Pediatrics of Bartlesville, Pllc

List all children that are patient's ask for additional sheet if needed

Child's Name:	Date of Birth:	🗆 Male	Preferred Name:
		🗆 Female	
Child's Race: American Indian or Alaska Native Asian African American White Unknown Patient Declined Other	Child's Ethnicity: Hispanic Not Hispanic or Latino P Declined Unknown		Patient Adopted or in Custody: Yes (if yes, please provide legal documentation for patient's chart) No
Insurance:	Medicaid#:		Social security #:

Child's Name:	Date of Birth:	MaleFemale	Preferred Name:
Child's Race: American Indian or Alaska Native Asian African American White Unknown Patient Declined Other	Child's Ethnicity: Hispanic Not Hispanic or Latino P Declined Unknown		Patient Adopted or in Custody: Yes (if yes, please provide legal documentation for patient's chart) No
Insurance:	Medicaid#:		Social security#:

Child's Name:	Date of Birth:	
Child's Race: American Indian or Alaska Native Asian African American White Unknown Patient Declined Other	Child's Ethnicity: Hispanic or Latino Not Hispanic or Latino Patient Declined Unknown	Patient Adopted or in Custody: ☐ Yes (if yes, please provide legal documentation for patient's chart) ☐ No
Insurance: □ Self-Pay □ Private □ Medicaid	Medicaid#:	Social security#:

st Financially Responsible Guardian here	Parent/Guardian Information		
Parent/Legal Guardian:	Parent/Legal Guardian:		
Date of Birth: SSN:	Date of Birth:	SSN:	
Address:	Address:		
City: State:	lip: City:	State:	Zip:
County:	County:		
Phone Number: Cell:	Phone Number:	Cell:	:
Consent to text: yes no (circ	one) Consent to text: ye	s no	(circle one)
Email Address:	Email Address:		
Register for patient portal: Yes No (c	cle one) Register for patient porta	al: Yes N	lo (Circle one)

Preferred contact number for appointme Preferred Pharmacy	ent reminders (we can only text one):	Ok to text
Emergency contact name	Phone	Relationship

Child's Name:	Date of Birth:	□ Male □ Female	Preferred Name:
Child's Race: □American Indian or Alaska Native □ Asian □African American □White □Unknown □ Patient Declined □Other	Child's Ethnicity: His Not Hispanic or Lating Declined Unknown	5	Patient Adopted or in Custody: Yes (if yes, please provide legal documentation for patient's chart) No
Insurance:	Medicaid#:		Social security#:

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Child's Race: American Indian or Alaska Native Asian African American White Unknown Patient Declined Other	Child's Ethnicity: Hispanic or Latino Not Hispanic or Latino Patient Declined Unknown		Patient Adopted or in Custody: □ Yes (if yes, please provide legal documentation for patient's chart) □ No
Insurance:	Medicaid#:		Social security #:

Child's Name:	Date of Birth:	🗆 Male	Preferred Name:
· · · · · ·		Female	
Child's Race: 🗆 American Indian or Alaska Native 🗆	Child's Ethnicity: Hispan	ic or Latino	Patient Adopted or in Custody:
Asian 🗆 African American 🗆 White 🗆 Unknown	🗆 Not Hispanic or Latino 🗌 Patient		Yes (if yes, please provide legal
Patient Declined Other	Declined 🗌 Unknown		documentation for patient's chart)
			□ No
Insurance:	Medicaid#:		Social security#:
□ Self-Pay □ Private □ Medicaid			

Child's Name:	Date of Birth:	□ Male □ Female	Preferred Name:
Child's Race: American Indian or Alaska Native Asian African American White Unknown Patient Declined Other	 Child's Ethnicity: □Hispanic or Latino □ Not Hispanic or Latino □ Patient Declined □Unknown 		Patient Adopted or in Custody: □ Yes (if yes, please provide legal documentation for patient's chart) □ No
Insurance:	Medicaid#:		Social security#:

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PEDIATRICS OF BARTLESVILLE, PLLC 3400 Frank Phillips Blvd., Suite 302 Bartlesville, Oklahoma 74006 918-331-2468 • FAX 918-331-2469 www.pediatricsofbartlesville.com

Gopal Chandrasekharan, M.D., FAAP

Linda Doyle, 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.

