Initial History Questionnaire

Name____ DOB _____________________________________

Age __________ Male Female Form completed by _________________________ Date ___________

Mother's Name ___________________ Place of employment ___________________Occupation ________________
Father's Name ___________________ Place of employment ___________________Occupation ________________

Household

Name	DOB	Relationship to child	Health Problems

Are there siblings not listed? If so, please list their names, ages & where they live. ___________________________

If mother & father are not living together or if child doe not live with parents, what is the custody status? __________________

If one or both parents are not living in the home, how often does the child see the parent not in the home? __________________

Birth History

Birth weight ___________________________
Was the baby born term? ____ Early? ___ Late?___
If early, how many weeks gestation? ____________
Did mother have any illness or problem with her Pregnancy? □ yes □ no Explain: ____________
____
During pregnancy, did mother:
Smoke □ Yes □ No Drink alcohol □ Yes □ No
Use drugs or medications □ Yes □ No
What _________________ When _____________

Was the delivery □ vaginal? □ C-section
If C-section, why? ____
Did your baby have any problems right after birth? □ yes □ no
Explain: ____
Was initial feeding □ bottle □ breast, how long ? ___________
Did baby go home with mother from the hospital?
□ Yes □ No Explain ___________________________________
____
Did baby pass hearing at birth? □ Yes □ No
Was PKU done after 48 hrs of age? □ Yes □ No
What hospital was baby born at? ____________________________

General

Preferred Pharmacy Name: _______________________________ Location: ____
Do you consider your child to be in good health? □ Yes □ No Explain ______________________________________
Does your child have any serious illness or medical condition? □ Yes □ No Explain ______________________________________
Has your child had serious injuries or accidents? □ Yes □ No Explain ______________________________________
Has your child had any surgery? □ Yes □ No Explain ______________________________________
Has your child ever been hospitalized? □ Yes □ No Explain ______________________________________
Is your child allergic to any medicines or drugs? □ Yes □ No Explain ______________________________________
Has your child had a reaction to immunizations? □ Yes □ No Explain ______________________________________
Where has your child gone for healthcare until now? ____
When was the last well child check-up? ____

Development

Are you concerned about your child's physical development? □ Yes □ No Explain ______________________________________
Are your concerned about your child's mental/emotional development? □ Yes □ No Explain ______________________________________
Are you concerned about your child's attention span? □ Yes □ No Explain ______________________________________
If your child is in school:
How is his/her behavior in school? ____
Has he/she failed or repeated a grade in school? ____
How is he/she doing in academic subjects? ____
Is he/she in special or resource classes? ____

(OVER)

Family History

Have any family members had the following:

Deafness	☐ Yes ☐ No	who ______________	Comments ______________________________
Nasal Allergies	☐ Yes ☐ No	who ______________	Comments ______________________________
Asthma	☐ Yes ☐ No	who ______________	Comments ______________________________
Tuberculosis	☐ Yes ☐ No	who ______________	Comments ______________________________
Heart Disease (before 50 years old)	☐ Yes ☐ No	who ______________	Comments ______________________________
High blood pressure (before 50 years old)	☐ Yes ☐ No	who ______________	Comments ______________________________
High Cholesterol	☐ Yes ☐ No	who ______________	Comments ______________________________
Anemia	☐ Yes ☐ No	who ______________	Comments ______________________________
Bleeding Disorder	☐ Yes ☐ No	who ______________	Comments ______________________________
Liver disease	☐ Yes ☐ No	who ______________	Comments ______________________________
Kidney disease	☐ Yes ☐ No	who ______________	Comments ______________________________
Diabetes (before 50 years old)	☐ Yes ☐ No	who ______________	Comments ______________________________
Bed-wetting (after 10 years old)	☐ Yes ☐ No	who ______________	Comments ______________________________
Epilepsy or convulsions	☐ Yes ☐ No	who ______________	Comments ______________________________
Alcohol abuse	☐ Yes ☐ No	who ______________	Comments ______________________________
Mental Illness	☐ Yes ☐ No	who ______________	Comments ______________________________
Mental retardation	☐ Yes ☐ No	who ______________	Comments ______________________________
Immune problems, HIV, or AIDS	☐ Yes ☐ No	who ______________	Comments ______________________________

Additional family history

____

____

____

Past History

Does your child have, or has he/she ever had:

Chickenpox	☐ Yes ☐ No	When ______________________________
Frequent ear infections	☐ Yes ☐ No	When ______________________________
Problems with ears or hearing	☐ Yes ☐ No	When ______________________________
Nasal Allergies	☐ Yes ☐ No	When ______________________________
Problems with eyes or vision	☐ Yes ☐ No	When ______________________________
Asthma	☐ Yes ☐ No	When ______________________________
Bronchitis, bronchiolitis, or pneumonia	☐ Yes ☐ No	When ______________________________
Any heart problem or heart murmur	☐ Yes ☐ No	When ______________________________
Anemia or bleeding problem	☐ Yes ☐ No	When ______________________________
Blood transfusion	☐ Yes ☐ No	When ______________________________
Frequent abdominal pain	☐ Yes ☐ No	When ______________________________
Constipation requiring doctor visits	☐ Yes ☐ No	When ______________________________
Bladder or kidney infection	☐ Yes ☐ No	When ______________________________
Bed-wetting (after 5 years old)	☐ Yes ☐ No	When ______________________________
(girls) Has she started menstrual periods?	☐ Yes ☐ No	When ______________________________
(girls) Are there problems with periods?	☐ Yes ☐ No	When ______________________________
Any chronic or recurrent skin problem (acne, eczema)	☐ Yes ☐ No	When ______________________________
Frequent headaches	☐ Yes ☐ No	When ______________________________
Convulsions or other neurologic problem	☐ Yes ☐ No	When ______________________________
Diabetes	☐ Yes ☐ No	When ______________________________
Thyroid or other endocrine problem	☐ Yes ☐ No	When ______________________________
Any other significant problem	☐ Yes ☐ No	When ______________________________
Use of alcohol or drugs	☐ Yes ☐ No	When ______________________________

Rivertown Pediatrics, P.C.

