DEVELOPMENTAL PEDIATRICS
HEALTH / WELLNESS PC
420 West 23rd Street, Suite AGF. New York, NY 10011

About Your Child:

Name: ____

Date of Birth: __________________ Gender: Male Female Race: _____________

Address: ____

Reason for Coming to Clinic:

What three specific questions about your child's development or behavior would you like to ask us?

1)____

2)____

3)____

Who referred you to us? ____

____

Pediatrician: ____

Neurologist: ____

Orthopedist: ____

Other: ____

Important Information:

What languages do you speak at home? ____

Do you or your child need an interpreter for your visit? ☐Yes ☐No

Do you or your child need any special assistance for your visit? ☐Yes ☐No If yes, describe:

____

Your Contact Information:

Parent/Caregiver 1:

Name: ____

Relationship to child: ____________________________________ Legal Guardian? Yes No

Address: ____

Home Phone: _______________ Mobile Phone: _______________

E-mail: ____________________________

Parent/Caregiver 2:

Name: ____

Relationship to child: ____________________ Legal Guardian? Yes No

Address: ____

Home Phone: _______________ Mobile Phone: ______________ E-mail _______________________________

Legal Guardian (if different from above):

Name: ____

Relationship to child: ____________________________________

Address: ____

Home Phone: _______________ Alternate Phone: ______________

E-mail Address: _______________________________

Pregnancy & Birth: Check if birth history is not known.

Was your child born on time? Yes No Number of weeks: ______

At the time of birth, how old was: Mother: _______ Father: ________

How many times has mother been pregnant before this child? _____

How many: Miscarriages? ___ Abortions? ____ Stillbirths? ____

Any problems during pregnancy? Yes No

If yes, please explain: ____

____

During pregnancy, did mother take: Prescription

medications? ____

Vitamins or supplements? ____ Drugs?

Yes No If yes, list: ____

Smoke? Yes No If yes, how many packs a day? ____________

Drink alcohol? Yes, No If yes, how much? ____

Where was baby born? ____

Was the baby born: Naturally (vaginally) C-section If C-section,

why? ____

Any problems during delivery? Yes No Apgar’s (if known)? ___1 min ___5 min

If yes, please explain: ____

How long did baby stay in the hospital? ___________ Which hospital? ________________________

Any medical problems while in the hospital? Breathing problems, Heart problems, Brain problems

Eye problems, Feeding problems, Infections, Stomach problems and Skin problems

If any problems, please explain: ____

____

Birth weight: ____________ Birth length: ____________ Head circumference: _____________

Was baby: Breastfed Bottle fed If breastfed, for how long? ______________

Your Child's Development:

When did your child first?

Motor Skills	Age/Difficulty	**Speech and Feeding**	Age/ Difficulty
Held head up		Smiled	
Sat without support		Babbled	
Crawled on the floor		Played games: Peek a boo ( ) Patti-cake ( ) Others: ( )	
Stood alone		Words/phrases	
Transferred from hand to hand		Simple sentences	
Held bottles		Baby Food	
Built blocks		Table Food	
Used spoon ( ) fork ( ) cup ( )		Drank from cup	
Did buttons ( ) tied shoes ( )		Pointed to body parts	
Toilet trained		Recognized colors	
Dry at night		Recognized Shapes	
		Recognized number	
		Recognized letters	

How old was your child when you first became worried about his/her development? ____________

What worried you at that time? ____

Did your child ever stop doing any skills that he/she had learned? Yes No

If yes, please explain: ____

How does your child communicate (Circle all that apply)?

Crying/Whining Single words Electronic devices/tablets Sign language Playful sounds Short phrases Picture communication boards Facial expressions Pointing Sentences Grabbing/Using your hand

Are you worried about your child's social or play skills? Yes No

If yes, please explain: ____

Are you worried about your child's?

