Angel Pediatrics

## BIRTH HISTORY

**CHILDS NAME:** _____ DOB: _____

Birth Weight_____ Length_____ Place of birth _____

Preterm or Full Term_____ Vaginal or C-Section Delivery_____

List any complications during pregnancy or delivery: _____

Length of baby's hospital stay after birth: _____

Did he/she have any problems? (E.g. Jaundice, respiratory distress, infection)

_____

## PAST MEDICAL HISTORY

Has the child ever had any problems with the following? If YES, please explain:

| | |
|---|---|
| ADHD | Yes_____ No |
| Asthma/RAD | Yes_____ No |
| Allergies (Food/Environmental) | Yes_____ No |
| Anemia/Blood Disorders | Yes_____ No |
| Bones/Joints | Yes_____ No |
| Diabetes | Yes_____ No |
| Ears (Multiple infections) Hearing | Yes_____ No |
| Eyes/Vision | Yes_____ No |
| Gastrointestinal (GE reflux/ Constipation/diarrhea | Yes _____ No |
| Heart | Yes_____ No |
| Repeated infections | Yes_____ No |
| Seizures/Headaches | Yes_____ No |
| Skin (Eczema) | Yes_____ No |
| Urine/Kidneys | Yes_____ No |
| Other | Yes _____ No |

Allergies to medicine Yes_____ No

Please list any hospitalizations, operations, serious illnesses or injuries with dates:

_____ Date: _____

_____ Date: _____

Please list any developmental problems or delays and when they occurred:

_____ Age: _____

_____ Age: _____

Immunizations up to date? Yes ___ No ___

Please list medications child is currently taking and reason:

| Medication | Reason |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Vaccines for Children (VFC) Program**
**Patient Eligibility Screening Record**

A record of all children 18 years of age or younger who receive immunizations must be kept in the health care provider's office for 6 years. The record may be completed by the parent, guardian, individual of record, or by the health care provider. VFC eligibility screening and documentation of eligibility status must take place with each immunization visit to ensure the child's eligibility status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine. Providers using a similar form (paper-based or electronic) must capture all reporting elements included in this form.

1. Child's Name: _____
   Last Name First Name MI

2. Child's Date of Birth: __ __/ __ __/__ __ __ __

3. Parent/Guardian/Individual of Record: _____
   Last Name First Name MI

4. Primary Provider's Name: _____
   Last Name First Name MI

5. To determine if a child (0 through 18 years of age) is eligible to receive federal vaccine through the VFC and state programs, at each immunization encounter/visit enter the date and mark the appropriate eligibility category. If Column A-E is marked, the child is eligible for the VFC program. If column F or G is marked the child is not eligible for federal VFC vaccine.

| | Eligible for VFC Vaccine | | | | | Not eligible for VFC Vaccine | |
|---|---|---|---|---|---|---|---|
| | A | B | C | D | E | F | G |
| Date | Medicaid Enrolled | No Health Insurance | American Indian or Alaskan Native | *Underinsured served by FQHC, RHC or deputized provider | **Enrolled in Kids Care | ***Other underinsured | Has health insurance that covers vaccines |
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*Underinsured includes children with health insurance that does not include vaccines or only covers specific vaccine types. Children are only eligible for vaccines that are not covered by insurance. In addition, to receive VFC vaccine, underinsured children must be vaccinated through a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) or under an approved deputized provider. The deputized provider must have a written agreement with an FQHC/RHC and the state/local/territorial immunization program in order to vaccinate underinsured children.

**Children enrolled in separate state Children's Health Insurance Program (CHIP). These children are eligible for VFC vaccines but will need to be billed to AHCCCS as KidsCare.

***Other underinsured are children that are underinsured but are not eligible to receive federal vaccine through the VFC program because the provider or facility is not a FQHC/RHC or a deputized provider. However, these children may be served if vaccines are provided by the state program to cover these non-VFC eligible children.

**Please be advised:**

**If your insurance company does not cover immunizations and you do not let us know at the time of the visit, it is your responsibility to pay the cost involved. We cannot make the Vaccines for Children Program retroactive and you are only eligible for the Vaccines for Children Program at the time of the visit. If you are unsure if immunizations and well check-ups are covered, please contact your insurance company.**

**Thank You.**

**Please sign below indicating that you understand and agree with the above statement.**

**Signature: _____Date:_____**