MILTON
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## *Attention Parents of Newborn Patients*

*Please make sure to add your newborn baby to your insurance policy immediately, if you have not already done so. Also, please make sure the baby's effective coverage begins on their date of birth. If your plan requires you to select a Primary Care Physician (PCP), please select the physician that you see at this office and make sure that this is effective as of their date of birth as well.*

*Please be aware that if the baby is not added to your plan correctly, we will not be able to bill claims to your insurance company. Therefore, payment will become the responsibility of the patient. We appreciate your prompt attention to this matter. Please feel free to contact our office if you have any questions, 781-356-6200.*

*Thank you,*

I have read the information above and fully understand that it is my responsibility to make sure that my newborn is properly added to my insurance plan. I also understand that I will be responsible to make payment to Milton Pediatric Associates if any claims are denied because the above conditions are not met.

Parent/Guardian Signature Date

340 Wood Road, Suite 301 Braintree, MA 02184 Phone: 781-356-6200 Fax: 781-356-6299 miltonpediatrics.com

**PATIENT INFORMATION**

Siblings (Last Name, First Name) Sex Birth Date

1.

2.

3.

4.

5.

Home Address:

_____

_____

_____

Primary Contact Phone Number and Name (This number will be used to confirm appointments): _____

Secondary Contact Phone Number and Name: _____

Email Address: _____

Parent #1 Full Name: _____

Parent #2 Full Name: _____

Name of Medical Insurance: _____

ID Number: _____

Name of person who carries insurance: _____

Hospital of Birth: _____

Emergency Contact (other than parent):

Name and Relationship: _____

Contact Number: _____

## ACKNOWLEDGEMENT

My signature below indicates that I have been provided with a copy of Milton Pediatric Associates' Notice of Privacy Practices.

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Signature of Patient or Legal Guardian Date

If I signed by Legal Representative, relationship to patient is: _____

Effective Date: _____

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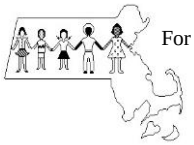
## For Office Use Only

Patient/parent given a copy of Milton Pediatric Associates' Notice of Privacy Practices.

However:

Notice given to patient/parent but signature not obtained.

***This form is to be filed in the patient/family medical record***



For Healthier Lives **MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH**
**IMMUNIZATION PROGRAM**
**VACCINES FOR CHILDREN PROGRAM (VFC)**

# Patient Eligibility Screening Form

For use in all Provider Sites, except Federally Qualified Community Health Centers

## Initial screening

Initial screening date _____ Child's date of birth_____

Child's full name_____

Parent, guardian or legal representatives full name _____

Health care provider's full name _____

## Check only one box below:

**This child is eligible for immunizations through the federal VFC program because he/she*:**

- ❑ is enrolled in Medicaid (includes MassHealth and HMOs, etc., if enrolled in Medicaid)
- ❑ does not have health insurance
- ❑ is American Indian (Native American) or Alaska Native

**This child is not VFC-eligible because he/she:** ❑ has health insurance (that covers all recommended childhood and adolescent vaccinations) and is not American Indian (Native American) or Alaska Native

**This form must be completed for all children under 19 years old at their initial visit, updated every time a vaccine is given and kept in the child's medical record or on file in the office.**

**The form may be completed by the parent, guardian, or legal representative, or by the health care provider.**

**Verification of responses is <u>not</u> required.**

*This form identifies which children are eligible for vaccines through the federal Vaccines for Children (VFC) program. If one of the first three boxes in the section above is checked, the child is VFC eligible.

## Screening at each subsequent visit (documentation required)

| | **VFC Eligible** | | | **Not VFC Eligible** |
|---|---|---|---|---|
| Date | Is enrolled in Medicaid (includes MassHealth and HMOs, etc., if enrolled through Medicaid) | Does not have health insurance | Is American Indian (Native American) or Alaska Native | Has health insurance |
| | | | | |
| | | | | |
| | | | | |
| [Type text] | | | | |