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™

Initial History Questionnaire

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.

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.

HE0328

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Wee Care Pediatrics

Where Compassion, Caring and Dedication Come First

Patient's Name:

Last: ______________________________ First: _____________________________ MI: ________ Sex: M / F

Birthdate: _____/______/_____ Home Phone #: __________________________Cell#: ___________________

Select as Primary ☐ Select as Primary ☐

Address: _____________________________________Apt #: ___________ City: ________________________

State: __________ Zip: _______________ Email: ____

Ethnicity: Hispanic/Non-Hispanic **Race:** African American / Asian / Caucasian / Native American

Pacific Islander / Other: ____________________ / Refuse **Preferred Language:** ________________________

Insurance Plan:________________________ Policy #___________________Subscriber:__________________

Mother's Name:

Last: _______________________________ First: __________________________ Birth Date: ____/____/____

SS #: __________________Home Phone #: ______________________Cell Phone #: _____________________

Address: __________________________ Apt: _____City: _________________ State: ______ Zip: __________

Employer: __________________________ Occupation: ________________Work Phone #: ________________

Father's Name:

Last: _______________________________ First: __________________________ Birth Date: ____/____/____

SS #: __________________Home Phone #: ______________________Cell Phone #: _____________________

Address: __________________________ Apt: _____City: _________________ State: ______ Zip: __________

Employer: __________________________ Occupation: ________________Work Phone #: ________________

Emergency Contact/Relationship: ___________________________________Phone #: ___________________

How were you referred to Wee Care Pediatrics? ____

Which pediatrician saw you in the hospital? __________________________ Hospital: ___________________

I HAVE READ AND UNDERSTAND THE FOLLOWING FINANCIAL STIPULATIONS:

I authorize Wee Care Pediatrics to provide medical care for my child as necessary. I understand that I am financially responsible for any amount not covered by my insurance plan and co-pay's or deductibles are due at the time of service. I authorize Wee Care Pediatrics to release my insurance information for the purpose of administrating claims for benefit reimbursement. I understand it is my responsibility to update changes on my health insurance or contact information, failure to do so may result in my financial responsibility and or collections and fees for unpaid balances due. All information provided will be protected in accordance with HIPAA guidelines.

Signature: ____ Date: __________________

Parent or Legal Guardian Print Name

Printed Name: ____________________________________ Relationship:___________________________

4785 S. Durango Dr. Ste 101 Las Vegas, NV 89147 Phone (702) 889-8444 Fax (702) 889-8454

Where Compassion, Caring and Dedication Come First

Payment Policy and Procedures

James A. Bakerink, M.D Ian Childs, PA-C Brittany Wood, PA-C Katelyn Kofford, PA-C

Thank you for choosing Wee Care Pediatrics for your child's medical care. The following is an explanation of our payment procedures and office policies. Please read carefully, print and sign below.

1. Payment is due at the time of service. We do not bill for deductibles or co-pays. We accept cash, Visa, MasterCard, Discover and American express. ***We do not accept personal checks***. Patients utilizing our cash pay program must pay before each visit.
2. The parent or guardian who brings the child for their visit is responsible for payment at the time of service. We do not intervene between divorced/separated parents or in the matter of custody issues– reimbursement will need to be between parents or guardians.
3. Appointments must be cancelled within 4 hours of the scheduled time in order to avoid a $45.00 No Show Fee. We never make appointments without your consent. We give a courtesy text, email or call 1 day and 4 days prior to your appointment. It is your responsibility to keep your contact information current and to cancel any appointments made. You may opt out of these communications at any time.
4. Account balances must be paid prior to any future visits. If a balance is due, a payment must be collected or payment arrangements made before being seen. Emergent cases will be considered.
5. Account balances that exceed 90 days past due are sent to an outside collection agency. You will be responsible for all collection and legal fees that accrue by the outside agency. Payment must be made before any future appointments.
6. We will gladly bill your primary and or secondary insurance for you. It is your responsibility to keep your **Coordination Of Benefits** current with your insurance providers. Failure to do so may result in lack of payment from your carriers. We are not responsible for non-payment from your insurance plan due to missing COB's and any balances will become subscriber responsibility due in full. ***Failure to disclose a Commercial Insurance as Primary when you have Nevada Medicaid constitutes Medicaid Fraud and Abuse**. Medicaid states we must bill your Primary Insurance first before billing Medicaid.
7. In order to bill your insurance company, we must have an up to date insurance card. If we are unable to verify your insurance coverage at time of service, you will be considered a cash pay patient.
8. Most importantly, Wee Care Pediatrics wants the best care possible for your child and we understand you may have certain financial difficulties. Please feel free to discuss any financial matters with our billing department.