Toileting? Yes, No If yes, explain: ____

Feeding? Yes, No If yes, explain: ____

Sleep? Yes, No If yes, explain: ____

Behaviors/ Personality – Please check all apply

Activity Level: () Quiet ( ) Average ( ) Overactive ( ) Hyperactive ( ) cooperative ( ) Self Confident
( ) Pays attention ( ) Follows directions ( ) Understands what is said ( ) Generally happy
( ) Frustrates easily ( ) Other: ____

How does your child interact with:

Siblings: ____

Friends: ____

Mother: ____ ____

Father: ____

Others: ____

Favorites Activities: ____
____

Dislikes: ____

Fears: ____

How do you discipline your child? ____

____

What areas of behavior are harder for you to deal with? ____

____

Does your child have difficulty separating from you? Yes ____________ No _____________

Is there anything else you would like us to know about your child? ____

____

____

Your Child's School

Please fill out all that apply:

	NOW	*PAST*	*DATES ATTENDED*	*NAME OF PLACE*	*SERVICES RECEIVED (PT,OT, speech,etc.)*
Early Intervention					
Daycare					
Preschool					
Kindergarten					

School Name: ________________________________ Grade: _____________________

Main Phone: _______________________ Fax: ___________________________

Does your child have an Individualized Education Plan (IEP)? ________

Does your child have a 504 plan? ______

Please list all services (physical Therapy, occupational therapy, speech, ABA, etc.) that your child receives.

() Physical Therapy Yes /No Frequency________________ Name: _____________________________

() Occupational Therapy Yes/ No Frequency_______________ Name: ______________________________

( ) Speech Therapy Yes/No Frequency _______________ Name: ______________________________

( ) Psychology Yes/No Frequency________________ Name: ______________________________

Please circle the number that best describes your child's current performance at school, or check "not applicable"

	NOT APPLIC-ABLE	**EXCELLENT**	**ABOVE AVERAGE**	**AVERAGE**	**SOMEWHAT OF A PROBLEM**	**PROBLEMATIC**
1.Overall school performance		1	2	3	4	5
2. Completing classroom assignments		1	2	3	4	5
3. Completing homework		1	2	3	4	5
4. Getting homework to and from school		1	2	3	4	5
5. Organizational skills		1	2	3	4	5
6. Reading		1	2	3	4	5
7. Spelling		1	2	3	4	5
8.Mathematics		1	2	3	4	5
9. Science		1	2	3	4	5
10.Written Expression		1	2	3	4	5
11. Handwriting		1	2	3	4	5

How does your child her along with other children at school?

____

____

How is your child's behavior at school?
____

Any other information that you would like us to know about how your child does at school?____
____
Has your child had any previous evaluations for concerns about development, behavior, or school?
____
____

Please include a copy of your child's most recent IEP and any reports from previous evaluations along with this paperwork.

Your Child's Medical History:

Please tell us whether you child has problems **now or in the past** with:

	YES	NO	DON'T KNOW	If yes, explain
Eyes/Vision				
Ear, Nose, Throat				
Hearing				
Stomach/Intestine/ Bowels				
Heart problems				
Heart Rhythm problems				
Lung/ Breathing problems				
Blood problems (anemia, leukemia)				
Brain/neurologic problem				
Muscle or movement problems				
Skin problems				
Thyroid problems				
Diabetes				
Other endocrines/hormones problems				
Joint or bone problems				
Kidney Problems				
Genetics or hereditary problems				
Accidents or injuries				
Mental health/emotional problems				
Learning problems (dyslexia)				
Intellectual disability/ mental retardation				
Autism Spectrum				
Attention deficit (ADHD, ADD)				

List surgeries or operations your child has had below: _____ none

Surgery type	Which hospital?	Date of surgery

Please list times your child had to stay in the hospital overnight: ____ none

Hospital Name	Why?	Dates of hospital stay

Are your child's shots up to date? ______
Has your child ever had?
MRI or CT Scan? _____ Explain ____
Genetic testing? ____ Explain ____
Hearing test by a hearing specialist? ______ Explain: _____________________________
Other procedures or medical tests? ______ Explain: _______________________________

