Commit to Change

with Dr. Renee B Bonin & Associates
200 Beaullieu Dr. Bldg 9B-1
Lafayette, LA 70508
Phone: 337-504-3483
Fax: 337-504-3573

Please be advised:

Initial appointments must be kept in order to further services.

If you are unable to come to the scheduled appointment, please call the office at least 24 hours in advance.

Thank you!

Commit to Change

with Dr. Renee B Bonin & Associates

Patient Information

Please print

Today's Date: ____________________

Patient's Full Name: __________________________________ Birthdate: _________

Home Address: ____

City: __________________________ State: ________ Zip: ________________

Mother's Name: ___________________________________ Birthdate: ___________

Father's Name: ____________________________________ Birthdate: ___________

Best Phone Number: ___________________ **O** Home **O** Cell **O** Work

Alt Phone Number: ___________________ **O** Home **O** Cell **O** Work **O** Other: ______

E-mail: ____________________________________

Appointment Reminders will be sent via e-mail, 48 hours before scheduled appointment.

Who do we e-mail for appointments? Please list names, relation, & information:

____

____

SSN for Parent (s)/Guardian(s): ____

Patient Gender: __Male __Female Religion: _____________________________

Race(s)/Ethnicity: ____

Native American: ___Yes ___No *If yes, tribe affiliation: _____________________

Primary Care Physician: ________________________

Phone: __________________ *Fax:* ____________________

Pharmacy: ________________________

Phone: __________________ *Fax:* ____________________

Emergency Contact Name: ______________________Phone: ______________

Reason for appointment: ____

Referred by: _________________________________

Insurance Information

Primary Insurance: ___________________________ Member ID#: ______________

Policy Holder: _____________________________ Birthdate: ___________________

SSN: _________________________ Company Phone #: ______________________

Secondary Insurance: ________________________ Member ID#: _______________

Policy Holder: ____________________________ Birthdate: ____________________

SSN: __________________________ Company Phone #: _____________________

Guarantor:

Name: __________________________ Birthdate: ___________________

Address: ____

City: ________________ State: __ Zip: __________ Relation: _______________

Phone Number: ______________________ SSN: _____________________

Billing Information

All professional services rendered are the responsibility of the patient/guarantor. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. If it is necessary to turn this service over to collection for non-payment after 60 days, then the patient must pay all fees to collection agency.

AUTHORIZATION TO PAY BENEFITS TO PROVIDER:
I hereby authorize payment directly to the undersigned Provider for my charges.

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize the undersigned Provider to release any information acquired in the course of my treatment to my insurance company in writing or by fax.

Parent/Guarantor Signature: ______________________ Date: ______________

Patient History

Please fill out this form to the best of your knowledge. If some questions are not applicable to you or your child, write N/A. If you need more space or wish to make additional comments, please write on the back or attach a separate page.

Form Completed by: ___________________________ Relation to child: ____________

Best Phone number: ______________________________ **O** Home **O** Cell **O** Work

Address: ____

City: ___________________________ State:_________ Zip Code: _________________

Current Medications		
Name of Drug	Dose (Strength & # per day)	Prescriber
1.		
2.		
3.		
4.		
5.		

Will child continue to get their medication prescribed by current provider?

___ Yes ___ No

If not, are you looking for a different provider? Please explain:

____

____

Drug Allergies: __No __Yes to:____

Extended Family and Caregivers					
Name	Relation	Age	Gender	Highest Grade	Living in Household?
					Yes No
					Yes No
					Yes No
					Yes No
					Yes No

Personal History

- Why are you seeking help for your child? ___________________________________
  ____
  ____
- What kind of services are you seeking for your child? __________________________
  ____
- Services/Interventions sought previously:
  - Medical Evaluation
  - Medication
  - School Modification
  - Neuropsychological Assessment
  - Neurological Exam
  - Psychological Counseling/Therapy
  - Educational Testing
  - Speech language Service
  - Occupation/Physical Therapy
  - Psychiatric Exam
  - Special Education
  - Tutoring
  - Other (Specify):____
- **Medical and Developmental History:**
  - Prenatal History:
    Please answer which of the following conditions may have occurred during this pregnancy and explain (month, amount, treatment) in the space below:
    - ☐ Edema (swelling of the hands and feet)
    - ☐ Vaginal Bleeding
    - ☐ Toxemia
    - ☐ Emotional Stress
    - ☐ High Blood Pressure
    - ☐ Infections (colds, flu, urinary tract)
    - ☐ Injuries
    - ☐ Preterm Labor
    - ☐ Smoked Cigarettes
    - ☐ Abnormal weight gain
    - ☐ Fever
    - ☐ Accidents
    - ☐ Medications Used
    - ☐ Forceps used
    - ☐ Breech Position
    - ☐ Induced Labor
    - ☐ Caesarean Delivery
    - ☐ Alcohol Used
    - ☐ Breathing Difficulties
    - ☐ Other (specify): ____
  - Birth History:
    - ☐ Place (City or county, and state): ______________________________
    - ☐ Hours of Labor: _____________________________
    - ☐ Was the baby on time? _yes   no
      - If no, was he/she: Early   Late
        - By how many weeks?_____________

