Patient Information

Patient Name: _____ Male/Female
Date of Birth: _____ Referred by: _____
Medication Allergies: _____
Names of Siblings: _____

Mother's Name: _____ DOB: _____
Address: _____Apt: _____
City: _____ ST: _____ Zip: _____
Home #: _____ Cell#: _____ Work#: _____
SS#: _____ Email Address: _____
Employer: _____

Father's Name: _____ DOB: _____
Address: _____Apt: _____
City: _____ ST: _____ Zip: _____
Home #: _____ Cell#: _____ Work#: _____
SS#: _____ Email Address: _____
Employer: _____

Primary Insurance: _____ Effec. Date: _____
Policy #: _____ Group#: _____ Copay: _____
Secondary Insurance: _____ Effec, Date: _____
Policy#: _____ Group#: _____Copay: _____

I hereby authorize release of information necessary to file a claim with my insurance company. I assign benefits to be paid to La Canada Pediatrics. I understand that I am financially responsible for charges for medical services rendered to the above name patient regardless of insurance coverage including but not limited to any and all immunizations. In the event of collection proceedings due to lack of payment on my part, I agree to pay any and all fees that may be added to my account in order to rover monies due.

X_____ _____
Parent/Guardian Signature Date

La Canada Pediatrics

All Co-Pays, Deductibles, Co-insurance and non-covered services are due and payable at the time of services. If you are unsure of what your policy does or does not cover: **(baby check-ups and immunizations are not covered after a certain age on many plans)**. Please call the insurance payer listed on your insurance ID card for the verification and explanation of your current benefits. We have contracted agreements with many different insurance plans. If you are not sure please ask prior to your examination. If we do not have a contract with your insurance company, charges for your child's office visits are due at the time of service. The parent or guardian will be provided with a copy of the bill to send to your insurance company for any possible reimbursement. Our billing department will be glad to assist you with any claim problems or question you may have. Parents without insurance coverage are required to pay as follows:

Sick: New $80 . . . Established $70

WCC: New $105 . . . Established $95

Follow Up: New/Established $50

As of September 1, 2009 we are no longer accepting personal checks. If on occasion we do accept check: Any returned check due to non-sufficient funds will be charged a $25.00 returned check fee, due payable in cash/credit.

NEWBORNS: We will bill your insurance company for the newborn care and hospitalization. After 60 days, unpaid balances will be the guarantor's responsibility. Most insurances policies require that the guarantor notify them of the birth and add the child to the policy no later than 30 days after the birth. If the child is not added within that time limit, she/he will not be eligible for benefits. The insurance company may also require documents such as birth certificate, marriage license, divorce decree, claim form written documentation that there is no other insurance coverage for the child. If these requirements are not met in a timely manner, the full amount will be due by the parent/guardian.

WALK-INS, NO SHOWS, & SAME DAY CANCELLATIONS: We accept sick patient walk-ins only **Monday to Friday from 8:00 to 10:00**. If you walk-in to be seen after the walk-in hours you must schedule an appointment for the next available appointment time. Please call the office before 9:00 AM if you are canceling your appointment for the same day.

I understand and agree that regardless of my insurance status, I am responsible for the balance on my child's account. I also agree to pay all collection fees up to 45% of the outstanding balance. If the delinquent account is referred to a collection agency or attorney, I agree to pay any attorney fees, court cost, filing fees, including charges of commissions that may be assessed by collection agency of the attorney retained to pursue the matter.

I have read and understand this agreement and agree to abide with the term and conditions.

_____ _____

Parent/ Guardian Signature Date

Minor Child Consent Form

I am the parent/guardian or personal representative of _____
(Child's Name)

And there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize: _____

_____

_____

_____

To sign for consent of treatment to include but no limited to X-rays which are deemed advisable by the doctor whether or not I am present when the treatment is rendered. I also authorized release of any and all medical information to the above named persons.

X _____

Parent/Guardian Guarantor Signature

_____

Printed Name

_____

Date

Initial History Questionnaire

Patient's Name:

Form Completed by _____ Date Completed _____

Birth Date: _____ Age: _____ M F

Household

Please list all those living in the child's home

Name	Relationship to Child	Birthdate

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

_____

_____

What is the child's living situation if not with both biological parents?

☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody

☐ Lives with foster parents

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home? _____

_____

Birth History ■ Don't Know Birth History

Birth Weight _____ Was the baby born at term _____ or Weeks _____

Were there any prenatal or neonatal complications?

☐ Yes ☐ No Explain _____

_____

Was NICU stay required ☐ Yes ☐ No Explain _____

_____

During pregnancy did mother:

Use tobacco ☐ Yes ☐ No

Use drug or medication ☐ Yes ☐ No

What _____

Drink alcohol ☐ Yes ☐ No

☐ Used prenatal vitamins

When _____

Was the delivery ☐ Vaginal ☐ Cesarean If cesarean why?

_____

_____

Was Initial feeding ☐ Formula ☐ Breast Milk

How long breastfeed? _____

Did your baby go home with mother from hospital?

☐ Yes ☐ No Explain _____

_____

_____

General DK= Don't Know

Do you consider your child in good health? ☐ Yes ☐ No ☐ DK Explain _____

_____

Does your child have any serious illness or medical conditions? ☐ Yes ☐ No ☐ DK Explain _____

_____

Has your child had any surgery? ☐ Yes ☐ No ☐ DK Explain _____

_____

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ DK Explain _____

_____

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ DK Explain _____

Biological Family History DK= Don't Know

Have any family members had the following?

