Pediatric Associates of Williamsburg

A practice of CHKD Health System

119 Bulifants Boulevard, Williamsburg, VA 23188
Phone: 757-564-7337 Fax: 757-564-3205

New Patient Information (Nueva información del paciente):

Patient Name (Nombre del Paciente): ____

Sex (Sexo): F________ M________ Birth Date (Fecha de Nacimiento): _________________________________

Mailing Address (Direccion Postal): ____

City, State (Ciudad, Estado):__________________________________ Zip (CodigoPostal)___________________

Primary Phone (Numrero de telefono primario): _______________________________________

E-mail: ____

Last 4 digits of your SSN for patient portal: _____________________

Pharmacy Preference: ____

Parents Names and Phone Numbers (Nombres de Padres y numero de telefono):

Mom (Madre) -____

Dad (Padre) - ____

Other (Otro): ____

Ethnicity (Etnicidad):

___ African American (Africano Americano)	___ Asian/Pacific Islander (Asiatico/Isleno Pacifico)	___ Hispanic /Latin (Hispano/Latino)	___ Multi-Racial (Multiples razas)
___ American Indian/Eskimo (Indio Americano/Eskimo)	___ Caucasian (Caucasico)	___ Indian/ M.E (Indio/del Medio Oriente	___ Unknown (Desconocido)

Responsible Party Information (Informacion de la Persona Encargada/Responsable):

Responsible Party Name (Nombre de la persona encargada)____

DOB (Fecha de Nacimiento)_______________ Social Security #(Seguro Social):__________________________

Cell Phone (Numero de telefono Cellular) ____

Address (Direccion)____

Primary Insurance:

Subscribers Name & Address (Nombre del suscriptor y Direccion): _____________________________________

____

Subscriber DOB (Fecha de Nacimiento del suscriptor)______________________________

Insurance Company (Compania de la Aseguranza) ____

Subscriber # (Numero del Suscriptor)____

Group# (Numero de Grupo)____________________________ Plan #: __________________________________

Relationship to Subscriber (relacion al suscriptor): ________ Self (mismo) ________ Spouse (esposo/a)
________ Child (hijo/a) _______ Other (otro)

Do you have a secondary insurance? ____

Pediatric Associates of Williamsburg-Family Information

Child's name (Nombre del paciente)_____________________________________ DOB: ___________________

Is this child taking medication now? (Este nino esta tomando algun medicamento actualmente)
Yes (Si)___ No___
Has this child been on long term medication in the past? (En el pasado, este nino ha tomado medicamentos por un period de teimpo largo?) Yes (Si)___ No___
Please list all long term meds (Por favor escriba todos los medicamentos que su nino ha tomado por mucho tiempo):____
Does this child have any medication allergies (Este nino es alergico a algun medicamento?) Yes (Si) ___ No___
Please list all medication allergies (por favor escriba los medicamentos que le ocasionan alergia a su nino)
____

Family Medical History (Historial Medico familiar):
Do any relatives (Parents, brothers, sisters or grandparents have? (Tiene algun pariente (padres, hermanos, hermanas o abuelos) alguna de las condiciones o enfermedades en la siguiente lista?) ***Please specify which Grandparent/Por favor especifique qué abuelo

	Parents (Padres)	Brothers (Hermanos)	Sisters (Hermanas)	Grandparents (Abuelos-Madre)***	Grandparents (Abuelos-Padre)***
Birth Defects (Defectos de nacimiento)					
Seizures (Convulsiones)					
Autism (Autismo)					
Mental Retardation (Retraso Mental)					
Allergies (Allergias)					
Asthma (Asma)					
Attention deficit (Deficit de atencion)					
Vision problems (Problemas con la vista)					
Cancer (Cancer)					
Diabetes (Diabetes)					
Hearing Problems (Problemas escuchando)					
Stroke (infarto)					
High blood pressure (Presion alta)					
High cholesterol (Colesterol alto)					
Heart disease before age 55 (Enfermedad del Corazon antes de la edad de los 55 anos)					

