

**PEDIATRICS OF BARTLESVILLE**  
**FAMILY INFORMATION SHEET**

DATE FORM COMPLETED: \_\_\_\_\_

Parent or Guardian responsible for this account: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ DOB: \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

Employer Name: \_\_\_\_\_

☐ check if same as above

Father's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

Employer Name: \_\_\_\_\_

☐ check if same as above

Mother's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Other than PARENT - List EMERGENCY contact Name: \_\_\_\_\_

Phone #: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Please list **ALL** your children (including newborns and foster children)

1) \_\_\_\_\_ DOB: \_\_\_\_\_ M or F SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

2) \_\_\_\_\_ DOB: \_\_\_\_\_ M or F SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

3) \_\_\_\_\_ DOB: \_\_\_\_\_ M or F SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

4) \_\_\_\_\_ DOB: \_\_\_\_\_ M or F SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**\*\*list any others on the back of this page**

Referred by: \_\_\_\_\_

**CONSENT FOR MEDICAL TREATMENT OF A MINOR (Optional)**

As a parent or legal guardian, I give my permission for the above named child(ren) to receive medical care (including diagnosis and treatment) in my absence.

Signature: \_\_\_\_\_

**PAYMENT FOR PROFESSIONAL SERVICES (Must be signed)**

It is the policy of this practice to require payment for all professional services (including laboratory work, immunizations and treatment(s) at the time the services are rendered unless other arrangements have been made in advance. The person responsible for this account is liable for all fees. We file insurance claims, however, any dispute by the insurance carrier is between you and the company.

You may be billed for after-hours telephone consultations with the pediatrician or medical assistant on call. You may be billed for failure to keep scheduled appointments.

I have read, understood and agree to the above statement of policy.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **PEDIATRICS OF BARTLESVILLE**

3400 Frank Phillips Blvd.

302 Medical Park Center

BARTLESVILLE, OKLAHOMA 74006

918-331-2468 • FAX 918-331-2469

*Gopal Chandrasekharan, M.D., FAAP*

*Linda Doyle, M.D., FAAP*

*Paul McQuillen, M.D., FAAP*

### **After Hours Telephone Consultations**

Please be aware that our office charges for after hours telephone consultations with either the physician on call or a medical assistant.

We consider after hour's telephone consultations an important service to our patients. When on call, we are available for prompt reply to all messages from the hospital operator. We obtain pertinent information from the parent so that the proper medical decision can be made. We are then responsible to formulate the appropriate treatment plan or advise and keep a permanent record of the phone call.

Many evening and late night phone calls are clearly not urgent. We encourage parents to call with questions during regular office hours. It is obvious that inappropriate and unnecessary nighttime phone calls are discouraged.

Please be aware in the future those people who choose to seek our medical advice and assistance after regular office hours will continue to be charged a professional fee for this service.

**These charges are not going to be covered by your insurance.**

I have read and understand the above statement of policy regarding after hours phone call and charges relating to these calls.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (*PHI*). The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

### I wish to be contacted in the following manner (check all that apply):

- |                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                           |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Home Telephone _____<br><input type="checkbox"/> O.K. to leave message with detailed information<br><input type="checkbox"/> Leave message with call-back number only<br><br><input type="checkbox"/> Work Telephone _____<br><input type="checkbox"/> O.K. to leave message with detailed information<br><input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> Written Communication<br><input type="checkbox"/> O.K. to mail to my home address<br><input type="checkbox"/> O.K. to mail to my work/office address<br><input type="checkbox"/> O.K. to fax to this number<br><br><input type="checkbox"/> Other _____<br>_____ |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

\_\_\_\_\_  
Patient/Authorized Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name(s) (List all children)

\_\_\_\_\_  
Birthdates (all children)

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for *PHI* to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of *PHI* disclosures. Information provided below, if completed properly, will constitute an adequate record.

***Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.***

### Record of Disclosures of Protected Health Information

| Date | Disclosed To Whom<br>Address or Fax Number | (1) | Description of Disclosure/<br>Purpose of Disclosure | By Whom Disclosed | (2) | (3) |
|------|--------------------------------------------|-----|-----------------------------------------------------|-------------------|-----|-----|
|      |                                            |     |                                                     |                   |     |     |
|      |                                            |     |                                                     |                   |     |     |
|      |                                            |     |                                                     |                   |     |     |
|      |                                            |     |                                                     |                   |     |     |
|      |                                            |     |                                                     |                   |     |     |
|      |                                            |     |                                                     |                   |     |     |
|      |                                            |     |                                                     |                   |     |     |
|      |                                            |     |                                                     |                   |     |     |
|      |                                            |     |                                                     |                   |     |     |

(1) Check this box if the disclosure is authorized

(2) Type Key: T=Treatment Records; P=Payment Information; O=Healthcare Operations

(3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other

**Marketing Health-Relation Services:** Our office does not use patient information for any marketing purposes. We will not use your children's health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your children's health information when it is required by law to do so (i.e. missing person, etc.).

