UNIONVILLE PEDIATRICS

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P.O.BOX 221
Unionville, Connecticut
06085
Telephone: (860) 673-6124
Fax: (860) 673-3290

Patient Information

(Please fill out completely. Please print neatly.)

Patient's Full Name: ______________________ Date of Birth: ____________ Sex: ___
Address: ____
Home Phone: ____________________ Cell Phone: ____________________

Father's Full Name: ______________________ Date of Birth: ____________
Address (if different from above): ______________________________
Employer's Name & Town, State: ______________________________
Home Phone: ____________ Cell Phone: ____________ Work Phone: ____________
Email Address: ____
Mother's Full Name: ______________________ Date of Birth: ____________
Address (if different from above): ______________________________
Employer's Name & Town, State: ______________________________
Home Phone: ____________ Cell Phone: ____________ Work Phone: ____________
Email Address: ____

Preferred Pharmacy: ____

Insurance Information

PRIMARY INSURANCE: ______________________________
ID#: ____________________ Group #: ____________________
Subscriber's Name: ______________________ Relationship: ____________
Address of Subscriber: ____
Home Phone: ____________ Cell Phone: ____________ SSN: ____________ DOB: ________

SECONDARY INSURANCE: ______________________________
ID#: ____________________ Group #: ____________________
Subscriber's Name: ______________________ Relationship: ____________
Address of Subscriber: ____
Home Phone: ____________ Cell Phone: ____________ SSN: ____________ DOB: ________

EMERGENCY CONTACT:
Full Name: ______________________________ Phone: ____________________

Signature of Parent of Legal Guardian: ____________________Date: ____________________

Person Responsible for Payment: ____________________Date: ____________________

Release of Information:

I authorize my physician, health care provider and their representatives to release any information pertaining to an illness, injury, diagnosis, care or treatment to my insurance company, health plan, Medicare, Medicaid, or third party payor or their agents, contractors, subcontractors or affiliates, provided they agree such information is kept confidential.

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Acknowledgment of Receipt: Notice of Privacy Practices

This document is to be signed by a legally responsible person for the patient's medical decisions relative to the treatment situation.

Patient's Name: ________________________________ **Patient's Date of Birth:** ____________

I, ________________________________, hereby acknowledge that Unionville Pediatrics has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me/my child may be used and disclosed, and how I can access this information. I understand that if I have any questions or complaints, I may contact: Unionville Pediatrics
(860) 673-6124

I also understand that I am entitled to receive updates upon request if Unionville Pediatrics amends or changes its Notice of Privacy Practices in a material way.

____
Signature

____
Relationship to Patient, if signed by someone other than the patient

____
Date

THIS SECTION IS TO BE COMPLETED BY Unionville Pediatrics IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgment of receipt of Notice of Privacy Practices from the above named patient, but was unable to because:

( ) Patient declined to sign this written acknowledgment

( ) Other (specify): ____

____
Name and Title of Employer

____
Date

CONNECTICUT VACCINE PROGRAM (CVP)

Patient Eligibility Screening Record

Child's Name:______________________________

Date of Birth:______________________________

Parent/Guardian:______________________________

Provider: UNIONVILLE PEDIATRICS

This child qualifies for immunization through the Connecticut Vaccine Program since he/she is under 19 years of age and (check only one box):

VFC eligible:

(A) Is enrolled in Medicaid (HUSKY A) ☐

(B) Has no health insurance/self-pay ☐

(C) Is American Indian or Alaskan Native ☐

(D) Is under-insured (has health insurance that does not cover vaccines or only covers select vaccines) and is a patient of a Federally Qualified Health Center (FQHC). These patients can receive all vaccines at their FQHC. ☐

State eligible:

(E) Is under-insured (has health insurance that does not cover vaccines or only covers select vaccines) and is a patient of a private health care provider. These patients can receive all vaccines at their private health care provider's office. ☐

(F) Is enrolled in S-CHIP (HUSKY B) ☐

(G) *Is Privately Insured ☐

*Note private insurance patients can receive all vaccines from the CVP except for Rotavirus, Human Papillomavirus Vaccine (HPV), Influenza for 5 through 18 year olds, Hepatitis A for 2 through 18 year olds and Meningococcal Group B vaccines; these vaccines are only available for patients in categories A, B, C, D, E & F.

A record must be kept in the healthcare provider's office (paper copy or in an EHR/EMR) that reflects the status of all children 18 years of age and younger who receive vaccine from the CVP.

Patient Eligibility must be verified and documented for **every immunization visit**. Please document that eligibility screening was verified with the initials of the person who performed the screening. If the screening result above (A-G) changed, please complete a new patient eligibility screening record.

Date of screening (mo/day/year)	Initials

Date of screening (mo/day/year)	Initials