I have read the above policy and agree to abide by the terms of this agreement.

Signature: ______________________________/____________________________ Date: ______________
Parent or Legal Guardian Print Name Signature

Patient Name: _____________________________________ DOB: ____________________

4785 S. Durango Dr. Ste 101 Las Vegas, NV 89147 Phone (702) 889-8444 Fax (702) 889-8454

Notice of Privacy Practices

James A. Bakerink, M.D Ian Childs, PA-C Brittany Wood, PA-C Katelyn Kofford, PA-C

This notice describes how medical information about you may be used and disclosed by Wee Care Pediatrics, your rights and how to access to this information in accordance with the Health Insurance Portability and Accountability Act of 1996, HIPAA Omnibus regulations and HITECH Act.

Uses and Disclosures

Treatment-Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. For example, we may need to disclose your health information when we refer you to a specialist for further treatment or diagnosis, to other medical professionals, nurses, physicians, medical students or other professionals to determine the best course of treatment.

Payment- Your health information may be used to file a medical claim to your health plan on your behalf to seek payment for medical services provided by Wee Care Pediatrics. For example, your health plan may request additional information such as the services provided, supportive documentation such as health history and the medical condition being treated.

Health Care Operations-Your health information may be used as necessary to support the day-to-day activities such as verifying your health insurance or to help assess the quality of healthcare and services we provide. For example, health insurances use a review team to audit the services and quality of care provided by medical practices.

Electronic communications-Your health and personal information may be disclosed or transferred by electronic data interchange or EDI. As of January 1, 2014, The American Recovery and Reinvestment Act of 2009, made it mandatory for all public and private healthcare providers to adopt Electronic Health Records or EHR. For example, your complete medical record, lab reports or consults are now kept electronically to improve accuracy and streamline health care. If you have disclosed your email address to Wee Care Pediatrics, we may send you email notifications for appointment reminders or account statements for balances due. These notifications will never include your protected health information. If you no longer wish to receive email notifications, you may submit a written request at any time to have your email address removed.

Business Associates- Your health or personal information may be disclosed to third parties or *"Business Associates"* to perform day-to-day activities. For example, we may utilize an outside billing company who will have access to your personal and medical information for filing medical claims. All *Business Associates* must follow the same privacy standards in place to protect your personal and or protected health information.

Other uses and disclosures that require your authorization-Disclosure of your health information or its use for any purposes other than those listed above require your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use that occurred before you notified us of your decision to revoke the authorization.

Wee Care Pediatrics

Where Compassion, Caring and Dedication Come First

Notice of Privacy Practices

Understanding Your Rights

You have certain rights under federal privacy standards which include: The right to request restrictions on the use and disclosure of your Protected Health Information or "PHI". The right to receive confidential communications concerning your medical condition and treatment; The right to inspect your PHI or health records- Requests to inspect your PHI may be done in writing or by submitting a records request form to our Privacy Officer. Your request will be reviewed within 10 days of receipt and will be provided to you at 0.60/page per NRS 629.061; The right to amend or submit corrections to your PHI; The right to receive an accounting of how and to whom your protected health information has been disclosed; The right to receive a printed copy of this notice. Medical record requests will be processed within 30 days from receipt.