We are committed to providing your child with the best possible medical care. The following information is provided to avoid any misunderstanding or disagreement for professional services.

Consent to Treat

We follow the guidelines of the American Academy of Pediatrics in the treatment recommended for your child. I authorize any physician or clinical staff member of Rivertown Pediatrics to provide medical treatment for my child/children. This includes hospitalizations, injections, anesthesia, immunizations, referrals and emergency treatment. ***Immunizations will be administered as recommended*** by the American Academy of Pediatrics and the Centers for Disease Control (CDC). If you do not wish for your child to receive immunizations, you must discuss this with the physician.

Financial Policy

We will file insurance as a COURTESY; however, YOU ARE ULTIMATELY RESPONSIBLE FOR YOUR CHILD'S CHARGES.

1. Our office participates with a variety of insurance plans.
   It is your responsibility to:
   - ***Bring your insurance card and photo I.D. at every visit.***
   - ***Pay your Co-Payment and/or any deductibles at each visit.*** Payment can be made by cash, check or credit card. We accept VISA and MasterCard. We do not bill for Co-Payments.
   - ***Pay in full for any medical care or services that are not covered by your insurance plan.***
2. If your child has insurance that we do not participate with, or your child does not have insurance, payment in full is expected at the time of service.
3. Your insurance plan may require you to choose a PCP (Primary Care Provider). You will need to choose a physician from our practice. If your insurance card lists another physician's name, we will see your child, but you will be required to pay at the time of service until the PCP has been changed to one of our physicians.
4. ***Secondary Insurance:*** We do not file secondary insurance. You may request a copy of the claim to file your child's secondary insurance yourself.
5. ***You are financially responsible for all charges incurred in your child's care and treatment if not covered by the insurance plan. Not all services may be covered by your plan.***
6. If you have questions about your insurance, we are happy to help. However, specific coverage issues should be directed to your insurance company member services department. The telephone number is located on your insurance card.
7. Failure to meet your financial obligations with this office could lead to dismissal from the practice. Any outstanding balances may be sent to an outside collection agency.
8. To protect your child's records, we ask you to provide our office with a driver's license or other picture identification. Annually, or as changes occur, we will ask you to update and sign our Registration Form. We will scan your insurance card, ID, and Registration Form into your child's electronic medical chart.
9. In cases of divorce and/or separation, the legal guardian will be held responsible for paying any balance originating from that visit. If you provide legal documentation that someone other than the legal guardian is financially responsible and you provide billing information for that responsible party, we will attempt to bill that party. However, if the balance is unpaid by that person, you will be held responsible for the balance on your child's account.

Late Arrival/No Show Policy

Appointments are scheduled specifically for each patient. If you arrive more than 15 minutes late for your appointment, you may be asked to reschedule to another day. If you cannot keep your appointment, we ask you to cancel at least 24 hours prior to the appointment time. If you "no show" three times we reserve the right to discharge your child/children from the practice.

Signature of Understanding and Consent: I have read, understand and consent to the above policies of Rivertown Pediatrics.

Childs Name: ____ Date of Birth: __________________
Childs Name: ____ Date of Birth: __________________
Childs Name: ____ Date of Birth: __________________
Childs Name: ____ Date of Birth: __________________

Signature of Parent/Guardian ____________________________ **Date** _________________________

PATIENT ACKNOWLEDGEMENT OF UNDERSTANDING OF RIVERTOWN PEDIATRICS, P.C. NOTICE OF PRIVACY PRACTICES

In 1996, Federal law was passed regarding the Privacy Regulations created from the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This was created as a direct result of the electronic filing and exchange of health information while protecting a patient's privacy.

Parent's Name: ___________________________________ **SSN:** __________________

Patient's Name: ___________________________________ DOB: _________________

Patient's Name: ___________________________________ DOB: _________________

Patient's Name: ___________________________________ DOB: _________________

Patient's Name: ___________________________________ DOB: _________________

I understand the patient's health information is private and confidential. I understand that Rivertown Pediatrics, P.C. works diligently to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Rivertown Pediatrics, P.C. may use and disclose the patient's personal health information to help to provide health care to the patient, to handle billing and payment, and to take care of other health care operations. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual.

Rivertown Pediatrics, P.C. has a detailed document called "Notice of Privacy Practices". This document contains more detailed information about the policies and practices protecting the patient's privacy. I understand I have the right to read the "Notice" before signing this acknowledgement. I understand Rivertown Pediatrics, P.C. will change and amend the Notice as it deems necessary without individual notification. I understand the most recent amended notice will be available for review for parents/guarantors.

Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include but are not limited to access to my medical records, restrictions on certain uses, receiving an accounting of disclosures as required by law, and requesting communication be by specified methods of communications or alternative action.

Rivertown Pediatrics, P.C. has established procedures which help them meet their obligations to patients. These procedures may include other signature requirements, written authorizations, reasonable time frames for requesting information, charges for non-routine needs, etc. I will assist Rivertown Pediatrics, P.C. by following these procedures if I chose to exercise any of my rights described in the "Notice of Privacy Practices".

My signature indicates I have been given the chance to review a current copy of Rivertown Pediatrics, P.C. "Notice of Privacy Practices".

____ ______________________________ _______ _______

Signature **Relationship to patient** **Date** **Time**