Previous medical/therapy evaluation (Please list: type of evaluation, facility, and clinician or physician)
____
____
Previous therapy/treatment (Please list: type of evaluation, facility, and clinician or physician)
____
____
Serious Illnesses/injures/loss of consciousness (Please list dates and types)
____
____

Your Child's Medications, Supplement and Allergies:

Please list all mediation your child takes now:

Name	Brand name	Dose	How often?	Who prescribes?	Started Date	Does it help?

Please list all medications your child has taken in the past:

Name	Brand name	Dose	How often?	Who prescribes?	Started Date	Side Effect/ Did it help?

Vitamins, Herbal or Supplements.

Name	Brand name	Dose	How often?	Who prescribes?	Started Date	Side Effect/ Did it help?

If you need more room, please write on a new sheet of paper.

Please list all allergies, including your child's reaction (hives, trouble breathing, etc.), below:

Food: ____

Medicines/Drugs: ____

Environmental/Seasonal: ____

Does your child eat a special diet? ☐No ☐Yes (explain): _________________________________

____

Please tell us other information about your child's medical history that you think we should know:

____

About the Family:

What is your child's living/custody arrangement (check all that apply)? ☐Birth Mother ☐Birth Father ☐Guardianship ☐Foster Care ☐Adoptive Family ☐Other (explain):

____

If child is in foster care or in an adoptive family, how old was the child when he/she came into your home?

____

Please list everyone currently living in the child's home, including you (use separate sheet if needed):

Name (first & last)	Birthdate	How related to child?	Highest education	Job/Work

Please list any birth parents and/or siblings not living in the child's current home.

Name (first & last)	Birthdate	How related to child?	Highest education	Job/Work	Where does he/she lives?

How often does your child get to see the other family members listed above who live elsewhere?

____

Is there anything about your family's religion, traditions, culture, or practices of your family that you would like us to know?

____

____

Family Medical History

Please tell us whether any of the child's biological family members has any of the following. *Biological family members (related to the child by blood) includes mother, father, grandparents, brother, sisters, aunts, uncles and first cousin.*

Condition	*Mother Side Who? And what problem?*	*Father Side Who? And what problem?*
Autism/ Asperger's/PDD		
Developmental Delay		
Learning Problems		
Intellectual Disability (formerly mental retardation)		
ADHD and ADD		
Speech or language problems		
Tics or other movements		
Seizures/ Brain problems		
Severe emotional problems (depression, bipolar, etc.)		
Anxiety		
Schizophrenia or psychosis		
Alcohol/drug problems		
Stillbirths		
Birth defects		
Heart problems		
Heart rhythm problems		
Sudden, unexplained death		
Diabetes		
Thyroid problems		
Hearing loss/problems		
Eye problems		
Genetic/ Hereditary problems		
Other:		

Thank You!

__________________________ Signature

______________________________ Printed Name

_______________ Date completed

__________________________ Relationship to Child

Please send completed packet to:
Developmental Pediatrics Health| Wellness
420 West 23rd Street Apt AGF
New York, NY 10011
Fax: 646-343-9068
Email: Staff@drasmasadiq.com

Insurance Information

Patient name: ________________________________ Date of Birth: _____________ Age: ___________

Address: ____

Sex: _____ Social Security: _________________ Phone #: ____________________ Work # _______________________

Email Address: _____________________________________

Responsible Insurance party information:

Name: _______________________________________ Date of Birth: ________________ Sex: ___________

Address: ____

Social Security: _______________________ Relationship to Patient: _________________________________

Home #: _________________________________ Work #: ______________________ Email: _______________________

Insurance Information:

Primary Insurance: _________________________ Insurance ID #: ___________________ Group #: ________________

Insurance Company Phone #: _____________________ Insurance Address: _____________________________________

