northside pediatrics

Please return the completed **New Patient Application** and **Vaccine Policy** with the following information:

- **copy of the parent's or guardian's photo ID**
- **copy of the parent's or child(ren)'s insurance card (front and back)**
- **vaccine record for your child(ren)**

If your child(ren) has a history of medical concerns, please request a **Medical Records Release** form from our staff. This will allow our clinical staff to have a thorough understanding of your child(ren)'s medical history to provide them proper care and treatment.

Please allow 3-5 business days for our office and clinical staff to process your application. We will contact you once your application has been approved to schedule any appointments you may need. Thank you for your patience!

4225 Vickers Drive Columbus, IN 47203 P: 812-379-9524 F: 812-799-7106 northside-pediatrics.org

Linda Guse, MD Tamara Stone Iorio, MD Scott Taylor, MD Mary Chambers, MD Michelle Richer, CPNP Lindsey George, CPNP

northside pediatrics
4225 Vickers Dr Columbus, IN 47203
phone 812-379-9524 fax 812-799-7106
www.northside-pediatrics.com

New Patient Application

PLEASE FILL OUT FORM COMPLETELY AND SUBMIT WITH CURRENT VACCINE RECORD

Northside Pediatrics follows the immunization guidelines recommended by the American Academy of Pediatrics, therefore, we will not accept new families that do not vaccinate their children on the recommended schedule

Date Submitted:

PARENT INFO

PARENT 1 Guarantor (Parent Responsible for Payment)

Full Legal Name: _____

Date of Birth: _____ SSN: _____

Address: _____

City: _____ State: ____ Zip: _____

Phone: _____

Email: _____

Do you carry insurance on your child/children? Yes ☐ No ☐

Insurance Co.: _____

I.D. Number: _____

Primary ☐ Secondary ☐

PARENT 2

Full Legal Name: _____

Date of Birth: _____ SSN: _____

Address: _____

City: _____ State: ____ Zip: _____

Phone: _____

Email: _____

Do you carry insurance on your child/children? Yes ☐ No ☐

Insurance Co.: _____

I.D. Number: _____

Primary ☐ Secondary ☐

Is there any one else that carries insurance on your child/children? if so list below

Name: _____ Insurance Co: _____ I.D.#: _____ Relationship to child: _____

Name: _____ Insurance Co: _____ I.D.#: _____ Relationship to child: _____

PATIENT INFO Space for additional children on back.

CHILD 1

Full Legal Name: _____ Date of Birth: _____ Male ☐ Female ☐

Who (listed above) does this child live with? PARENT 1 ☐ PARENT 2 ☐ OTHER ☐

Medical Conditions/Concerns: _____ Current Medications: _____

Date of Last Well Visit: _____ All Vaccines given in Indiana? Yes ☐ No ☐ If "No", vaccine record must be attached

Who (listed above) carries insurance on this child? PARENT 1 ☐ PARENT 2 ☐ OTHER ☐ MEDICAID ☐

Indiana Medicaid Info (**REQUIRED**, even if not currently using) RID #: _____ Currently Eligible: Yes ☐ No ☐

CHILD 2

Full Legal Name: _____ Date of Birth: _____ Male ☐ Female ☐

Who (listed above) does this child live with? PARENT 1 ☐ PARENT 2 ☐ OTHER ☐

Medical Conditions/Concerns: _____ Current Medications: _____

Date of Last Well Visit: _____ All Vaccines given in Indiana? Yes ☐ No ☐ If "No", vaccine record must be attached

Who (listed above) carries insurance on this child? PARENT 1 ☐ PARENT 2 ☐ OTHER ☐ MEDICAID ☐

Indiana Medicaid Info (**REQUIRED**, even if not currently using) RID #: _____ Currently Eligible: Yes ☐ No ☐

Previous Physician/Office: _____ Reason for Change: _____

Physician Requested: _____ Referred to our office by/Relationship: _____

OFFICE USE ONLY

Date Reviewed: _____ Reviewed By: _____ Approved: Yes ☐ No ☐

Date Contacted: _____ First Appt Date: _____ Time: _____ Physician: _____

PATIENT INFO

CHILD 3

Full Legal Name: _____ Date of Birth: _____ Male ☐ Female ☐

Who (listed above) does this child live with? PARENT 1 ☐ PARENT 2 ☐ OTHER ☐

Medical Conditions/Concerns: _____ Current Medications: _____

Date of Last Well Visit: _____ All Vaccines given in Indiana? Yes ☐ No ☐ If "No", vaccine record must be attached