**Abuse or Neglect:** We may use or disclose your children's health information to appropriate authorities if we reasonably believe that the children are possible victims of abuse, neglect, or domestic violence or the possible victims of other crimes. We may disclose your children's health information to the extent necessary to avert a serious threat to their health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to lawfully authorized federal officials health information required by lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your children's health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

**Patient Rights:**

**Access:** You have the right to look at or get copies of your children's health information, with limited exceptions. You must make a request in writing to obtain access to your children's health information. You may obtain a form to request access by contacting our office. We may charge you a reasonable cost-based fee for expenses such as copies and staff time.

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your children's health information for any purpose, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your children's health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your children's health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or locations, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your children's health information. Your request must be in writing. It must explain why the information should be amended. We may deny your request under certain circumstances.

**Questions and Complaints:** If you desire further information about our privacy practices or if you have questions, please contact us. If you are concerned that we may have violated your children's privacy rights, or you disagree with a decision we made about access to your children's health information or in response to a request you made to amend or restrict the use or disclosure of your children's health information or to have us communicate with you by alternative means or locations, you may complain to us using the contact information listed at the top of this notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the Department of Health and Human Services.

I have read, understand and agree to the above statement of policy regarding my children's protected health information and that of any children over whom I have legal guardianship.

Signature\_\_\_\_\_Date\_\_\_\_\_



**Pediatrics of Bartlesville**  
**3400 SE Frank Phillips Blvd., Suite 302**  
**Bartlesville, OK 74006**  
**Phone 918-331-2468 Fax 918-331-2469**

**Notice of Privacy Practices**

This notice is to inform you that the personal health information of the patients of Pediatrics of Bartlesville will only be used for purposes of treatment in our facility and will not be misused or disclosed by or to anyone outside of our practice in any way other than those described below. You may gain access to this information if you desire.

**Our Legal Duty:** We are required by applicable federal and state law to maintain the privacy of protected health information. We are also required to give you this notice about our privacy practices, our legal duties and your rights concerning protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice became effective April 14, 2003. We reserve the right to change our privacy practices and the terms of this notice at any time provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request. You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact our office.

**Uses and Disclosures of Protected Health Information:**

We may use and disclose protected health information concerning your children as well as any children over whom you are appointed legal guardian, henceforth referred to as "your children". Information may be used or disclosed for treatment, payment, and other healthcare operations. Some examples of these disclosures:

- Treatment:** We may use or disclose your children's health information to a physician or other healthcare provider who is currently providing treatment to your children.
- Payment:** We may use or disclose your children's health information to obtain payment for services we provide. (i.e. insurance companies).
- Healthcare Operations:** We may use or disclose your children's health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance. Conducting training programs, accreditation and certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your children's health information for treatment, payment or other healthcare operations, you may give us written authorization to use your children's health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect. Unless you give a written authorization, we cannot use or disclose your children's health information for any reason except those described in this notice.

**Your Family and Friends:** We must disclose your children's health information to you, as described in the Patient Rights section of this notice. We may disclose your children's health information to a family member, friend or other person to the extent necessary to help with your children's healthcare or with payment for your children's healthcare only if you specifically authorize us in writing to do so.

**Persons Involved in Care:** We may use or disclose health information to notify, or assist in the notification of (included identifying or locating) a family member, your personal representative or another person responsible for your children's care, your location, your general condition, or death. If you are present, then prior to use or disclosure of your children's health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to that person's involvement in your children's healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your children's best interest in allowing a person to pick up prescriptions, medical supplies, x-rays, or other similar forms of health information.

**VACCINE FOR CHILDREN PROGRAM  
ELIGIBILITY SCREENING**

**Today's Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Child's Name:** \_\_\_\_\_  
Last First MI

**Child's Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **M / F**

**Mother's Name:** \_\_\_\_\_  
Last First MI

**Mother's Maiden Name:** \_\_\_\_\_

**Father's Name:** \_\_\_\_\_  
Last First MI

**Address:** \_\_\_\_\_

\_\_\_\_\_  
City State Zip Code

Please answer the following questions: (Circle the answer that applies)  
**IF YOU DO NOT CIRCLE ONE OF THE FOLLOWING, WE WILL  
ASSUME YOU WILL PAY FULL PRICE FOR THE VACCINE or  
your insurance covers vaccines.**

My child qualifies for the VFC program because he/she:

- A. Is enrolled in Medicaid (SoonerCare)
- B. Does NOT have health insurance
- C. Is an American Indian or Alaskan Native

Child's Medicaid (SoonerCare) number: \_\_\_\_\_

Child's Race: \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_

## Initial History Questionnaire

FORM COMPLETED BY \_\_\_\_\_

DATE COMPLETED \_\_\_\_\_

Name \_\_\_\_\_

ID NUMBER \_\_\_\_\_

BIRTH DATE \_\_\_\_\_

AGE \_\_\_\_\_

M F

### Household

Please list all those living in the child's home.