Childhood hearing loss	☐ Yes	☐ No	☐ DK	Who _____	Comment _____
Nasal Allergies	☐ Yes	☐ No	☐ DK	Who _____	Comment _____
Asthma	☐ Yes	☐ No	☐ DK	Who _____	Comment _____
Tuberculosis	☐ Yes	☐ No	☐ DK	Who _____	Comment _____
Heart Disease (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comment _____
High cholesterol/takes cholesterol medication	☐ Yes	☐ No	☐ DK	Who _____	Comment _____
Anemia	☐ Yes	☐ No	☐ DK	Who _____	Comment _____
Bleeding disorder	☐ Yes	☐ No	☐ DK	Who _____	Comment _____
Dental decay	☐ Yes	☐ No	☐ DK	Who _____	Comment _____
Cancer (before 55 years old	☐ Yes	☐ No	☐ DK	Who _____	Comment _____

PATIENT'S NAME: **DATE OF BIRTH:**

Biological Family History (continued from front side) DK= Don't Know

Liver disease	☐ Yes	☐ No	☐ DK	Who		Comment	
Kidney disease	☐ Yes	☐ No	☐ DK	Who		Comment	
Diabetes (before 55 years old)	☐ Yes	☐ No	☐ DK	Who		Comment	
Bed-wetting (after 10 years old)	☐ Yes	☐ No	☐ DK	Who		Comment	
Obesity	☐ Yes	☐ No	☐ DK	Who		Comment	
Epilepsy or convulsions	☐ Yes	☐ No	☐ DK	Who		Comment	
Alcohol abuse	☐ Yes	☐ No	☐ DK	Who		Comment	
Drug abuse	☐ Yes	☐ No	☐ DK	Who		Comment	
Mental illness/depression	☐ Yes	☐ No	☐ DK	Who		Comment	
Developmental disability	☐ Yes	☐ No	☐ DK	Who		Comment	
Immune problems, HIV, or AIDS	☐ Yes	☐ No	☐ DK	Who		Comment	
Tobacco use	☐ Yes	☐ No	☐ DK	Who		Comment	

Additional family history _____

_____

Past History DK= Don't Know

Does your child have, or has your child ever had

Chickenpox	☐ Yes	☐ No	☐ DK	When	
Frequent ear infections	☐ Yes	☐ No	☐ DK	Explain	
Problems with ears or hearing	☐ Yes	☐ No	☐ DK	Explain	
Nasal allergies	☐ Yes	☐ No	☐ DK	Explain	
Problems with eyes or hearing	☐ Yes	☐ No	☐ DK	Explain	
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	☐ DK	Explain	
Any heart problem or heart murmur	☐ Yes	☐ No	☐ DK	Explain	
Anemia or bleeding problem	☐ Yes	☐ No	☐ DK	Explain	
Blood transfusion	☐ Yes	☐ No	☐ DK	Explain	
HIV	☐ Yes	☐ No	☐ DK	Explain	
Organ transplant	☐ Yes	☐ No	☐ DK	Explain	
Malignancy/bone marrow transplant	☐ Yes	☐ No	☐ DK	Explain	
Chemotherapy	☐ Yes	☐ No	☐ DK	Explain	
Frequent abdominal pain	☐ Yes	☐ No	☐ DK	Explain	
Constipation requiring doctor visit	☐ Yes	☐ No	☐ DK	Explain	
Recurrent urinary tract infections and problems	☐ Yes	☐ No	☐ DK	Explain	
Congenital cataracts/retinoblastoma	☐ Yes	☐ No	☐ DK	Explain	
Metabolic/Genetic disorders	☐ Yes	☐ No	☐ DK	Explain	
Cancer	☐ Yes	☐ No	☐ DK	Explain	
Kidney disease or urologic malformations	☐ Yes	☐ No	☐ DK	Explain	
Bed-wetting (after 5 years old)	☐ Yes	☐ No	☐ DK	Explain	
Sleep problems; snoring	☐ Yes	☐ No	☐ DK	Explain	
Chronic or recurrent skin problems (e.g., acne, eczema)	☐ Yes	☐ No	☐ DK	Explain	
Frequent headaches	☐ Yes	☐ No	☐ DK	Explain	
Convulsions or other neurologic problems	☐ Yes	☐ No	☐ DK	Explain	
Obesity	☐ Yes	☐ No	☐ DK	Explain	
Diabetes	☐ Yes	☐ No	☐ DK	Explain	
Thyroid or other neurologic problems	☐ Yes	☐ No	☐ DK	Explain	
High Blood Pressure	☐ Yes	☐ No	☐ DK	Explain	
History of serious injuries/fractures/ concussions	☐ Yes	☐ No	☐ DK	Explain	
Use of alcohol or drugs	☐ Yes	☐ No	☐ DK	Explain	
Tobacco use	☐ Yes	☐ No	☐ DK	Explain	
ADHD/anxiety/mood problems/ depression	☐ Yes	☐ No	☐ DK	Explain	
Developmental delay	☐ Yes	☐ No	☐ DK	Explain	
Dental decay	☐ Yes	☐ No	☐ DK	Explain	
History of family violence	☐ Yes	☐ No	☐ DK	Explain	
Sexually transmitted infections	☐ Yes	☐ No	☐ DK	Explain	
Pregnancy	☐ Yes	☐ No	☐ DK	Explain	
(For girls) Problems with her periods	☐ Yes	☐ No	☐ DK	Explain	

Has had first period ☐ Yes ☐ No Age of first period: _____

Any other significant problem _____

_____