. We strive to provide guidance and knowledge to their parents and caregivers that will enable them to help their children maintain optimum health and wellbeing. Please check out our web site, NashPeds.wustl.edu, for more information about our practice and staff.

Urgent after hours calls are handled by pediatric nurses via St. Louis Children's Hospital After Hours Service at 314-362-2128. If necessary, the call is referred to the pediatrician on call, either Dr. Alison Nash, Dr. Earl Beeks, Dr. Seth Brownridge or Dr. Denise Johnson.

St. Louis Children's Hospital has a smartphone app called Kid Care. This app provides you with "care guidelines that help you make appropriate decisions on what level of medical care (if any) is needed and how to provide symptom relief for minor illnesses and injuries at home". Check it out!

If you think that your child is having a medical emergency, call 911 or go to the closest emergency room.

** A parent **MUST** accompany the child to the first visit **
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PLEASE PRINT CLEARLY AND COMPLETE ALL BLANKS

Patient Information

Child's Full Name:_____ DOB:_____

Sex:_____ Current Age: _____ Is your child **adopted**? __ Yes __ No If yes, at what age? _____

Parent(s) or Guardian(s) Information

_____Father _____Mother _____Grandparent _____Foster Parent _____Other:_____

Full Name: _____ DOB: _____ SSN: _____

Home Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone:_____

Email: _____

Occupation: _____ Employer: _____

Work Address: _____ City: _____ State: ____ Zip: _____

ARE YOU THE CUSTODIAL PARENT please check one: ____ YES ____ NO

_____Father _____Mother _____Grandparent _____Foster Parent _____Other:_____

Full Name: _____ DOB: _____ SSN: _____

Home Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone:_____

Email: _____

Occupation: _____ Employer: _____

Work Address: _____ City: _____ State: ____ Zip: _____

ARE YOU THE CUSTODIAL PARENT please check one: ____ YES ____ NO

In case of emergency, notify**:** _____ Phone**:** _____

Relationship to patient: _____

HEALTH INSURANCE

PRIMARY INSURANCE INFORMATION ***You must provide a copy of the front and back of the ID card***

Subscriber's Name: _____ Relationship to Patient _____

Address of Insured (if different from patient) _____ City: _____

State: _____ Zip: _____ DOB: _____ SSN# _____

Insurance Company: _____

ID# _____ Group # _____ Effective Date: _____

Customer Service/Provider Service Phone Number (circle one) _____

Employer: _____

SECONDARY INSURANCE INFORMATION ***You must provide a copy of the front and back of the ID card***

Subscriber's Name: _____ Relationship to Patient _____

Address of Insured (if different from patient) _____ City: _____

State: _____ Zip: _____ DOB: _____ SSN# _____

Insurance Company: _____

ID# _____ Group # _____ Effective Date: _____

Customer Service/Provider Service Phone Number (circle one) _____

Employer: _____

Family History

Patient Name:_____ DOB:_____

Please circle if a parent, sibling, grandparent, aunt or uncle have any of the following conditions:

Anemia, asthma, allergies, diabetes, high blood pressure, heart problems, HIV/AIDS, hepatitis, breathing problems, ADHD/ADD, depression, schizophrenia, alcoholism, drug abuse, mental illness, tuberculosis, cancer, sickle cell disease or trait, cystic fibrosis, stomach or GI problems, thyroid problem, deafness, vision problems, immune system problems

Any other medical problems in the family:_____

_____

Social History **(Circle the appropriate answers)**

Parents: Married Divorced Separated Single	
Siblings - please list:	
How many people live in your home? _____ Adults _____ Children	
Is your child currently enrolled in daycare or school? No Yes	
Does your child participate in regular exercise? No Yes explain:	
Any pets at home? No Yes If yes, please list	
Any smokers at home? No Yes	
Are there smoke detectors at home? No Yes	Carbon Monoxide detectors? No Yes
Are guns kept in your home? No Yes If **Yes**, is the gun unloaded and locked up? Yes No	Are the bullets locked and stored in a separate place? Yes No
Do all family members use Seat belts/care safety seats? No Yes	Do all family members use Helmets when biking? No Yes
Any issues we should be aware of? No Yes Please list:	

Birth History

1. Mother's age at delivery _____

2. Number of pregnancies _____

3. Number of living children _____

4. Prenatal care provider _____

5. Health problems during pregnancy? No Yes
list_____

6. Did mother receive Tdap? No Yes

7. Hospital where baby was born_____

8. Type of delivery: ___ Vaginal ___ C-Section

9. Was the patient born: ___ Full Term ___ Premature

10. If premature how many weeks? _____

11. Birth weight _____

13. Were there any problems with labor or delivery? If yes: explain _____

14. Any problems in the hospital (jaundice, infection, breathing problem, NICU admission)?
_____

Medical History

Patient Name:_____ DOB:_____

Hospitalizations? None Yes - list:

Surgeries? None Yes - list:

Any regular medications (over the counter or prescription)? Include does and frequency.