| Name | Relationship to child | Birth date | Health problems |
|------|-----------------------|------------|-----------------|
|      |                       |            |                 |
|      |                       |            |                 |
|      |                       |            |                 |
|      |                       |            |                 |
|      |                       |            |                 |
|      |                       |            |                 |

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 family

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 a NICU stay required? ☐ Yes ☐ No Explain \_\_\_\_\_

During pregnancy, did mother

Use tobacco ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ NoUse drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins

What \_\_\_\_\_ When \_\_\_\_\_

Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, why? \_\_\_\_\_Was initial feeding ☐ Formula ☐ Breast milk How long breastfed? \_\_\_\_\_

Did your baby go home with mother from the hospital?

☐ Yes ☐ No Explain \_\_\_\_\_

### General

DK = don't know

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ DK Explain \_\_\_\_\_Does your child have any serious illnesses 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 \_\_\_\_\_Do you feel your family has enough to eat? ☐ Yes ☐ No ☐ DK Explain \_\_\_\_\_

### Biological Family History

DK = don't know

Have any family members had the following?

|                                               |                                                                                      |           |                |
|-----------------------------------------------|--------------------------------------------------------------------------------------|-----------|----------------|
| Childhood hearing loss                        | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK | Who _____ | Comments _____ |
| Nasal allergies                               | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK | Who _____ | Comments _____ |
| Asthma                                        | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK | Who _____ | Comments _____ |
| Tuberculosis                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK | Who _____ | Comments _____ |
| Heart disease (before 55 years old)           | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK | Who _____ | Comments _____ |
| High cholesterol/takes cholesterol medication | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK | Who _____ | Comments _____ |
| Anemia                                        | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK | Who _____ | Comments _____ |
| Bleeding disorder                             | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK | Who _____ | Comments _____ |
| Dental decay                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK | Who _____ | Comments _____ |
| Cancer (before 55 years old)                  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK | Who _____ | Comments _____ |

(Biological Family History continued on back side.)

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



Initial History Questionnaire

## Biological Family History (Continued from front side.) DK = don't know

|                                  |                              |                             |                             |           |                |
|----------------------------------|------------------------------|-----------------------------|-----------------------------|-----------|----------------|
| Liver disease                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Who _____ | Comments _____ |
| Kidney disease                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Who _____ | Comments _____ |
| Diabetes (before 55 years old)   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Who _____ | Comments _____ |
| Bed-wetting (after 10 years old) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Who _____ | Comments _____ |
| Obesity                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Who _____ | Comments _____ |
| Epilepsy or convulsions          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Who _____ | Comments _____ |
| Alcohol abuse                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Who _____ | Comments _____ |
| Drug abuse                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Who _____ | Comments _____ |
| Mental illness/depression        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Who _____ | Comments _____ |
| Developmental disability         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Who _____ | Comments _____ |
| Immune problems, HIV, or AIDS    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Who _____ | Comments _____ |
| Tobacco use                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Who _____ | Comments _____ |
| Additional family history _____  |                              |                             |                             |           |                |

## Past History DK = don't know

Does your child have, or has your child ever had,

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

**This American Academy of Pediatrics Initial History Questionnaire is consistent with Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 3rd Edition.**

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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**OKLAHOMA STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)**

**Patient Name:** \_\_\_\_\_

**Medical Record #:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Social Security #:** \_\_\_\_\_

I hereby authorize \_\_\_\_\_  
Name of Person/Organization Disclosing PHI + phone#

to release the following information to \_\_\_\_\_  
Name and Address of Person/Organization Receiving PHI + phone#

**Information to be shared:**

- ☐ Psychotherapy Notes (if checking this box, no other boxes may be checked)    ☐ Entire Medical Record  
☐ Billing Information for \_\_\_\_\_    ☐ Mental Health Records  
☐ Substance Abuse Records    ☐ Medical information compiled between \_\_\_\_\_ and \_\_\_\_\_  
☐ Other: \_\_\_\_\_

**The information may be disclosed for the following purpose(s) only:**

- ☐ Insurance    ☐ Continued Treatment    ☐ Legal    ☐ At my or my representative's request  
☐ Other: \_\_\_\_\_

**I understand that by voluntarily signing this authorization:**

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person/organization disclosing the information and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment or payment of claims.
- My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea or HIV or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.
- I understand I may change this authorization at any time by writing to the person/organization disclosing my PHI.
- I understand I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Privacy Regulation.

Unless revoked or otherwise indicated, this authorization's automatic expiration date will be one year from the date of my signature or upon the occurrence of the following event: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Legal Representative's Authority

\_\_\_\_\_  
Expiration date (if longer than one year from date of signature or no event is indicated)