SANDUSKY PEDIATRICIANS

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**Phone** 419-626-3821
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Dear New Patient:

Welcome to Sandusky Pediatricians !

Thank you for choosing us to provide medical care for your children. We appreciate this opportunity and look forward to establishing a provider-patient relationship with your family.

Enclosed you will find the necessary paperwork required to create accounts for your family in both our Electronic Medical Record (EMR) system and Billing system.

FORMS TO BE COMPLETED AND RETURNED PRIOR TO YOUR APPT:
***(Please have these forms completely filled out before you arrive and you may fax to 419-626-2477 or email to SanduskyGP@uhhospitals.org to expedite your appointment)***

1. **Pediatric Health History form**
2. **Registration/Demographics form**
3. **Parent/Guardian Consent to Treat Minor Patients**, *if you want to authorize someone besides parents/legal guardians to bring your child to appointments.*
4. **Appointment & No Show Notification**
5. **Parent/Guardian Account PHR Request form** for access to your child(ren)'s UH Personal Health Record. THIS FORM IS OPTIONAL.

FORMS YOU MAY KEEP:

6. **Authorization for Release of Medical Records**. Our providers would like to review medical records from your former pediatrician prior to your child's appointment. You may use this HIPAA compliant form to send to your former pediatrician if you have not already requested they send us the records -- you will need to write in the name of your former pediatrician's name in the *Disclosing Institution* field.
7. **Late Arrival Policy**
8. **Well Child / Baby Care Check Up Policy**
9. **UH RPCI: 2018 Recommended Vaccination Schedule** that is still current.
10. **Sandusky Pediatricians brochure** (if one is not included it is still in our revision process)

**We ask that you arrive 15 minutes prior to your scheduled appointment**.

Thank you again. We look forward to seeing you.

Sandusky Pediatricians
University Hospitals Medical Practices

**Sandusky Pediatricians**
2800 Hayes Avenue Bldg B
Sandusky, OH 44870
Phone: 419-626-3821
Fax: 419-626-2477

# Pediatric Health History Form

CHILD'S NAME: _____

DATE OF BIRTH: _____ AGE: _____

CHILD'S PEDIATRICIAN/PRIMARY CARE PROVIDER: _____

PRESENT HEALTH CONCERNS:

_____

MEDICINES / VITAMINS:

_____

HERBS / HOME REMEDIES:

_____

ALLERGIES / REACTIONS TO MEDICINES OR VACCINATIONS:

_____

## PREGNANCY & BIRTH

Is the child yours by: birth adoption stepchild other:

_____

Please, indicate any medical problems during pregnancy.

none

other: _____

Delivery by: vaginal birth caesarian

If caesarian, why? _____

If premature, why? _____

Birth weight: _____ Birth length: _____ APGAR score 1 min _____ 5 min_____

Please indicate any medical problems during the baby's newborn period.

none other _____

## NUTRITION & FEEDING

Was your child breastfed? No Yes If yes, how long? _____

Has your child had any unusual feeding/dietary problems? No Yes

If yes, specify:_____

Milk intake now: Circle type

Cow milk (non-fat 1% fat 2% fat whole milk) soy milk rice milk

Average ounces per day (Note: 8 ounces are in 1 cup)_____

## SLEEP

Hours per night: _____ Naps (number and length): _____ Any sleep problems?

_____

## DEVELOPMENT

At what age did your child: sit alone _____ walk alone _____ say words _____

Toilet train (daytime) _____ Girls only: Age at first menstrual period _____

## DENTAL HISTORY

Has child been seen by a dentist? No Yes If yes, how often _____ Date of last visit _____

Has child had: filling cap/crown bridge braces other orthodontic work _____

## PAST MEDICAL HISTORY

Has your child had: chickenpox measles mumps rubella meningitis tuberculosis (TB)

***Please, bring a copy of your child's immunization record to your appointment***

Please, describe any major medical problems and their dates:

_____

_____

_____

Hospitalizations / Operations (with dates): _____

_____

Broken bones or severe strains / sprains (with dates): _____

_____

Major falls, traumas or other injuries (with dates): _____

_____

## FAMILY HISTORY

Please, circle any family history of the following (indicate who has/had the condition):

| | | |
|---|---|---|
| Alcoholism / drug abuse | Heart disease or stroke before age 60 | Seizures |
| Psychiatric disorder | Thyroid disease | Kidney Disease |
| High blood pressure | Bleeding / clotting problem | Birth defect |
| Asthma/hay fever | Eczema Inherited/genetic diseases | |