Who (listed above) carries insurance on this child? PARENT 1 ☐ PARENT 2 ☐ OTHER ☐ MEDICAID ☐

Indiana Medicaid Info (**REQUIRED**, even if not currently using) RID #: _____ Currently Eligible: Yes ☐ No ☐

CHILD 4

Full Legal Name: _____ Date of Birth: _____ Male ☐ Female ☐

Who (listed above) does this child live with? PARENT 1 ☐ PARENT 2 ☐ OTHER ☐

Medical Conditions/Concerns: _____ Current Medications: _____

Date of Last Well Visit: _____ All Vaccines given in Indiana? Yes ☐ No ☐ If "No", vaccine record must be attached

Who (listed above) carries insurance on this child? PARENT 1 ☐ PARENT 2 ☐ OTHER ☐ MEDICAID ☐

Indiana Medicaid Info (**REQUIRED**, even if not currently using) RID #: _____ Currently Eligible: Yes ☐ No ☐

CHILD 5

Full Legal Name: _____ Date of Birth: _____ Male ☐ Female ☐

Who (listed above) does this child live with? PARENT 1 ☐ PARENT 2 ☐ OTHER ☐

Medical Conditions/Concerns: _____ Current Medications: _____

Date of Last Well Visit: _____ All Vaccines given in Indiana? Yes ☐ No ☐ If "No", vaccine record must be attached

Who (listed above) carries insurance on this child? PARENT 1 ☐ PARENT 2 ☐ OTHER ☐ MEDICAID ☐

Indiana Medicaid Info (**REQUIRED**, even if not currently using) RID #: _____ Currently Eligible: Yes ☐ No ☐

CHILD 6

Full Legal Name: _____ Date of Birth: _____ Male ☐ Female ☐

Who (listed above) does this child live with? PARENT 1 ☐ PARENT 2 ☐ OTHER ☐

Medical Conditions/Concerns: _____ Current Medications: _____

Date of Last Well Visit: _____ All Vaccines given in Indiana? Yes ☐ No ☐ If "No", vaccine record must be attached

Who (listed above) carries insurance on this child? PARENT 1 ☐ PARENT 2 ☐ OTHER ☐ MEDICAID ☐

Indiana Medicaid Info (**REQUIRED**, even if not currently using) RID #: _____ Currently Eligible: Yes ☐ No ☐

Age	Vaccine
Birth	Hep B
1 Month	Hep B
2 Months	Pentacel (DTap, IPV, Hib), Pneumocaccal Vaccine (PCV15/PCV20), Rotateq
4 Months	Pentacel (DTap, IPV, Hib), Pneumocaccal Vaccine (PCV15/PCV20), Rotateq
6 Months	Pentacel (DTap, IPV, Hib), Pneumocaccal Vaccine (PCV15/PCV20), Rotateq
9 Months	Heb B
12 Months	Hep A, Pneumococcal Vaccine (PCV 15/PCV 20), MMR
15 Months	Pentacel (DTap, IPV, Hib), Varivax
18 Months	Hep A
2-3 Years	No vaccines if up to date
4-5 Years	Quadracel (DTap, IPV), Proquad (MMR, Varivax)
6-10 Years	No Vaccines if up to date
11 Years	Adacel (Tdap), Meningococcal Vaccine (MenQuadfi)
12-15 Years	No vaccines if up to date
16 Years	Meningococcal Vaccine Booster (MenQuadfi), Meningococcal B Vaccine (Bexero)
17-18 Years	Meningococcal B Booster (Bexero)

At Northside Pediatrics, we strongly believe that all children and young adults should receive all of the recommended vaccines according to the schedule published by the American Academy of Pediatrics. We believe that vaccinating is one of the most important interventions we perform as healthcare providers and that you can perform as parents/caregivers.

Our vaccination policy will be firmly enforced beginning January 1, 2024. Failure to vaccinate in a timely manner will prevent us from continuing to provide healthcare services to your child.

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My signature below acknowledges that I have fully read, understand, and agree to vaccinate my child according to the AAP guidelines. I understand that failure to do so will result in dismissal from Northside Pediatrics

_____

Parent/Guardian (print)

_____ _____

Parent/Guardian Signature **Date**