- Child's Post Delivery Period:
  Check which of the following problems may have occurred after the child's birth and explain the treatment in the space below.
  - ☐ Trouble Breathing
  - ☐ Cord Around the neck
  - ☐ Required a blood transfusion
  - ☐ Hemorrhage (bleeding) in head.
  - ☐ Hydrocephalus (water on the brain)
  - ☐ Need for ventilation
  - ☐ Jaundice
  - ☐ Poor Feeding
  - ☐ Vomiting
  - ☐ Floppy Muscle Tone
  - ☐ Incubator Care
  - ☐ Infection
  - ☐ Fever
  - ☐ Cyanosis (Turned blue)
  - ☐ Number of day's infant was hospitalized after delivery: ____________
- Infancy:
  Were any of the following present in your baby to a significant degree during the first few years of life? If so, please describe:
  - ☐ Did not enjoy cuddling
  - ☐ Difficult to comfort
  - ☐ Excessive irritability
  - ☐ Difficult feeding
  - ☐ Extremely Passive
  - ☐ Was not calmed by being held or stroked
  - ☐ Excessive Restlessness
  - ☐ Frequent head banging
  - ☐ Sleeping Difficulties
- Developmental Milestones:
  Please list the age at which your child accomplished the following developmental milestones. If you feel the milestone is not appropriate yet for the age of your child, please write N/A.
  - ☐ Crawl Independently: _________________________
  - ☐ Walk Independently: ___________________________
  - ☐ Put two words together: _________________________
  - ☐ Put 4 to 5 sentences together to relate an experience: _____________
  - ☐ Knew primary colors: __________________________
  - ☐ Say the letters of the alphabet: ____________________
  - ☐ Print first and last name: __________________________
  - ☐ Tie shoes: __________________________
  - ☐ Snap, zip, button clothing: ____________________
  - ☐ Began to read: ________________________
  - ☐ Toilet trained: ________________________
- Health History:
  - ☐ When was your child's last physical exam? Date: _________________
    Where? :____
  - ☐ Does your child have any:
    - Vision Problems? Yes No Date of last vision exam: ________
    - Hearing Problems? Yes No Date of last hearing exam: _______

- Please check which of the following your child has had and note age, complications, and frequency below:
  - ______ Hospitalizations: ________________________________
    ____
    ____
  - ______ Surgery: ______________________________________
    ____
  - ______ Trauma (Stitches/ Broken Bones):__________________
    ____
    ____
  - ______ Head Trauma: __________________________________
  - ______ Loss of Consciousness: ___________________________
  - ______ Coma: ____
  - ______ Seizures: ______________________________________
  - ______ Tics: ____
  - ______ Staring Spells: __________________________________
  - ______ Tremor: _______________________________________
  - ______ Poor Muscle Tone: ______________________________
  - ______ Falls Frequently: ________________________________
  - ______ Anemia: _______________________________________
  - ______ Persistent High Fever: ___________________________
  - ______ Headaches: _____________________________________
  - ______ Vision Problems: ________________________________
  - ______ Hearing Problems: _______________________________
  - ______ Asthma: _______________________________________
  - ______ Allergies: ______________________________________
  - ______ Stomach Aches: _________________________________
  - ______ Excessive Vomiting: ______________________________
  - ______ Pica (eating non-food items): _____________________
  - ______ Sleep Problems: _________________________________
  - ______ Bed wetting: ____________________________________
  - ______ Stool Soiling: ___________________________________
  - ______ Bowel Problems: _________________________________
  - ______ Ear Infections (how many?): _______________________
  - ______ Other Infections: ________________________________
  - ______ Accidental Poisoning: ____________________________
- Any other medical problems: _________________________________
  ____
  ____