## FAMILY PROFILE

Are the parents: Married? ☐ Separated? ☐ Divorced? ☐ Single? ☐ Widowed? ☐

Father's Name: _____ Age: _____ Highest School Grade? _____ In good health? _____

Mother's Name: _____ Age: _____ Highest School Grade? _____ In good health? _____

Other brothers/sisters:
Name: _____ Birth date: _____
Name: _____ Birth date: _____
Name: _____ Birth date: _____
Name: _____ Birth date: _____

Any one in the family smoke: Yes ☐ No ☐ Who does the child live with? _____

Who? _____ _____

**FAMILY ILLNESSES Please list all the child's blood relatives who have the following problems.**
**Use these abbreviations: (F) Father; (M) Mother; (S) Sister; (B) Brother; (MM) Mother's Mother; (MF) Mother's Father; (FM) Father's Mother; (FF) Father's Father; (A) aunt; (U) Uncle; (C) Cousin.**

| | | | |
|---|---|---|---|
| Abuse (child, sexual, spouse) | _____ | Frequent cancer (Type?) | _____ |
| ADHD | _____ | Genetic disease | _____ |
| Alcoholism/Drug Abuse | _____ | Hearing problems | _____ |
| Allergies | _____ | Heart attack/Stroke | _____ |
| Anemia/Blood disease | _____ | High blood pressure | _____ |
| Asthma | _____ | High cholesterol | _____ |
| Arthritis | _____ | Kidney disease | _____ |
| Birth defects | _____ | Mental retardation | _____ |
| Bleeding problems | _____ | Mental illness | _____ |
| Crohn's disease | _____ | Migraine | _____ |
| Depression | _____ | Overweight | _____ |
| Diabetes | _____ | Thyroid disease | _____ |
| Eczema | _____ | Ulcers/Reflux | _____ |
| Epilepsy/Seizures | _____ | Ulcerative colitis | _____ |
| Eye disease (other than glasses) | _____ | Other | _____ |

## SOCIAL HISTORY

Birthplace: _____ Current (or upcoming) grade: _____

Who lives at home?

| Name | Age | Relationship | Highest Education Level | Smoker? |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Are the child's parents: married unmarried separated divorced

If divorced, when? _____

Parents' occupations: Mother _____ Father _____

Child care situation: parents others (specify who and hours per day)

_____

_____

Concerns about your child: Alcohol use Tobacco Sexual activity Aggressive behavior

Is violence at home a concern? No Yes Are there guns in the home? No Yes

Any concerns about lead exposure? (old home / plumbing / peeling paint) No Yes

TV hours daily _____ Computer hours daily_____ Video games hours daily _____

## SCHOOL HISTORY

Did/does your child attend preschool? No Yes

Current grade _____ Name of school _____

Any concerns about school performance? _____

Any concerns about relationships with:

Teachers No Yes _____

Students No Yes _____

If over 4 years old, does your child have a best friend? No Yes

Sports / exercise: Type _____ How often? _____

How long (minutes) _____

## REVIEW OF ORGAN SYSTEMS

If child has more than one symptom on a line, circle the relevant one(s).

Constitutional / Endocrine
- Fever/Chills/Excessive sweating
- Unexplained weight loss/gain

Eyes
- Squinting/ "crossed" eyes/
- Asymmetric gaze

Ears/Nose/Throat
- Unusually loud voice/Hard of Hearing
- Mouth breathing/Snoring
- Bad Breath
- Frequent runny nose
- Problems with teeth/gums

Respiratory
- Cough/Weeze

Gastrointestinal
- Nausea/Vomiting/Diarrhea
- Vomiting

Cardiovascular
- Tires easily with exertion
- Shortness of breath
- Fainting

Genitourinary
- Bedwetting
- Pain with urination
- Discharge: penis or vagina

Neurological
- Headache
- Weakness
- Clumsiness

Musculoskeletal
- Muscle/Joint pain

Allergy
- Hayfever/Itchy eyes

Skin
- Rashes/Unusual moles

Psychiatric/Emotional
- Speech problems
- Anxiety/stress
- Problems with sleep/ nightmares
- Depression
- Nail biting/thumb sucking
- Bad temper/breath holding
- jealousy

