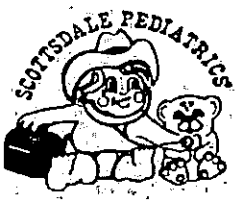

SCOTTSDALE PEDIATRIC CENTER, P.C.

Fellows of the American Academy of Pediatrics
RUSSELLE WALLACE, M.D.
WENDY KAYE, M.D.
TRACI L. HURLEY, M.D.

Scottsdale Pediatrics is converting to an electronic medical record and we need to update and obtain some new information.

Date: _____

Child's Name: _____ Sex: M / F Date of Birth: _____

Mother's Name: _____ Date of Birth: _____

Address: _____

_____

Home Phone: _____ Cell Phone: _____

Occupation: _____

Employer: _____

Languages Spoken: _____

Father's Name: _____ Date of Birth: _____

Address: _____

_____

Home Phone: _____ Cell Phone: _____

Occupation: _____

Employer: _____

Languages Spoken: _____

Financially Responsible Party: _____

For medical issues (mainly results), who should be contacted? _____

Home phone or cell phone?

For reminders, who should be contacted? _____

Home phone or cell phone?

Primary Insurance Co. Name: _____

Insured's Name: _____ ID # _____ Group # _____

Secondary Insurance Name: _____

Insured's Name: _____ ID # _____ Group # _____

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We are required to ask the following questions, but you can decline to answer.

Ethnicity of child:

- ☐ Unknown
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Decline to answer

Race:

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black
- ☐ Hawaiian Native or Pacific Islander
- ☐ White
- ☐ Decline to answer

Contacts:

Who may be told medical information? (please circle and if other indicate name and relationship)

Mother Father Other:_____

PATIENT REGISTRATION

NAME | [M] [F] DATE OF BIRTH | DATE

STREET ADDRESS | CITY STATE, ZIP | PHONE ( )

SCHOOL | REFERRED BY

PEDIATRIC - PATIENT QUESTIONNAIRE

Completed by..... Relation .....

Please check [Y] yes or [N] no, circle or explain where required. N/A-Not Applicable

Reason for today's visit •

Previous medical care • Dr. Dental Care [Y] [N] _____ Eye Exam [Y] [N] _____

PREGNANCY & BIRTH

Mother's age at pregnancy? _____

Any illness during pregnancy? [Y] [N] _____

Medications during pregnancy? [Y] [N] _____

(exclude vitamins & iron) _____

Smoking • alcohol • street drugs • during pregnancy? _____

Was baby early • late • on time? _____

Type of delivery? _____ Birth weight _____ Length _____

Complications? [Y] [N] _____ Apgar _____

Problems with baby at birth? Breathing [Y] [N] Jaundice [Y] [N]

Other _____

Problems soon after? Nursery or home? _____

PAST MEDICAL HISTORY

Allergic reactions? Medicine [Y] [N] Food [Y] [N] Animals [Y] [N]

Insect bites [Y] [N] _____

Medications taken on a regular basis? (exclude vitamins) _____

Immunizations • up to date? [Y] [N] Do you have a record? [Y] [N]

Hospitalizations • (when•where•why?) _____

_____

Serious injuries (when•where?) _____

Red Measles	[Y] [N]	Mumps	[Y] [N]	German Measles (3 day)	[Y] [N]
Chicken Pox	[Y] [N]	Whooping Cough	[Y] [N]	Rheumatic Fever	[Y] [N]
Scarlet Fever	[Y] [N]	Recurrent Ear Infect(s) (3 or more)	[Y] [N]	Throat	[Y] [N]
Asthma/Wheezing	[Y] [N]	Eczema/Hives	[Y] [N]	Seizures	[Y] [N]
Anemia	[Y] [N]	Hepatitis	[Y] [N]	hearing	[Y] [N]
Bleeding Tendency	[Y] [N]			Problems with • vision	[Y] [N]
Blood Transfusions	[Y] [N]	Other _____			

FEEDING & NUTRITION

Food Allergies

Appetite usually good? [Y] [N]

Colic or feeding problems during the first 3 months? [Y] [N]

Breast Fed? [Y] [N] Number of month's? [Y] [N]

Formula? [Y] [N] Current brand? _____

Vitamins? [Y] [N] Brand _____ Fluoride? [Y] [N]

Special Diet? [Y] [N] _____

FEEDING & NUTRITION

Parents • Married? ☐ Separated? ☐ Divorced? ☐

Father's age? Highest school grade? _____ Health? _____

Mother's age? Highest school grade? _____ Health? _____

_____

_____

_____

FAMILY MEDICAL HISTORY

List all blood relatives of your child who have had the following problems.

