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?

Condition					
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

Condition	Yes	No	DK	Who	Comments
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,

Condition	Yes	No	DK	Explain
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.

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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: _____________________________________

How would you like to receive communications from us: Text Email Phone call

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

Pacific Islander / Other: ___________________ / Refuse **Preferred Language:** _______________________

Primary Insurance Plan:__________________ Policy #________________ Subscriber:_________________

Secondary Insurance Plan:__________________ Policy #________________ Subscriber:_______________

Parent/Guardian's Name:

Last: ______________________________ First: _________________________ Birth Date: ____/____/____

SS #: _________________Home Phone #: _____________________Cell Phone #: ____________________

Address: _________________________ Apt: _____City: ________________ State: ______ Zip: __________

Employer: _________________________ Occupation: _______________Work Phone #: _______________

Parent/Guardian's Name:

Last: ______________________________ First: _________________________ Birth Date: ____/____/____

SS #: _________________Home Phone #: _____________________Cell Phone #: ____________________

Address: _________________________ Apt: _____City: ________________ State: ______ Zip: __________

Employer: _________________________ Occupation: _______________Work Phone #: _______________

Emergency Contact/Relationship: _________________________________Phone #: __________________

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: __________________

Printed Name: ___________________________________ Relationship: _________________________
Parent or Legal Guardian

Payment Policy and Procedures

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 to avoid a $45.00 No Show Fee.
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 Vegas Valley Collection Service. You will be responsible for all collection and legal fees that accrue by the agency. Payment must be made before any future appointments. By signing below, you are agreeing that Vegas Valley may contact you via phone or personal email if your account is sent to collections.
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: ____________________

Patient Name: _____________________________________ DOB: _________________

Acknowledgement of Notice of Privacy Practices

The Notice of Privacy Practice describes how this office will use and disclose your protected health information, your privacy rights regarding your protected health information, this office's obligations concerning the use and disclosure of your protected health information. I acknowledge that the Notice of Privacy Practices will be furnished to me for my review at any time upon my request. I further acknowledge that the Notice of Privacy Practices may be located at www.weecarelv.com under patient forms as well as posted in office for review. Please advise our front desk if you would like a copy for immediate review.

Signature: _____________________________/ _______________________Date: _________________
Parent or Legal Guardian Printed Name

No Show Policy

A **$45.00 No Show fee** will be billed to those who miss their scheduled appointments. You are responsible for canceling or rescheduling your appointment if you cannot attend. We gladly send a courtesy reminder by voice, text, or email prior to your appointment day and time. Upon the 4th No show, you may be dismissed from the practice. 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.

3 Strike Policy

Wee Care Pediatrics tries to provide a welcoming and friendly experience and does not tolerate the mistreatment of staff or property. Instances where a strike may be given: Abusive behavior towards staff, destruction of any Wee Care property such as furniture or exam rooms, will receive a strike. Extreme instances such as theft of Wee Care property, supplies or equipment will result in immediate dismissal. We simply ask that patience and kindness be observed while at Wee Care Pediatrics.

Signature: _____________________________/ _______________________Date: _________________
Parent or Legal Guardian Printed Name

Wee Care Pediatrics
Exceptional People Providing Exceptional Care

OVER THE RAINBOW
PEDIATRIC URGENT CARE & WELLNESS

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

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: ____________________

Referral information

How did you hear about Wee Care Pediatrics / Over the Rainbow Pediatric Urgent Care:

- Obstetrics office
  - If yes, please state which office: _______________________
- Daycare/School
  - If yes, please state which daycare/school: ______________________
- Friend/Family member
- Google Search
- Insurance Provider Directory
- Social Media
- Other: _______________________