Blood/Lymph
- Unexplained lumps
- Easy bruising/bleeding

**The information that I have provided is to the best of my knowledge true.**

**Signature** _____ **Date** _____

**Printed name** _____ **Relationship to patient** _____

**Date intake reviewed** _____ **Physician's signature** _____

## OFFICE USE ONLY

PROBLEM LIST — Date of Onset

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____
10 _____

ALLERGIES - MEDICATIONS

| | Date | Reaction |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |
| 4 | | |
| 5 | | |

ENVIRONMENTAL ALLERGIES — Date

1 _____
2 _____
3 _____
4 _____

(*Internal Use: initial/date when entered _____ ** give copy to OM if no shared parenting*) Rev 07/21

**Sandusky Pediatricians**
Registration for minor children to be completed each year and for any changes by Mother, Father, Legal Guardian ONLY

Today's Date: _____/_____/_____ Completed by: _____

**Name of the Financially Responsible Guarantor who agrees to receive bills**: _____
*(UH does not follow Court Order billing. If Guarantor is other than yourself, you will be responsible if above party does not pay)*

- **PRIMARY insurance policy holder for the children:** **Mother** **Father** **Other**_____
  *(UBR states it is parent w/ the first birthdate of a calendar year, UNLESS waived by a Court Order)*
- **PRIMARY Residential Parent, if parents do not live together:** **Mother** **Father** **Other**_____

| | Minor Child's LEGAL Name | Date of Birth | M/F | Social Security #: |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |

**Appointment Reminder preferences - Please complete each line with one of each. COMPLETE EACH ONE PLEASE.**

- Appt Reminder via **Email:** _____ initial to opt out_____
- Appt Reminder via **Phone Call#:** _____ initial to opt out_____
- Appt Reminder Via **Text#:** _____ initial to opt out _____

**PLEASE ASK RECEPTIONIST FOR A SEPARATE FORM FOR CHILDREN WITH DIFFERENT PARENTS**

**********

**Mother / Legal Guardian**

Legal Name_____ Birthdate_____ SS#_____

Maiden Name (if applicable)_____

Mailing Address: _____ City_____ State_____

Home Phone _____ Cell Phone_____ Work Phone_____

Email Address: _____ Employer Name_____

Step Father Name (if applicable) _____ Birthdate_____

***If biological parents are divorced, do you have Shared Parenting? _____YES or _____NO** If NO, Please provide Court Order**

**********

**Father / Legal Guardian**

Legal Name_____ Birthdate_____ SS#_____

Mailing Address: _____ City_____ State_____

Home Phone _____ Cell Phone_____ Work Phone_____

Email Address_____ Employer Name_____

Step Mother Name (if applicable) _____ Birthdate_____

***If biological parents are divorced, do you have Shared Parenting? _____YES or _____NO** If NO, Please provide Court Order**

**********

**Name of an Emergency Contact who does not live with you:**

Name_____ Phone _____ Relationship to child_____

University Hospitals

NAME OF OFFICE PRACTICE: SANDUSKY PEDIATRICIANS

# PARENT/GUARDIAN CONSENT TO TREAT MINOR PATIENTS

Accompaniment

**SECTION # 1:** ***Please complete this section to authorize someone <u>besides a biological parent or legal guardian</u> to bring your child(ren) to appointments. (Ex: step-parents, grandparents, babysitters)***

I, the Legal Guardian, _____, of the minor child(ren):

1. Minor Child's Name: _____ Birthdate: _____
2. Minor Child's Name: _____ Birthdate: _____
3. Minor Child's Name: _____ Birthdate: _____
4. Minor Child's Name: _____ Birthdate: _____

give my consent for my children to be accompanied by the individuals listed below to office visits and treatment that requires only general consent. I have already signed the general consent form.

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

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No Accompaniment

**SECTION # 2:** ***Please complete this section ONLY if you consent for any of your minor children to transport himself/herself <u>ALONE</u> to office visits and treatment that requires only general consent.***

My minor child(ren) has my permission to transport himself/herself to receive general treatment that does not require general consent, which I, (*print name of legal guardian*)_____ as guardian, have already given.

1. Minor Child's Name: _____ Birthdate: _____
2. Minor Child's Name: _____ Birthdate: _____
3. Minor Child's Name: _____ Birthdate: _____
4. Minor Child's Name: _____ Birthdate: _____

---

Signature

**SECTION # 3:** ***<u>LEGAL GUARDIAN SIGNATURE</u>**

You can contact me by phone:

Home:_____ Cell:_____ Work:_____

I understand that this consent is in place until revoked by me and/or the expiration of one year.

