

CHILD HEALTH HISTORY QUESTIONNAIRE (12 y/o and younger)

Name: _____ **Preferred Name:** _____

DOB: ____ / ____ / ____ **How did you hear about us?** _____

Family Information:

Other members of household, including ages: _____

Parents' marital status: _____

If separated/divorced:

Are both parents involved in care? Yes No

Who does the child live with most often? _____

Please list the names of both parents:

1. _____

Home # _____ Cell# _____ Work# _____

2. _____

Home # _____ Cell# _____ Work# _____

Allergies to medications (please circle): Yes None Known If yes, please list medication(s) and type of reaction:

Allergies to foods or other (please circle): Yes None Known If yes, please list food(s) and type of reaction:

Medications: Please list any medications currently taken, including doses, frequency, etc. Please include any vitamins or supplements.

Health History:

Was your child born prematurely? Yes No Any developmental problems? Yes No

Please list any current medical problems, including when diagnosed:

Any hospitalizations (please circle)? Yes No Details: _____

Any surgeries (please circle)? Yes No Details: _____

Please list any other conditions your child has seen a doctor for more than twice? (i.e. frequent ear infections, asthma, etc)

Does your child see any other doctor on a regular basis? Yes No Details: _____

When was your child's last check-up? _____

Is your child up to date on immunizations (please circle)? Yes No Don't Know

Social History:

Is your child in daycare? _____

Is your child exposed to tobacco? _____

Are there any behavioral problems you are concerned about? _____

List any family members ever diagnosed with:

Allergy, asthma or eczema:

Migraines:

Blood clot/bleeding disorder:

High blood pressure:

High cholesterol:

Heart disease/valve disease (list age at diagnosis):

Heart attack (list age at diagnosis):

Stroke:

Thyroid problems:

Diabetes:

Colon polyps/Crohn's/Colitis:

Depression/Suicide:

Other Psychiatric problems:

Alcohol/drug abuse:

Birth defects/genetic diseases (list type):

Cancer (list type and age at diagnosis):

PATIENT REGISTRATION

PATIENT:

Last Name: _____ First Name: _____ MI: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Phone: H: _____ Cell: _____ Work: _____

Email: _____ Pharmacy: _____

DOB: _____ SS: _____ Sex: F M

Employer: _____ Occupation: _____

Emergency contact:

Name: _____ Relationship: _____ Ph: _____

GUARANTOR:

Person responsible for the bill: Self Spouse Parent Other

Last name: _____ First Name: _____ MI: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Phone: H: _____ Cell: _____ Work: _____

DOB: _____ SS: _____ Employer: _____

INSURANCE INFORMATION:

Insurance Company:

Patient ID: _____ Group #: _____

Claims Address:

City: _____ State: _____ Zip: _____

Family Medicine at Lowry
Practice Policy & Procedures

Just as we are dedicated to providing you with the best possible medical care, we are also committed to extending this same level of service to our business and financial policies. It is crucial that you understand these policies, especially in view of the ongoing changes in the health care industry. These changes may affect you in the services that are covered by your insurance carrier or in the services that are determined by insurance to be due and payable directly to you.

Financial Responsibility

I hereby accept responsibility for all charges incurred for treatment that is not covered by my insurance. I agree to responsible attorney and/or collection agency fees if my account is turned over to an attorney and/or collection agency for collection. I understand I must furnish a copy of my insurance card(s) and a valid ID or I will be responsible for payment of all charges.

COLLECTIONS INFORMATION: Your insurance company will notify both you and our office with an EOB (explanation of benefits) if there is a balance due that is your responsibility. Balances over 30 days will incur a 2% interest charge per month. Accounts that have gone beyond 60 days will be considered delinquent and it will be in everyone's best interest to send this account to an outside collection agency. Your balance to them will also include a \$25 fee for their processing charge.

Print Name

Signature

Date

Co-Payment Policy (if applicable)

Per insurance laws and regulations, all patients are expected to pay their co-pay at the time of the office visit. Most insurance companies have co-payments, which is a flat fee per visit, and is a portion of the cost at the time the service is rendered. We will no longer bill for co-payments. In the event a bill is sent for the co-pay, an additional charge of \$15.00 to cover the cost of processing billing for you co-payment will be incurred. If you have any questions, comments or concerns, please contact the Office Manager.

Print Name

Signature

Date

A photocopy of this authorization shall be as valid as the original from the initial date of completion. This consent is valid until specifically revoked in writing.

Cancellation/No-Show/Reschedule Policy

The physicians at Family Medicine at Lowry are committed to providing quality care. If you are not present for your appointment, or cancel/reschedule with little notice, we are unable to fill that time slot and cannot run our office efficiently. Therefore, our policy requires that you give us at least 24 hours notice (not including weekends and holidays) if you need to cancel or reschedule your appointment. ***Failure to show up for your appointment or a cancellation/reschedule less than 24 hours before the appointment, will result in the patient being billed \$100 for new patient and immigration appointments, and \$50 for existing patient appointments. Appointments will not be rescheduled until all fees have been paid. Also note, that if you are scheduled for a "same day" appointment, and cancel or no show, you will still be responsible for the \$50 cancellation fee. Thank you in advance for your cooperation.***

Print Name	Signature	Date
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Late Arrival Policy

Patient's that arrive 10 minutes or later for their scheduled appointment check in time will be asked to reschedule, and the reschedule fee described above will be applied. Please make every effort to arrive at the given check-in time to avoid any disruption in your care.

Print Name	Signature	Date
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Prescription & Prescription Refill Policy

Prescription Refills will be approved or denied within 72 hours of receipt. We receive hundreds of refill requests each day! The easiest and most efficient way to get the prescription refills you need is to CALL YOUR PHARMACY, even if your bottle says "no refills." The pharmacist will contact us directly for approval. From there, you simply have to visit your pharmacy, and pick up your refill. Please call several days BEFORE you run out of your medication. For medications such as BIRTH CONTROL, HORMONES, THYROID, and CHOLESTEROL that have 0 Refills, there may be a need to return to our office, BEFORE refills will be authorized. For NARCOTIC Prescriptions, you will be asked to visit our office for a hard copy of the prescription. In addition, you will be asked to sign a "pick up verification" slip.

Print Name	Signature	Date
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A photocopy of this authorization shall be as valid as the original from the initial date of completion. This consent is valid until specifically revoked in writing.

Patient Contact Information

I understand that the office will at times need to get a hold of me during the day. I give permission to Family Medicine at Lowry **TO LEAVE DETAILS** regarding my care, test results, billing, or appointment reminders on a voicemail at the following number(s) in this order:

- 1. _____ **home work cell**
- 2. _____ **home work cell**
- 3. _____ **home work cell**

I authorize Family Medicine at Lowry to *speak* with the following person(s) about my care:

_____ Name _____ Relationship

_____ Name _____ Relationship

_____ Name _____ Relationship

I understand that if I choose not to be contacted in one of these ways, I must prepare and present written notice to Family Medicine at Lowry.

_____ **Print Name**

_____ **Date**

_____ **Signature**

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Family Medicine at Lowry
HIPAA Policy

I authorize the release of medical information necessary to process my insurance claim.

_____ (INITIAL)

I have reviewed this office's "Notice of Privacy Practices" which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document if I so request.

_____ (INITIAL)

I have read and understand the HIPAA policy for Family Medicine at Lowry.

Print Name

Signature

Date

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