Pediatrics of Bartlesville GENERAL ACKNOWLEDGEMENT AND CONSENT

Consent for medical treatment of a minor: (optional)

As a parent or legal guardian, I give my permission for my child/children to receive medical care (including but not limited to diagnosis and treatment) in my absence.

Parent or guardian initials:

Financial Policies and payment for professional services:

As a courtesy to our patients, we bill insurance for services rendered. I understand my insurance may not cover all visits, e.g., preventive care, hearing & vision screenings, labs, vaccines, etc. I understand I am financially responsible for all services or fees regardless of insurance coverage. I further authorize the release of necessary information to my insurance company/or their agents to determine benefits payable for related services. I also authorize the payment of benefits directly to Pediatrics of Bartlesville.

Parent or guardian initials: _____

Late Appointments: Patients arriving more than 15 minutes late will be rescheduled.

Parent or guardian initials:

Failed appointments

When a patient "no-shows", other patients who are ill or needing to be seen are denied that time slot. As a courtesy we ask that you please give 24 hours' notice to reschedule or cancel your appointment. If you do not cancel at least an hour before your scheduled time you may be charged for a failed appointment. Patients who repeatedly miss appointments may be dismissed from the practice.

Parent or guardian initials:

I have read and understand the after-hours telephone consult policy and realize I may be charged for this service:

Parent or guardian initials: _____

Notice of Privacy Practices/Patients' Rights and Responsibilities/HIPPA:

I have the right to request the Patient Rights and Responsibilities/notice of Privacy Practices/HIPPA prior to signing this consent. Pediatrics of Bartlesville reserves the right to revise these documents at any time.

Parent or guardian initials: _____

Custody Documentation

After hours telephone policy

I understand unless otherwise prohibited by court order or statue, all records and information pertaining to the child/children shall be equally available to both parents in all types of custody arrangements. Please be aware that all information will be available to both parents regardless of custody arrangements unless legal documentation is presented to Pediatrics of Bartlesville revoking all parental rights.

Parent or guardian initials: _____

Medication History

I authorize Pediatrics of Bartlesville to obtain/have access to my child/children's medication history.

Parent or guardian initials:

Signature of parent or guardian

Date

Pediatrics of Bartlesville, PLLC

HIPAA - Patient Consent of Information

Pediatrics of Bartlesville, in order to comply with the HIPAA Privacy Regulation, requires an authorization from the patient before detailed messages are left for the patient. This policy is to protect the privacy of the patient and to protect the physicians and staff of Pediatrics of Bartlesville from violating the patient's confidentiality. If there is not a signed consent on file, physicians and staff will only leave their name and telephone number on an answering machine, voicemail or with a live person answering the phone requesting the patient to return the call.

By completing the consent below, you are allowing Pediatrics of Bartlesville physicians and its staff to leave a message on an answering machine, voicemail or with a specified individual. You may specify what information is left and with whom by noting the information on the bottom of this form. By signing, you are also consenting to the mailing or faxing of any results, requested by you, to your primary care physician or another physician involved in your care.

I give my consent to Pediatrics of Bartlesville physicians and staff to leave a message regarding scheduling, treatment, surgery, lab or radiology results, or other information as necessary (check all that apply):

on an answering machine or voicemail at home or cell phone on an answering machine or voicemail at work				
on an answering machine or voicemail at work				
on an answering machine or voicemail at work				
with relationship				
with relationship				

I do not consent to messages being left at home, work or with any other person. I wish to be contacted directly

Patient's Name (Please Print)

Patient's Signature

Date

Date of Birth

Witness

Date

HIPAA – Notice of Privacy Practice Acknowledgement

____I have been provided a copy of Pediatrics of Bartlesville Privacy Practice.

_____I have declined a copy of Pediatrics of Bartlesville Notice of Privacy Practice.

Patient's Signature

Date

Patient Eligibility Screening Record Vaccines for Children (VFC) Program

VFC eligibility screening must be conducted whenever a child age 18 years or younger receives state-supplied vaccine. Although screening must take place during EACH immunization visit to ensure the child's eligibility status has not changed, documentation on this form is required only during the initial visit of a VFC-eligible child and during any subsequent visit in which it is determined the child's eligibility status has changed. The screening record may be completed by the parent/guardian/individual of record or by the health care provider. Verification of responses is not required. This form (or similar information) must be maintained in the child's medical record.

