Pediatrics of Bartlesville, Pllc

Patient 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: ☐Self-Pay ☐Private ☐Medicaid	Medicaid#:	Social security #:

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Insurance: ☐Self-Pay ☐Private ☐Medicaid	Medicaid#:	Social security#:

List 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: Zip:	City: State: Zip:
County:	County:
Phone Number: Cell:	Phone Number: Cell:
Consent to text: yes no (circle one)	Consent to text: yes no (circle one)
Email Address:	Email Address:
Register for patient portal: Yes No (circle one)	Register for patient portal: Yes No (Circle one)

Preferred contact number for appointment reminders (we can only text one): _____ Ok to text_____

Preferred Pharmacy _____

Emergency contact name _____Phone _____Relationship_____

_____ _____ _____

Parent or Legal Guardian (Print) Signature - Parent or Legal 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):

_____ via text message
_____ on an answering machine or voicemail at home or cell phone
_____ 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) Date of Birth

_____ _____
Patient's Signature Date

_____ _____
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

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: _____

After hours telephone policy
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
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**

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 Provider's Name: **Pediatrics of Bartlesville**

Initial Screening Date: _____ Child's Date of Birth _____

Child's Name: _____
Last Name First MI

Child's Birth Country: _____ Birth State: _____ Language Spoken: _____

Mother's Maiden Name: _____

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

For access from home to your child's immunization record please provide the following information:

Email Address _____ Cell Phone: _____

Does this patient qualify for the VFC program? ☐ Yes ☐ No

If yes, check one eligibility box:

- ☐ Medicaid
- ☐ American Indian/Alaska Native
- ☐ Uninsured
- ☐ Underinsured (health insurance does not cover cost of vaccines)

Eligibility Changes

Although VFC eligibility status must be reviewed EVERY time a vaccine is administered, documentation is required on the table below ONLY when changes in VFC eligibility occur.

Date	VFC Eligibility Status *(place an "x" under the appropriate category)*				
	Medicaid	American Indian/ Alaska Native	Uninsured	Underinsured*	Does not meet eligibility criteria
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
	☐	☐		☐	☐
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐

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

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

to release the following information to _____
Name and Address of Person/Organization Receiving PHI

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)

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.)

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.

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