- Family History:
  - Child currently lives with: (please check all that apply)
    - ☐ Natural Mother
    - ☐ Natural Father
    - ☐ Stepmother
    - ☐ Stepfather
    - ☐ Adoptive Mother
    - ☐ Adoptive Father
    - ☐ Foster Mother
    - ☐ Foster Father
    - ☐ Grandmother
    - ☐ Grandfather
    - ☐ Other (Specify): ___________________________________
  - **Mother's History**
    - ☐ Mother's name: ____
      First *Middle* *Last*
    - ☐ Home Phone: ____________________ Cell Phone: _______________
    - ☐ Address: ____
      City: ________________________ State: _____ Zip: ______
    - ☐ Place of Employment: _________________________________
      Occupation: ____
      Work Phone: __________________________
    - ☐ School History: Highest grade completed: _________________
      Learning problems? Yes No Attention Problems? Yes No
    - ☐ Does mother have any medical problems? Yes No
      If yes, please describe: _____________________________________
    - ☐ Are there problems similar to those of your child on the maternal side of the family? Yes No
      If yes, please describe: _____________________________________
  - **Father's History**
    - ☐ Father's name: ____
      First *Middle* *Last*
    - ☐ Home Phone: ____________________ Cell Phone: ________________
    - ☐ Address: ____
      City: ________________________ State: _____ Zip: ______
    - ☐ Place of Employment: _________________________________
      Occupation: ____
      Work Phone: __________________________
    - ☐ School History: Highest grade completed: _________________
      Learning problems? Yes No Attention Problems? Yes No
    - ☐ Does father have any medical problems? Yes No
      If yes, please describe: _____________________________________
    - ☐ Are there problems similar to those of your child on the paternal side of the family? Yes No
      If yes, please describe: _____________________________________

- History of Family Stressors or Transitions:
  *Please check all that apply for the past **12** months.*
  - ☐ Family moved
  - ☐ Death in the family/loss
  - ☐ Changed school
  - ☐ Parent changed job
  - ☐ Family financial problems
  - ☐ Repeat a grade
  - ☐ Parental separations and/or divorce
  - ☐ Family accident or illness
  - ☐ History of abuse
  - ☐ Conflict in family
  - ☐ New baby at home
  - ☐ Other (Specify) : ____
    ____
- Family Psychiatric History:
  Has anyone in child's family been diagnosed with or treated for: (please state relation)
  - ☐ Bipolar Disorder: ____
  - ☐ Post-Traumatic Stress: ____________________________________
  - ☐ Schizophrenia: ____
  - ☐ Alcohol Abuse: ____
  - ☐ Depression: ____
  - ☐ Anxiety: ____
  - ☐ Violence: ____
  - ☐ Anger: ____
  - ☐ Suicide: ____
  - ☐ Other Substance Abuse: ___________________________________

- **Educational History**
  - School Experience:
    If your child does not yet attend school, write N/A on the marked "Name of Child's School" and move down to the section marked "Home Life."
    - ☐ Did your child attend preschool? Yes No
      If yes, at what age? ____________
      - Name of Preschool: __________________________________
      - Were you concerned about your child's ability to succeed in preschool? Yes No
    - ☐ Name of child's current school: ______________________________
      - School District: ______________________________________
      - Grade: __________________
      - Teacher: __________________
      - Phone:__________________

- Present class placement:
  - ___ Regular Class
  - ___ ESL
  - ___Bilingual
  - ___ Special Class (specify): ________________________
- Has testing been completed by school? Yes No

  If yes, Date: ________________
- Is your child absent from school? Often Seldom Never
  - Usual reason for absence? ________________________________
- Has your child ever been retrained? Yes No
  - If yes, what grade? ______________

    Why? ____
- At what level do you feel your child is functioning, compared to other children their age? ____
- Has your child ever been:
  - ___ Suspended from school Number of Suspensions: _____
  - ___ Expelled from School Number of Expulsions: ______

- **Home Life**
  - What are the child's favorite activities? _________________________________
  - Is your child assigned regular chores to complete? _______________________
  - How often must you discipline your child & for what? ____________________
  - What forms of discipline are used? _____________________________________
  - Describe your child's typical mood: ___________________________________
  - Most of the time, are your child's interactions with other kids:
    - Poor
    - Fair
    - Great
  - Does your child play with other kids?
    - Never
    - Seldom
    - Sometimes
    - Always
  - Does your child get along best with:
    - Older
    - Same Age
    - Younger children

Other information:

Please list any other information you would like the provider to have that was not addressed in this information: ____

____

____

____

____

No Show/Late Cancellation Appointments

Appointments must be cancelled or rescheduled at least 24 hours in advance, or a **$50 fee** will be charged to the patient/guarantor. *Payments not made within 48 hours, any future appointments will be cancelled.* We will call twice after late cancelled/no show appointments.

Patient/guarantor must call the office within a week during our office hours (Mon-Thurs 8-5) and speak to either an office assistant or office manager. If no called is made back to our office, within the week, we will send the bill to collections.

Appointments are booked for an entire hour, unless for medication only, and we do not double book.

Please sign, acknowledging that you have read and will pay the fee, if necessary.

Parent/Guarantor Printed Name: ____

Parent/ Guarantor Signature: _____________________________________ **Date:** _____________

HIPAA Signature Compliance

Your signature below acknowledges that you understand and agree to the office policies outlined in the three page document for Dr. Bonin and that you have been given a copy of the HIPAA policies (located in office binder). If you would like your own copy for your records, please ask receptionist.

Parent/Guardian Printed Name: ____

Parent/Guardian Signature: ____ **Date:** ___________