

# 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 does 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 you 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	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	who _____	Comments _____
Nasal Allergies	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	who _____	Comments _____
Asthma	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	who _____	Comments _____
Tuberculosis	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	who _____	Comments _____
Heart Disease (before 50 years old)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	who _____	Comments _____
High blood pressure (before 50 years old)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	who _____	Comments _____
High Cholesterol	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	who _____	Comments _____
Anemia	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	who _____	Comments _____
Bleeding Disorder	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	who _____	Comments _____
Liver disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	who _____	Comments _____
Kidney disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	who _____	Comments _____
Diabetes (before 50 years old)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	who _____	Comments _____
Bed-wetting (after 10 years old)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	who _____	Comments _____
Epilepsy or convulsions	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	who _____	Comments _____
Alcohol abuse	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	who _____	Comments _____
Mental Illness	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	who _____	Comments _____
Mental retardation	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	who _____	Comments _____
Immune problems, HIV, or AIDS	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	who _____	Comments _____

Additional family history

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## Past History

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

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