Primary Prov	vider's Name: <u>Pe</u>	ediatrics of Bartlesvi	ille			
Initial Screer	ing Date:	Child's	Date of Birth			
Child's Nam	e:	Last Name				
		First	MI			
Child's Birth	Country:	Birth State:Language Spoken:				
Mother's Ma	iden Name:					
Parent/Guar Individual c	of Record:					
For access		Name our child's immuniza		MI provide the follow	ving information:	
Email Addres	SS		Cell Phone:			
Does this pa	atient qualify for t	he VFC program?				
	cone eligibility bo					
	Medicaid					
	American Ir	ndian/Alaska Native				
	Uninsured					
	Underinsur	ed (health insurance o	does not cover cost	of vaccines)		
Eligibility						
		bility status must b uired on the table belo				
	,		VFC Eligibility Sta		.,	
Date		(place an	"x" under the appropr			
Butt	Medicaid	American Indian/ Alaska Native	Uninsured	Underinsured*	Does not meet eligibility criteria	
			b			
				II		

*To be supported with VFC vaccine, underinsured children must be vaccinated through a Federally Qualified Health Center.

Name Birth Health problems Ware b child dite problems What is the child's living situation if not with both biological parents? Uves with adoptive parents Joint custody Single custody Birth display display Uves with adoptive parents Joint custody Single custody Birth display display display display Uves with adoptive parents display Birth display Don't know birth history Birth weight Was the baby born at term? OR weeks Ware there any prenatal or necontal complications? OR weeks Was the delivery Vaginal Cesarean If cesarean, why? Were there any prenatal or necontal complications? Ves No Explay Dif your baby go hone with mother from the hospital? During pregnancy, did mother Use drags or medicalions or Yes No DK Explain dif yes No DK Explain Do you consider your child to be in good health? Yes No DK Explain dif yes No DK Explain Has your child had any surgery? Yes No DK Explain disore		\bigcirc				\bigcirc
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Cancer (before 55 years old)	Cancer (before 55 years old)	🗆 Yes	🗆 No	🗆 DK	Who	Comments

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



Initial History Questionnaire

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

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Liver disease	□ Yes	□ No		Who	Commente
Kidney disease	□ Yes	□ No			Comments
Diabetes (before 55 years old)	□ Yes	□ No			Comments
Bed-wetting (after 10 years old)	🗆 Yes	□ No		5	Comments
Obesity	□ Yes	□ No			Comments Comments
Epilepsy or convulsions	🗆 Yes	🗆 No			Comments
Alcohol abuse	🗆 Yes	🗆 No			
Drug abuse	□ Yes	🗆 No			
Mental illness/depression	□ Yes	🗆 No			Comments
Developmental disability	🗆 Yes	🗆 No			Comments
Immune problems, HIV, or AIDS	🗆 Yes	🗆 No			Comments
Tobacco use	□ Yes	□ No			Comments
Additional family history					

Past History DK = don't know

Does your child have, or has your child ever had,				
Chickenpox		_		
Frequent ear infections	□ Yes	□ No	🗆 DK	When
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		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
	Yes	🗆 No	🗆 DK	Explain
	□ Yes	🗆 No	🗆 DK	Explain
Organ transplant Malignansu//	🗆 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		Explain
Chronic or recurrent skin problems (eg, acne, eczema)	🗆 Yes	🗆 No	🗆 DK	Explain
Frequent headaches	□ Yes	🗆 No		Explain
Convulsions or other neurologic problems	□ Yes	□ No		Explain
Obesity	□ Yes	🗆 No		Explain
Diabetes	□ Yes	🗆 No		Explain
Thyroid or other endocrine problems	🗆 Yes	□ No		Explain
High blood pressure	🗆 Yes	□ No	🗆 DK	Explain
History of serious injuries/fractures/concussions	🗆 Yes	□ No		Explain
Use of alcohol or drugs	🗆 Yes	🗆 No		Explain
Tobacco use	□ Yes	🗆 No		Explain
ADHD/anxiety/mood problems/depression	🗆 Yes	🗆 No		Explain
Developmental delay	🗆 Yes	🗆 No		Explain
Dental decay	□ Yes	□ No		Explain
History of family violence	🗆 Yes	□ No		Explain
Sexually transmitted infections	🗆 Yes	□ No		Explain
Pregnancy	□ Yes	□ No		Explain
(For girls) Problems with her periods	🗆 Yes	🗆 No		Explain
Has had first period \square Yes \square No \square 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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