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 arrangments 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):

☐ Home Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number

☐ Other _____

_____

_____ _____
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 Address or Fax Number	(1)	Description of Disclosure/ 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 l4, 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 infornation 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.

OSIIS Demographic Form

Vaccine for Children Screening

Today's Date: _____

Child's Name: _____
Last First Middle

Child's Date of Birth: _____/_____/_____ Gender: M / F

Birth Country: _____ Birth State: _____

Language Spoken: _____

Ethnicity: (circle one) Hispanic or Latino or Not Hispanic or Latino

Race: (circle one) American Indian/Alaskan Native; Asian; Black/African American
Native Hawaiian/Other Pacific Islander; or White

Mother's/Father's/Legal Guardian's Name: _____

Mother's Maiden Name: _____

Address: _____

_____
City State Zip Code

VFC Elig Screening:

Does the patient have Medicaid/Soonercare? _____

Medicaid/Soonercare #, if applicable: _____

Is the patient American Indian or Alaskan Native: _____

Is the patient Self Pay/Does not have health insurance? _____

Signature of Parent or Guardian: _____

Initial History Questionnaire

Name

ID NUMBER

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	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 ☐ No

Use 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	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Asthma	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tuberculosis	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Heart disease (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
High cholesterol/takes cholesterol medication	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Anemia	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bleeding disorder	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Dental decay	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Cancer (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

(Biological Family History continued on back side.)

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

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

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

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 vision	☐ 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 visits	☐ 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 (eg, 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 endocrine 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 _____

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

HE0328

9-52/Rep0814

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)