WEST HILLS CHILDREN'S MEDICAL GROUP

Scott Calig, M.D., F.A.A.P.

Susanne Sager, M.D., F.A.A.P.

Phone: 818 593-KIDZ (5439)
Fax: 818 593-3460

7301 Medical Center Dr., Suite 300
West Hills, CA 91307

Please COMPLETELY print the following information

Child's Name: _____ M____ F____ Date of Birth _____

Child's Name: _____ M____ F____ Date of Birth _____

Child's Name: _____ M____ F____ Date of Birth _____

Child's Name: _____ M____ F____ Date of Birth _____

Mother's Name: _____ DOB: _____ Driver's License # _____

Home Address: _____
Street Address City State Zip Code

Home Phone: _____ Cell Phone: _____

Work Phone: _____ E-Mail: _____

Employer's Name and Address: _____

_____

Father's Name: _____ DOB: _____ Driver's License # _____

Home Address: _____
Street Address City State Zip Code

Home Phone: _____ Cell Phone: _____

Work Phone: _____ E-Mail: _____

Employer's Name and Address: _____

_____

Primary Contact Phone Number (where automated reminders and lab results will be sent) _____

Would you like us to leave a message on your voice mail if we can't reach you? Y___N___

Do we have permission to send you reminders via-e-mail? Y___N___

Language Spoken at Home: _____ Race: _____ Ethnicity: _____

Emergency Contact Name and Phone Number: _____
(Emergency Contact must be a third party other than parents)

Referred by: _____

Financial Responsibility: Mother _____Father _____ Other (please specify) _____

Preferred Pharmacy Name: _____Preferred Pharmacy Phone: _____

Insurance Company: _____Insured's Name: _____

As a courtesy, we will bill your insurance company, but please remember that payment is your obligation regardless of insurance or other third party involvement

Additional Children Information:

Child's Name: _____M ____F ____ Date of Birth_____

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Child's Name: _____M ____F ____ Date of Birth_____

Child's Name: _____M ____F ____ Date of Birth_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY, THE PRIVACY OF YOUR MEDICAL INFORMATION IF IMPORTANT TO US.

The undersigned Patient or legally authorized representative ("Agent") of the Patient acknowledges that he or she personally received a copy of the Scott Calig, M.D., Inc. Notice of Privacy Policies on the date indicated below:

Patient: _____

Signature: _____ Date: _____

Name of person signing: _____

Information about Agent (attach appropriate documentation):

Agent: _____

Title: _____

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VERIFICATION OF MEDICAL INSURANCE

Name of Insurance Co: _____

Subscriber's Information:

_____

Name | Date of Birth | Social Security Number

_____

Employer | Policy Number | Group Number

PATIENTS WHO CARRY MEDICAL INSURANCE SHOULD REMEMBER THAT PROFESSSIONAL SERVICES ARE RENDERED AND PAYMENT IS THE RESPONSIBILITY OF THE PATIENT/PARENT. INSURANCE BILLING AND ASSISTANCE WITH THE INSURANCE FORMS IS A COURTESY PROVIDED BY OUR OFFICE, HOWEVER, FULL RESPONSIBILITU FOR PAYENT REMAINS WITH THE PATIENT.

TO AVOID DELAYS AND MISUNDERSTANDINGS, IT IS IMPORTANT TO LEARN, BEFOREHAND, EXACTLY WHAT BENEFITS YOUR POLICY PROVIDERS AND WHAT TYPE OF COVERAGE YOU HAVE.

ALL DEDUCTIBES, COPAYMENTS AND COINSUANCE PAYMENTS ARE DUE AND PAYABLE AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE PRIOR TO THE MEDICAL SERVICES BEING RENDERED.

YOUR SIGNATURE BELOW INDICATES THAT YOU ARE IN AGREEMENT WITH OUR FINANCIAL RESPONSIBILTY STATEMENT.

_____ _____

Signature | Date

WEST HILLS CHILDREN'S MEDICAL GROUP

Scott Calig, M.D. Susanne Sager, M.D.

Pediatric Past Medical History

Child's Name:_____Date of Birth: _____Birth weight:_____

Pregnancy:

Prenatal Care ___ Y ___N Maternal Age _____

Problems During Pregnancy ___ Y ___ N (If yes, comment)

During pregnancy and of the following:

___ Swelling of Extremities
___ High Blood Pressure
___ Convulsions
___Anemia
___Diabetes
___STD
___Rubella
___PPD Positive
___ X-Rays During Pregnancy
___Surgery
___STD
___Pos. hepatitis screen
___ Smoking
___ Alcohol use
___Vaginal Bleeding
___Prescription drugs/OTC drugs
___Drug use
___Other

Birth Site: ___Hospital ___Home ___Other _____

Gestation: (weeks) _____ ___Vaginal delivery ___C-Section

Neonatal Problems (First six weeks) ___Y ___N (If yes, comment)

___Congenital Abnormalities
___Breathing
___Jaundice
___Anemia
___Feeding
___Infection
___Re-hospitalization
___Other _____

Childhood Problems: (7 weeks – 12 years old)

___Hospitalization
___Operation(s)
___Serious Injury
___Drug Allergy
___Poisoning
___Gastro/urinary
___Eye
___Ear/Nose/Throat
___Heart
___Respiratory
___Gastrointestinal
___Nervous System
___Muscular/Skeletal
___Skin
___Allergies
___Anemia
___Asthma
___Convulsions
___Developmental
___Endocrine
___Psychological
___Tuberculosis
___Other: _____

Adolescent: (13 years – 18 years)

___Problem with school/family ___Smoking

Adolescent Girls:

___Sexually active ___ETO use Menarche: _____years old Pregnancies ____

___Any offspring ___Drug use Interval: _____Days Duration: ____

Medical History:

___ Allergies to food, environment, medications _____

___Hospitalizations _____

___Surgeries _____

___Injuries, Accidents, Significant Illnesses _____

Family History:

Mother Alive Y/N Father Alive Y/N Number of Siblings (living) _____

Family history of any serious illnesses/disease? Y/N

If yes, indicate relationship

___Alcohol/drugs
___Developmental
___Blood diseases
___Birth defects
___Asthma
___Tuberculosis
___Cancer
___Hypertension
___Heart Disease
___Thyroid

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www.westhillschildrens.net

Continuing Consent to Treatment

(Minor or Child/Children)

I, the undersigned, parent or guardian of _____,
a minor child, does Hereby consent to medical or surgical diagnostic or treatment to said minor, under the general or specific instructions of Scott Calig, M.D. and Susanne Sager, M.D., or their designee, licensed to practice in the State of California, whether such diagnosis or treatment is rendered at the doctor's office or at a hospital licensed by the State of California.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required, but is given in order that said physician may have the opportunity to exercise their best judgment as to the action, which may be necessary or required to protect the life and health of said minor child/children.

_____
Signature of Parent/Guardian Date

_____
Signature of Witness Date

This consent shall remain effective until revoked by a writing delivered to said physician

Additional child/children to be added to the above consent form:

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

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I give permission for the following people to bring my child(ren) in to West Hills Children's Medical Group for treatment/physicals.

NAMES OF PEOPLE ALLOWED TO BRING MY CHILD(REN) TO WEST HILLS CHILDREN'S :

_____

_____

_____

_____

_____

CHILD(REN) NAMES: **DOB:**

_____

_____

_____

_____

_____

Parent's Signature: _____ Date: _____