Has your child seen a specialist? No Yes If yes, when?

Drug Allergies? None Yes - list:

Food Allergies? None Yes – list:

Did you bring a copy of child's immunization record? No Yes If no, please provide as soon as possible.

Any medical issues we should be aware of? None Yes - list:

Has your child had a history of any of the following conditions? (please circle)

Asthma/Wheezing	Eczema	Vision Problems
Allergies	Diabetes	Hearing Problems
Anemia	Seizure Disorder	Depression
Heart Problems/Murmur	Behavior Problems	Bleeding Problems
Kidney Problems	ADD/ADHD	Urinary Tract Infection
Pneumonia	Developmental Delay	Broken Bones
Learning Problems	Cerebral Palsy	Rash or skin condition
Sickle Cell Disease or Trait	Reflux	Hepatitis
HIV/AIDS	Migraines	Tuberculosis
Immune System Problems	Neurological Problems	

Washington University in St. Louis
SCHOOL OF MEDICINE

AUTHORIZATION FOR MEDICAL TREATMENT AND FINANCIAL RESPONSIBILITY

Patient Name and DOB: _____

1. CONSENT

I authorize my physician and other physicians who may attend me, their assistants, including those employed by the Washington University School of Medicine and its wholly owned subsidiaries (hereinafter referred to as "WU"), its house staff, employees, and students to provide the medical care, tests, procedures, drugs, blood and blood products, services and supplies considered advisable by my physician. These services may include pathology, radiology, emergency services and other special services ordered by my physician(s). In consenting to treatment, I have not relied on any statements as to results. I further authorize my physician to examine, use, store, and/or dispose of in any manner (except for organ donation and/or transplantation) any bones, organs, tissue, fluids or parts removed from my body.

In the event that any personnel assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substance that are capable of transmitting disease and I am unable to consult timely with my physician prior to testing, I consent to limited testing to determine the presence, if any, of antibodies to hepatitis A, B, and C and HIV.

2. STORAGE AND RELEASE OF INFORMATION

I hereby consent to the transfer of ownership of my medical records from St. Louis Pediatric Practitioners, Inc. to WU as my treating physician is an employee of WU effective April 1, 2016. I consent to the electronic storage and transmission of patient health information. I hereby authorize my treating physician, WU, to release by electronic means or otherwise any medical and/or billing information concerning my care, including copies of my medical records, to the following:

a. Any governmental or other entity as required by law for purposes of reporting, or for purposes of determining eligibility in government sponsored benefit programs.
b. The supplier of any blood or blood products which may be administered to me for the purposes of quality control and recipient monitoring
c. Any continuing care, residential or long-term care facility, or home health agency for the purposes of providing services for my care.

3. MEDICARE/TRICARE INSURANCE BENEFITS

I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize the release of medical or other information to the Medicare Program or its Intermediaries or carriers concerning this or a related claim filed by WU. I request that payment of authorized benefits be made on my behalf. I understand that I am responsible for the Part B deductible for each year and/or visit, the remaining co-insurance and any other non-covered personal charges.

I (or my representative) certify that I (or he/she) have read (or if the patient/representative is unable to read has had the form read to him/her) and understand, accepts the above and further certify that I am the patient, or am duly authorized on behalf of the patient to execute such an agreement.

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4. GUARANTEE FOR PAYMENT

In accordance with the above terms and in consideration of the services provided to the above-named patient by WU, the undersigned agrees, whether he/she signs as patient or guarantor, to pay WU for all services ordered by the attending physician, or requested by the patient and/or the patient's family. If the requirements for referral, second opinion or pre-certification of care, as outlined by my insurer, benefit plan or other payer, have not been followed, the patient and/or guarantor may in some instances be personally responsible for all charges incurred.

5. ASSIGNMENT OF INSURANCE BENEFITS

In consideration of any and all medical services, care, drugs, supplies, equipment and facilities furnished by WU, all attending physicians, I authorize direct payment to WU of all insurance benefits applicable to these medical services, which are now or which shall become due and payable to me.

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HIPAA – Notice of Privacy Practices Acknowledgement

I acknowledge that I have received or I have been provided the opportunity to receive a copy of the "Notice of Privacy Practice" that explains when, where, and why my confidential health information may be used or shared. I acknowledge that WU, the physicians, the nurses and other University staff may use and share my confidential health information with others in order to treat me, in order to arrange for payment of my bill and for issues that concern WU operations and responsibilities.

Initials of patient or person authorized to sign HIPAA Notice for patient _____

_____ _____
Signature of patient or person Authorized to consent Date Patient's relationship to person

_____
Printed name of patient Patient DOB

_____ _____
Signature of Guarantor Date Patient's Relationship to Guarantor

_____
Signature of Witness Date