Anemia/Blood Dis _____

Asthma _____

Mental Retardation _____

Drug Problem _____

Alcoholism _____

Cancer _____

Aids _____

Cystic Fibrosis _____

Musc. Dystrophy _____

Tuberculosis _____

Arthritis _____

Epilepsy / Seizures _____

Heart Disease _____

High Blood Pressure _____

_____

Cholesterol Problem _____

_____

Migraine _____

Sudden Infant Death _____

Birth Defects _____

Early Deafness _____

Diabetes _____

DEVELOPMENT & BEHAVIOR

Age at which child •

Sat alone_____ Walked_____ Used sentences _____

Toilet trained_____ Bicycled _____

Development compared to other children?

_____

Grade in school___ Problems in School? [Y] [N]

_____

Learning problems? [Y] [N]

Getting along with other children? [Y] [N]

Behavior problems? [Y] [N]

Bad habits? _____ Bedwetting? [Y] [N]

Nail biting? [Y] [N] Sleeping? [Y] [N] Hobbies • sports • social activities? _____

Use of street or illegal drugs? [Y] [N]

_____

SYNOPSIS

_____

_____

_____

_____

REORDER # 99-07984

10752 N. 89th Pl. – Suite 126
Scottsdale, Arizona 85260

TEL (480) 860-1161
FAX (480) 860-4306

SCOTTSDALE PEDIATRIC CENTER, P.C.

Patient Consent for Use and Disclosure of Protected Health Information

With your consent, Scottsdale Pediatric Center, P.C. may use and disclose protected health information (PHI) about you to carry out treatment, payment and health care operations (TPO). Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures. You have the right to review our Notice of Privacy Practices prior to signing this consent. We reserve the right to revise our Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to our Privacy Officer at 10752 N. 89th Pl., Suite 126, Scottsdale, Arizona 85260.

With your consent, Scottsdale Pediatric Center, P.C. may call your home or office and leave a message in reference to any items that assist the practice in carrying out TPO such as appointment reminders, insurance items and any call pertaining to your clinical care.

With your consent, Scottsdale Pediatric Center, P.C. may mail to your home or office any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements.

You have the right to request that we restrict how we use or disclose your PHI to carry out treatment, payment and health care operations. However, we are not required to agree to your requested restrictions, but if we do, we are bound by our agreement.

By signing this form, you are consenting to our use and disclosure of your PHI to carry out treatment payment and health care operations. This consent may be revoked in writing except to the extent that we may have already made disclosures in reliance upon your prior consent. <u>If you decline to sign this consent, we may decline to provide treatment for you.</u>

Signature of Patient or Legal Guardian _____

Patient's Name _____ Date_____

Print Name of Patient or Legal Guardian _____

7/24/12

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FINANCIAL AGREEMENT

Scottsdale Pediatric Center accepts cash, check, MasterCard, Visa, American Express and Discover as payment for services. Please remember it is your full responsibility to know exactly what your insurance benefits are and if you need referrals to see specialists. If you have any concerns regarding your coverage, please call the number on the back of your insurance card and they will clarify your coverage. Our financial Policy is as follows:

- Insurance Co-Payments - All copayments must be paid at the time of service.
- Deductibles/Co-insurance - If your deductible has not been met, full payment for the service will be required.
- Private Pay/Non-Contracted Insurance Company - If you do not have insurance coverage or have an insurance that we are not contracted with, you will be responsible for payment in full at the time of service. Please contact our billing office for an estimate of cost If you are out of network, we will file your claim for a direct reimbursement..
  Laboratory Services - Lab services will be billed out by Sonora Quest. Any lab services will be billed to you directly from the lab and you will need to contact them for any questions.
- No Show Charges - If you miss an appointment or do not cancel more than *24* hours before your scheduled appointment, you may be charged a fee of $25.

It is very important to stay informed regarding your insurance coverage. If you have a new insurance, it is your responsibility to provide updated Information to our office. You will be asked to show your insurance card at every visit. You will be held responsible for the total amount of any unpaid claims that are denied due to incorrect insurance information.

I have read and agree to abide by the above financial policy for Scottsdale Pediatric Center.

_____

*Parent signature/Guarantor *Date

_____

*Print name