Secondary Insurance: _________________________ Insurance ID #: ___________________

Group #: _________________

Insurance Company Phone #: _____________________ Insurance Address: _____________________________________

Pharmacy Information

Name: _____________________________________ Address: ____

Telephone Number: _________________________________ Fax Number: _________________________________

Patient Name: _________________

Lab Fee

We feel that having a laboratory in the office is imperative to providing the highest level of care for your children. In order to maintain the operation of this laboratory, there will be an additional $25- $30 fee for the on-site blood draw, which is not covered by insurance. If you do not wish to pay this fee, you have the option to go to an outside lab that is approved by your insurance company.

I agree to pay the laboratory fee if I choose to have my child's blood work done in the office.

Parent's signature: ___________________________ Date: ____________________

HIPAA/ Prescription CONSENT FORM

I give Developmental Pediatrics Health/Wellness, PC my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, to view any past prescription histories, and for health care operations like quality review.

I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for the information already used or disclosed.

Parent's Signature: ___________________________________ Date: __________________

Patient Name: ________________

Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payment.

Assignment of Benefits

I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including private insurance and any other health/medical plan, to issue payment check(s) directly to ***Dr. Asma J Sadiq, Developmental Pediatrics Health/Wellness, PC*** *for medical services rendered to my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.*

Authorization to Release Information

I hereby authorize Dr. Asma J Sadiq, Developmental Pediatrics Health/Wellness, PC to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Dr. Asma J Sadiq, Developmental Pediatrics Health/Wellness, PC on behalf of my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the dare that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____________________________ ________________

Patient/Responsible Party Signature *Date*

Patient Name: ________________

Office Policy on Insurance and Payments

As a courtesy to you: our office participates with several insurance carriers. Please familiarize yourself with your insurance's practices and policies.

1. In your insurance carrier requires you to pay a portion of your healthcare visits (i.e. Copays, deductible or co-insurance), we are legally required to collect these and no exceptions will be made. You are required to pay your copay at the time of your visit.
2. If your insurance requires you to meet an annual deductible before your healthcare is covered, you will be billed for the services rendered if you have met your deductible.
3. You will be asked to leave a credit card number at the time of check in. This information will be held securely until your insurance have paid their portion and notifies us of your share. At that time any remaining balances owed by you will be charged to your credit card, and a copy of the charge will be mailed to you. Please note that this will not compromise your ability to dispute a charge or your insurance company's determination of payment.
4. If yours require an insurance referral from the insurance company issue by your provider, you will need to obtain the insurance referral before appointment.
5. **If your child cannot make the schedule appointment time, you must notify the office 24 hours prior to the scheduled appointment. If we are not notified 24 hours prior to the appointment, there will be a $75.00 cancellation fee per child.**
6. **$150.00 cancellation/no-show for Initial Consultation and $75.00 cancellation/no-show for follow-up,** if cancelled same day or less than 24 hours' notice.
7. **If your child cannot make the scheduled weight management appointment with Dr. Asma Sadiq, you must notify the office 48 hours prior to the scheduled appointment. If we are not notified 48 hours prior to the appointment, there will a $150.00 cancellation fee per child/per appointment.**
8. Any forms that need to be fill out, an appointment is needed with a form fee of **$50.00.**
9. Phone/web consult fee for follow-up appointment fees: (**under 10 mins): $ 75.00, (11 mins to 20 mins) $150.00, (30 mins to 45 mins) $275.00 and 1 hour (per hour) $550.00.**
10. **Additional fee will be listed at the front desk.**

I, ____________________________ (print name) authorize Developmental Pediatrics Health | Wellness, LLC to charge outstanding balances/cancellation and no-show fees to the following credit card:

	Account Number	**Expiration Date**	**3-digit code(V-Code)**
American Express			
Master Card			
Visa			
Discover			

Email: ___________________________

Name on Card: ___________________________

____
Signature