

Coker Pediatrics, LLC

Patient Information Update

Patient Information

Child's Name _____ Male Female
(First) (Middle) (Last)

Name preferred _____ Child's DOB _____

Child's Street Address _____

Child's Mailing Address _____

City _____ State _____ Zip _____ Home # _____

Ethnic group (please select one): Hispanic/Latino Non Hispanic/Latino

Race (please select one or more of the following racial categories):

American Indian or Alaska Native Asian African American

Native Hawaiian or Pacific Islander Caucasian Other

Preferred Language: _____

With whom does child live with? Mom and Dad Mom Dad Other

Who has legal custody? Mom and Dad Mom Dad Other

Who is responsible party? Mom and Dad Mom Dad Other

List all household members and their relationship to patient:

Emergency Contact & Relationship (Someone Not in Home)

1. Name _____ Phone # _____

2. Name _____ Phone # _____

Pharmacy Information

Our office prefers to fax medications to the pharmacy. Please list your preferred pharmacy. If you prefer the prescription to be hand written so that you can take it to the pharmacy of your choice, please inform our staff.

Preferred Pharmacy _____

Mother/Guardian Information

Name _____ Maiden Name _____
Address (if different than patient's) _____
Phone # _____ Cell # _____ Work # _____
Employer _____ Employer Address _____
DOB _____ SS # _____
Relationship to patient _____

Father/Guardian Information

Name _____
Address (if different than patient's) _____
Phone # _____ Cell # _____ Work # _____
Employer _____ Employer Address _____
DOB _____ SS # _____
Relationship to patient _____

Insurance Information (Please give card to receptionist)

Insurance Company name _____ Co-pay amount \$ _____
Policy/ID _____ Group # _____
Policy holder's full name _____ DOB _____
Policy holder's relationship to patient: _____ Effective date _____

I understand that payment of all medical care is ***due at the time of service***. In case of divorced parents, responsibility and payment shall be ***that of the guardian bringing the child in for treatment***. I understand that it is my responsibility to pay any deductible, co-insurance, or any other balance not paid by my insurance company. I understand that I am responsible for any costs incurred in the collection of patients account in case of default, including reasonable attorney fees and court costs.

I understand that insurance companies have agreements with certain laboratories for lab work and that it is my responsibility to know which laboratory my Insurance authorizes and to inform the staff of Coker Pediatrics, LLC as to which laboratory my insurance covers.

I hereby grant permission to Coker Pediatrics to release any pertinent information to my insurance company upon request, and I also assign and authorize payment directly to Coker Pediatrics. A photo static copy of this authorization shall be considered as effective and valid as the original.

Signature: _____ Date: _____

Has your child been to the Emergency room in the past year? Yes No

If yes, where? _____

When? _____

For what reason? _____

Has your child been hospitalized in the past year? Yes No

If yes, where? _____

When? _____

For what reason? _____

Has your child had any surgeries in the past year? Yes No

If yes, what type? _____

When? _____

For what reason? _____

Has your child seen any specialists or therapists (including mental health providers) in the past year? Yes No

If yes, who? _____

If yes, when? _____

For what reason? _____

Has your child had any lab work obtained or x-ray performed in the past year? Yes No

What was performed? _____

Have you had any concerns about your child's development within the past year? Yes No

If yes, please explain:

Have there been any changes in your child's family in the past year, such as a death in the family, separation, divorce or new member in the family (sibling, step sibling). Yes No

If yes, please explain _____

Are there any other changes that have happened in your child's life in the past year that we should know about?

Yes No

If yes, please explain _____

Our goal is to provide you with the best health care and service possible. In an effort to better meet your needs and expectations, we ask that you take a few minutes to fill out this patient satisfaction survey, which allows you to rate different aspects of your visit.

	Poor	Fair	Good	Very Good	Excellent	Does Not Apply
HOW EASY WAS IT TO MAKE AN APPOINTMENT AND GET IN TO SEE YOUR PROVIDER?						
1. When I called the office for my child's appointment, the length of time spent on the phone to set up my appointment was	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. The number of days between my call and my child's actual appointment was	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. The staff's helpfulness in scheduling my child's appointment was	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
FACILITY AND CONVENIENCE						
4. Transportation, parking, and entry to the building were	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Neatness, cleanliness, and general appearance of the office were	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. The convenience of office hours was	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. The length of time, if any, that I had to wait past my child's appointment time before seeing my practitioner was	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
STAFF INTERPERSONAL SKILLS						
8. The staff's promptness and efficiency were	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. The staff's effort to explain the reason for any delay was	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. The staff's help with scheduling any follow-up visits, referrals, or tests was	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. The staff's explanation of billing and payment/insurance issues was	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

STAFF CLINICAL SKILLS						
12. The nurse/medical assistant's skill and care (e.g., in taking my child's blood sample, medical information, weight, temperature, administering shots) was	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
PRACTITIONER CLINICAL SKILLS						
13. The practitioner's apparent understanding of the reason for my child's visit was	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. The practitioner's interest in my child's overall health was	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. The practitioner's overall skill and thoroughness in examining or evaluating my child were	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

PRACTITIONER INTERPERSONAL SKILLS	Poor	Fair	Good	Very Good	Excellent	Does not apply
16. The practitioner's explanations of my evaluation and diagnosis and treatment options were	0	0	0	0	0	0
17. The practitioner's encouragement for me to ask questions and his or her responses to them were	0	0	0	0	0	0
18. The explanation of when and how I would hear about my test results was	0	0	0	0	0	0
19. The practitioner's instruction (oral/written) about any prescription drugs was	0	0	0	0	0	0
20. The practitioner's reassurance about my diagnosis and treatment was	0	0	0	0	0	0
21. The practitioner's encouragement to call with problems or questions was	0	0	0	0	0	0
22. The length of time my practitioner spent with me was	0	0	0	0	0	0
YOUR OVERALL SATISFACTION						
23. My overall satisfaction with the quality of care I received during the visit is	0	0	0	0	0	0
24. My willingness to recommend this practitioner and practice to a close friend or family member is	0	0	0	0	0	0
HEALTH AND STATUS						
25. The primary reason for my visit today was						
<input type="radio"/> A well child check up and immunizations						
<input type="radio"/> A sports physical						
<input type="radio"/> A sick/problem visit						
<input type="radio"/> A regular follow-up chronic illness visit (e.g., asthma, diabetes)						

Any other comments?

Thank you for your assistance!