**Legal Guardian Signature:**_____ **Date:**_____

Relationship of Legal Guardian to child:_____

**Internal Use:** Staff, please initial/date when entered: _____

*REV 05/21*

# MINOR PATIENTS

Internal Use: entered by initials/date:_____

University Hospitals

## University Hospitals Physician Services: No-Show Policy

Sandusky Pediatricians

### Missed Appointments Hurt Everyone

Missing a scheduled appointment without notification prevents others from having desired appointments. We understand that situations may arise which make it impossible for you to keep a scheduled appointment. The earlier you let us know, the more likely we can offer the appointment time to another patient.

Giving the office at least 24-hour notice of the need to cancel an appointment is considerate of other patients and greatly appreciated. We strive to provide compassionate care in a cost-effective manner. Missed appointments waste valuable physician and staff resources, and prevent other patients from obtaining care.

### No-Show Policy

A missed appointment (with no phone call) is considered a "No-show." It is important to call us if you cannot make your scheduled appointment. We prefer you call us the day prior to your appointment to reschedule or cancel. Failure to call to cancel prior to your appointment time may result in a $25.00 fee. *(Note: insurance companies will not cover this fee.)*

*Repeated missed appointments may result in dismissal from our practice.*

I acknowledge receipt and review of the No Show Policy

Printed Name _____

Signature _____ Date _____

MINOR Patient Names:

1. _____ Birthdate:_____
2. _____ Birthdate:_____
3. _____ Birthdate:_____
4. _____ Birthdate:_____
5. _____ Birthdate:_____

University Hospitals

# Parent/Guardian Account Request Form

Person requesting access must be a parent or legal guardian.

A Parent/Guardian Account allows a parent or legal guardian to have access to the UH Personal Health Record (PHR) of a patient in his/her care. To open a Parent/Guardian Account, please fill out the form below and return to your doctor's office.

By completing and signing this form:

1. I certify that I am the parent/legal guardian of the patient and I have the legal right to access his or her health information.
2. I understand that any individuals I name below will have online access to personal health information, including, but not limited to, viewing portions of the health record, requesting appointments, and requesting medication refills.
3. I understand that additional information may be made available to me through the PHR in the future.
4. I understand that this form only gives access to the patient's PHR. This form does not authorize the release of the patient's medical record by other methods or in other formats. To request copies of the patient's medical record, please contact your doctor's office or any UH Hospital.
5. I understand that access to the patient's PHR is provided by University Hospitals as a convenience to its patients. University Hospitals has the right to deactivate access to the PHR at any time, for any reason.

## PATIENT INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____ DOB: _____

## PARENT/GUARDIAN INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Phone Number: _____ Date of Birth: _____

Email Address (please print): _____

Relationship to Patient: ☐Birth or Adoptive Parent ☐Legal Guardian* ☐Other* _____

Parent/Legal Guardian Signature: _____ Date: _____

*Any person signing this form other than the birth or adoptive parent of the patient MUST provide a copy of legal paperwork that such person has the right to this information. Failure to submit legal paperwork will result in denial of access.

## ADDITIONAL PARENT/GUARDIAN ACCOUNT(S)

By completing this section, I am requesting UH to give access to the patient's PHR to the following individual(s):

First Name: _____ Middle Initial: _____ Last Name: _____
Address: _____ City: _____ State: _____
Zip Code: _____ Phone Number: _____ Date of Birth: _____
Email Address (please print): _____
Relationship to Patient: ☐Birth or Adoptive Parent ☐Legal Guardian* ☐Other* _____

First Name: _____ Middle Initial: _____ Last Name: _____
Address: _____ City: _____ State: _____
Zip Code: _____ Phone Number: _____ Date of Birth: _____
Email Address (please print): _____
Relationship to Patient: ☐Birth or Adoptive Parent ☐Legal Guardian* ☐Other* _____

(Rev. 8/20/18)

Provider Office Use Only – REQUIRED INFORMATION:
MRN: _____ Practice/Office: SANDUSKY PEDIATRICIANS
Reviewer Name: _____ Office Phone #: 419-626-3821
Date: _____ Office Email: SanduskyGP@UHhospitals.org
☐ Requestor(s) Eligible for Access ☐ Requestor(s) Not Eligible for Access
Reason: _____

You may use this form to request medical records be sent to us from your child's former physician if you wish. After you complete this authorization, please mail or fax it your former physician's office. Our providers would like to have your child's medical records prior to your appointment.