Has this child had any chronic medical problems (Este paciente ha tenido algun problema medico cronico) Yes (Si)__ No ___ If Yes please explain (Si la respuesta a la pregunta anterior es si, por favor explique)
____
Has this child been hospitalized? (Este paciente ha sido hospitalizado anteriomente) Yes (Si)___No___
If Yes, please explain (Si la respuesta a la pregunta anterior es si, por favor explique)
____
Has this child had any surgery? (Este paciente ha tenido alguna cirugia?) Yes (Si)___ No___
If Yes please explain (Si la respuesta a la pregunta anterior es si, por favor explique)
____

Children's Hospital of The King's Daughters
Medical Group

Pediatric Associates of Williamsburg

Main Office 757-564-7337 Fax 757-564-3205
Phone hours of Operation Monday thru Friday 7:30 am to 4:30 pm Saturday 8:00am to 11:30 am

We strive to provide excellent service to all of our families. To assist in this process we have put the following policies in place to help meet your needs.

Medication Refills: Medication Refill Line: 757-564-7337 Option 3

- Patients receiving routine/maintenance medications to manage chronic conditions must have a re-check appointment every six months.
- We need 48 hrs. to process a medication refill request. Please plan ahead and request your refill when you have a one week supply of medication left.
- A request for medication refills during a sick visit cannot be a substitute for a medication re-checks appointment. As explained above, chronic conditions must have a re-check appointment every six months. (Asthma, Allergy, ADHD & Birth Control)
- When requesting a medication refill please utilize our medication refill line (757-564-7337 option 3) and please leave the following information:
    - State your child's name and spelling of the first and last name with their date of birth
    - State the parent's name and phone number to be reached if we have any questions
    - State the pharmacy name and number you want your prescription to go to
    - State the medication name, dosage, schedule and how many refills you would like.
    - Please note your request will be complete in 48hrs and to check with your pharmacy. We will not call you unless we have questions.
- **ADHD Medications and Narcotics/Controlled Medications** cannot be called into the pharmacy due to Federal/State prescribing laws/regulations. These prescriptions must be picked up by a parent/guardian with a picture ID (or other authorized individual as documented in the patients' medical record). Picture ID is required at the time of each pickup. Prior Authorizations may take up to 1 week to process.

Appointment Cancellations, No-Shows and Late Arrivals: To make/change or cancel an appointment 757-564-7337 option 2

- Please note that all appointment cancellations should be done during regular office hours and at least 24 hrs. In advance.
- If you miss your appointment and have not called with in the 24 hr. time frame you will be charged a $25.00 fee. Chronic No-Shows can be cause for dismissal from our practice.
- If you arrive to your appointment 15 mins or more after the scheduled appointment time you will be rescheduled to the next available appointment.

Form Completion and Medical Records: 757-564-7337 option 4 then 1

- Any forms that need to be completed on our behalf for your children (i.e. sports, camp, summer activities, and college or school entrance) you will need to allow 72 hrs. for these forms to be completed. We cannot complete these forms if your child has not obtained a physical in the last 12 months.
- All medical record request will be processed in the order received and will be ready within 72 hrs. You can request medical records on line at www.chkd.org/paw

Have you signed up for the CHKD Patient Portal? All of your request can be handled online and you have access to your child's Medical Record. Please ask the front desk to assist you in signing up today!!!!

Please note that our office policy for form(s) completion is 72 hrs. from the time your drop it off.

Form(s) dropped off on:	Form(s) to be picked UP between 1:30 and 4:30pm:
Monday	Thursday
Tuesday	Friday
Wednesday	Monday
Thursday	Tuesday
Friday	Wednesday
Saturday	Thursday

Medication refills will be completed within 48 hrs. of your request.

Medication Refill Line (757) 564-7337 option 3

Medication Refill Request placed on:	Check with your Pharmacy or pick-up in office after 3:00 pm:
Monday	Wednesday
Tuesday	Thursday
Wednesday	Friday
Thursday	Monday
Friday	Tuesday
Saturday	Wednesday

Thank you
Pediatric Associates of Williamsburg