Our Responsibilities

Wee Care Pediatrics is required by law to maintain the privacy of your "Protected Health Information" and to provide you with this notice of privacy practices. We are required to abide by the privacy policies outlined in this notice. In the event your information is compromise by a breach of unsecured "PHI," it is our duty to notify you. As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes may be required by federal and state laws regulations. Upon request, we will provide you with the most recent revised notice at any time. The revisions will apply to all PHI we maintain.
***Medical Record Retention Policy:** Medical records will be retained until the patient is at least 23 years of age. For patients that have attained the age of 23 years on the date of proposed destruction and have been retained for at least 5 years or a longer period provided by federal law, may be destroyed in accordance with Nevada and Federal Law pursuant to NRS.629.051. (www.leg.state.nv.us/nrs/NRS-629.html)

Complaints-If you would like to submit a comment or complaint about our privacy practices, or if you believe your privacy rights have been violated, you may do so in writing by submitting a letter describing the cause of your concern and any details of how you believe your privacy has been violated. You will not be penalized or retaliated against for filing a complaint. All concerns should be sent to our Privacy Officer/Office Manager 4785 S. Durango Dr. Ste 101 Las Vegas, NV 89147 or fax (702) 933-4282. You may also file a complaint with the Secretary of Health and Human Services (HHS).

I acknowledge that I have read the Notice of Privacy Practices Wee Care Pediatrics has provided with an effective date of September 1, 2001. I understand that if I have any questions regarding this notice, I may contact the Privacy Officer at any time and I may request a printed copy of this notice upon signing.

Signature: ____ Date: _________________
Parent or Legal Guardian

Printed Name: ___________________________________ Relationship: _________________

Patient Name: ____ DOB: _________________

Wee Care Pediatrics
Where Compassion, Caring and Dedication Come First

Treatment Authorization

I authorize Wee Care Pediatrics to provide medical care, treat and diagnose my child

____/_________________.
Patient Name DOB

The following people are authorized to bring my child in for medical care in my absence.

____/______________________
Name Relationship to child

____/______________________
Name Relationship to child

____/______________________
Name Relationship to child

____/______________________
Name Relationship to child

I understand that the above parties will remain on the list of authorized persons to bring my child in for medical care until I update or revoke it. I will have the opportunity to update or change this list on the Annual Update Sheet every year. Furthermore, I agree to be directly responsible for all costs and expenses connected with the examination, medical treatment and diagnosis for my child/dependent in my absence. I understand that the copay, deductible or account balance is still due at the time of service.

Signature: ____ Date: _________________
Parent or Legal Guardian

Printed Name: ______________________________ Relationship: ___________________

Wee Care Pediatrics
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No Show Policy

Patient Name: __________________________ DOB:____________

A **$45.00 NO SHOW fee** will be billed to those who fail to cancel an appointment. You are responsible for canceling your appointment if you cannot attend. We will send a courtesy reminder by voice, text or email 4 days and 1 day prior to your appointment. This service allows you to respond to confirm or **reschedule/cancel** your appointment. Upon the 4th No show, you will be dismissed from the practice and status reported to your insurance carrier. I understand that it is my responsibility to arrive on time for my appointment and that I may not be seen if I am late.

No Shows:

1) ☐ Date___________ 2) ☐ Date___________ 3) ☐ Date_________

3 Strike Policy

Wee Care Pediatrics does not tolerate the mistreatment of staff or property. Parents who are disruptive or verbally abusive towards staff will receive a strike. Destruction of any Wee Care property, furniture, exam rooms or tables will also lead to a strike. If a parent reaches 3 strikes they will be dismissed from our practice. Extreme instances, theft of Wee Care property, supplies or equipment will result in immediate dismissal.

We kindly ask that you just be…. **Nice.**

Strikes:

1) ☐ Date__________ 2) ☐ Date_____________ 3) ☐ Date__________

Signature:__________________________________ Date:_________________
Parent or Legal Guardian

Print Name: ______________________________