University Hospitals

# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

**Records to be released from:**

Case Medical Center ☐ Ahuja ☐ Bedford ☐ Conneaut ☐ Geneva ☐ Geauga ☐ Richmond ☐ UH Home Care ☐ UHPS ☑

Patient Name _____
(Please Print) Last First M/I

Date of Birth _____ Social Security Number (last four digits) _____

Address _____ Phone Number (____)-_____
_____ Medical Record Number _____
_____ Prior MR # _____

Treatment Date(s) BIRTH TO PRESENT

**Please Release Medical Information to the Following Recipient:**

Name of Person or Organization SANDUSKY PEDIATRICIANS Phone # 419-626-3821
Address 2800 HAYES AVENUE, BLDG B Mailstop _____
SANDUSKY, OH 44870 Fax # 419-626-2477
City State Zip Code

Purpose of Disclosure ☑ at the patient's request

## Description of Information to be Released:

☐ Pertinent Summary (includes all * items)

| | | |
|---|---|---|
| ☐ Admission Form | ☐ Facesheet / Demographics | ☐ Physical Therapy |
| ☐ ***Discharge Summary** | ☐ Lab Reports | ☒ Entire Record |
| ☐ ***Emergency Room Report** | ☐ ***Radiology Report** | ☐ Physician's Notes |
| ☐ ***History & Physical** | ☐ ***EKG Report** | ☐ Other _____ |
| ☐ ***Consultation Report** | ☐ ***Pathology Report** | _____ |
| ☐ ***Operative Report** | ☐ ***Card Cath Report** | _____ |

*I, the undersigned, authorize* * _____ *(Disclosing Institution) and its employees to release Information from my medical records as described above. I understand and acknowledge that the medical record may contain Information regarding psychiatric disorders, Human Immune Virus (HIV) test results, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related conditions, alcohol, and/or drug dependence/abuse. I also understand that Information used or disclosed according to this authorization may be subject to redisclosure by the recipient and may no longer be protected. My failure to sign this authorization may result in my Information not being released.*

*I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____ . If I fail to specify an expiration date, event or condition, this authorization will expire in one year.*

*I understand that treatment, payment, enrollment, or eligibility for benefits will not be conditioned on my failure to sign this authorization.*

*I understand there may be charges for the copying and release of Information and accept financial responsibility.*

X _____ ____/____/____
Signature of Patient/Legal Representative** Date Signed

_____ ☐ Patient unable to sign
Description of Legal Representative's Authority to Act on Behalf of Patient (if applicable)

☐ By signing this form as the patient's legal representative, I am certifying that there is no court order or other legal reason (such as a binding arbitration decision or final mediation agreement) prohibiting me from obtaining a copy of the requested records. *This box must be checked for ALL releases of records authorized by legal representatives.*

**If other than patient's signature, a copy of legal documents MUST accompany the authorization when presented; the exception is a parent of minors under 18 years of age.

*HIM13018*



* You will need to fill in the name of your former physician in the field titled DISCLOSING INSTITUTION

Patient ID Label

# Late Arrival Policy

Our providers, nurses and staff aim to make your visit a pleasurable one. In our efforts to make your visit more comfortable and to minimize your wait time, our office has implemented a late arrival policy.

**If a patient is more than 15 minutes late for an appointment, the appointment may need to be rescheduled.**
This is to ensure that the patients who arrive on time do not wait longer than necessary to see the provider. You may be given the option to wait for another appointment time on the same day if one is available. We will try to accommodate late-comers as best as possible, but cannot compromise on the quality and timely care provided to our other patients.

**New patients are encouraged to complete new patient paperwork that we mail to you and fill it out prior to coming in. The paperwork may also be printed from our website, Rainbow.org/SanduskyPeds.**
Otherwise, new patients need to arrive at the office at least 15 minutes prior to the scheduled appointment to complete the paperwork. If a new patient's paperwork is not completed in a timely fashion upon arrival, we may need to accommodate other patients who arrive on time.

The providers and staff at **Sandusky Pediatricians** truly appreciate your compliance and understanding with this policy so that we can continue to provide excellent medical care as well as excellent customer service.

Thank you

*SANDUSKY PEDIATRICIANS*
*UNIVERSITY HOSPITALS MEDICAL PRACTICES*

# WELL CHILD / BABY CARE CHECK UP POLICY

Dear Patient:

Our records indicate we have not seen your child for a ***well child*** check up (routine preventative examination) in over one year. **Yearly medical well child check ups performed by your child's established primary care provider meet the standard of care as determined by the American Academy of Pediatrics (AAP).** As members of the AAP, we support this standard and feel it is important for quality medical care. Therefore, check ups are mandatory to provide the medical care your family deserves.

A well child check up is a scheduled appointment when your child is not ill. This visit includes a history and physical examination, developmental assessment, and health supervision issues appropriate for your child's age, *all of which are **not** provided at illness visits.*

A scheduled well child check up will be billed to your insurance company as a Preventative Visit. We realize this may be determined a non covered or limited service by your insurance company. However, the fact that your insurance company does not pay for this service does not mean that your child should not receive it.

Our Preventative Check Up Schedule is as follows. Compliance with this schedule is required to maintain *current patient status.*

**Age 0-1**
Check Up required at 1, 2, 4, 6, 9, and 12 months.

**Age 1-2 years**
Check Up required at 15, 18, 24 months.

**Age 2-18 years**
Check Up required at 2 ½ years, and annually beginning at age 3 years to 18 years of age.

Maintaining *current patient status* enables us to provide the following:

- *Illness visits*
- *After hours Emergency On-Call Provider Availability*
- *Immunizations*
- *College, School, Daycare Form completion*
- *Telephone Consultation by Nurse or Provider*
- *Prescription refills, and school medication permission form completion*
- *Sports Card, Work Permit form completion*
- *Referrals and Consultation to Specialty Providers*
- *Use of Telephone Hour (8:00 AM –9:00 AM – Monday through Friday)*
- *Other miscellaneous paperwork and/or orders for required services.*

Thank you for your understanding and cooperation with this Policy. It is our privilege to provide your medical care.

University Hospitals | Rainbow Babies & Children's Hospital | SANDUSKY PEDIATRICIANS

# UH RPCI: 2018 Recommended Vaccination Schedule

| Vaccine | MFG | CPT Code | Birth | 2 Mths | 4 Mths | 6 Mths | 9 Mths | 12 Mths | 15 Mths | 18 Mths | Year 2 | Year 4-5 | Year 11 | Year 12 | Year 16 | Year 17 | Year 18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Hiberix (Hib) | GSK | 90648 | | X | X | X | | | X | | | | | | | | |
| Pediarix (DTaP, IPV, HepB) | GSK | 90723 | | X | X | X | | | | | | | | | | | |
| RotaTeq oral solution (not injection) | Merck | 90680 | | X | X | X | | | | | | | | | | | |
| Prevnar 13 (Pneumococcal) | Wyeth | 90670 | | X | X | X | | | X | | | | | | | | |
| Vaqta (Hep A) | Merck | 90633 | | | | | | X | | X | | | | | | | |
| Varivax (Varicella) | Merck | 90716 | | | | | | X | | | | | | | | | |
| MMR II | Merck | 90707 | | | | | | X | | | | | | | | | |
| ProQuad (MMRV) | Merck | 90710 | | | | | | | | X | | | | | | | |
| Infanrix (DTaP) | GSK | 90700 | | | | | | | X | | | | | | | | |
| Kinrix (DTaP/IPV) | GSK | 90696 | | | | | | | | | | X | | | | | |
| Menveo (Men A, C, W-135, Y) | GSK | 90734 | | | | | | | | | | | X | | X | | |
| Gardasil 9 (HPV) (male & female patients) | Merck | 90651 | | | | | | | | | | | X | X | | | |
| Boostrix (Tdap) | GSK | 90715 | | | | | | | | | | | X | | | | |
| Bexsero (Men B) | GSK | 90620 | | | | | | | | | | | | | X,X | | |
| Influenza Quadrivalent 0.25 mL *(preserv free)* | GSK | 90685 | 6 -35 months | | | | | | | | | | | | | | |
| Influenza Quadrivalent 0.5 mL *(preserv free)* | GSK | 90686 | | 36 months-8 years: 1 to 2 doses per guidelines* | | | | | | | | 9+ years = 1 dose | | | | | |

* *If first flu dose, give two doses 1 month apart.*

**Please contact your insurance company to confirm coverage by providing the correct CPT code.**

*Appropriate administration fees are billed per vaccine*