

CHILDREN'S OASIS PEDIATRICS

HEALTH HISTORY

NAME _____	DATE OF BIRTH _____
SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	RACE/ ETHNICITY _____

PLEASE LIST ALL PEOPLE IN THE HOUSEHOLD:

NAME	DATE OF BIRTH	OCCUPATION	EDUCATION
Father			
Mother			
Other			
Other			
Other			
Other			

Have there been any recent major changes or stresses in the child's life? YES NO
 If YES, explain _____

Does child go to: Private Sitter Relative Daycare Center Home Daycare
BIRTH HISTORY: Birth Weight _____ Length _____
 Place: Chandler / Mercy Gilbert Banner Hospital Other _____

During the pregnancy did the mother see a doctor regularly? YES NO

During the pregnancy did mother: (If YES, explain) EXPLANATION

Have any medical problems? YES NO _____

Smoke or drink? YES NO _____

Use any medications? YES NO _____

Use alcohol or other drugs? YES NO _____

Have problems with labor/delivery? YES NO _____

How long did the baby stay in the hospital after birth? _____

PAST MEDICAL HISTORY: Is the child's general health: GOOD FAIR POOR
 (If YES, to the questions below please explain) EXPLANATION

Does the child have any allergies? YES NO _____

Is the child taking any medications? YES NO _____

Please list any hospitalizations, operations, serious illnesses or accidents with dates:

_____ Date _____

_____ Date _____

BACKSIDE TO BE DONE

Has the child ever had any problems with the following. If YES, please explain.

- | | | | |
|---------------------|------------------------------|-----------------------------|-------|
| Eyes/Vision | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Digestion/Nutrition | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Ears/Hearing | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Urine/Kidneys | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Joints | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Skin | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Lungs | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Teeth | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Heart | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Seizures | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |

FAMILY HISTORY

Have any of the child's brothers or sisters died? YES NO

If YES, give age and cause _____

Have any of the child's blood relatives had the following diseases?

If other, please specify if maternal or paternal grandmother or grandfather

Heart Diseases NO FATHER MOTHER OTHER.

- | | | | | | |
|-------------------------|-----------------------------|---------------------------------|---------------------------------|--------------------------------|-------|
| Tuberculosis | <input type="checkbox"/> NO | <input type="checkbox"/> FATHER | <input type="checkbox"/> MOTHER | <input type="checkbox"/> OTHER | _____ |
| High Blood Pressure | <input type="checkbox"/> NO | <input type="checkbox"/> FATHER | <input type="checkbox"/> MOTHER | <input type="checkbox"/> OTHER | _____ |
| Kidney Disease | <input type="checkbox"/> NO | <input type="checkbox"/> FATHER | <input type="checkbox"/> MOTHER | <input type="checkbox"/> OTHER | _____ |
| Allergies | <input type="checkbox"/> NO | <input type="checkbox"/> FATHER | <input type="checkbox"/> MOTHER | <input type="checkbox"/> OTHER | _____ |
| Asthma | <input type="checkbox"/> NO | <input type="checkbox"/> FATHER | <input type="checkbox"/> MOTHER | <input type="checkbox"/> OTHER | _____ |
| Diabetes | <input type="checkbox"/> NO | <input type="checkbox"/> FATHER | <input type="checkbox"/> MOTHER | <input type="checkbox"/> OTHER | _____ |
| Mental/Emotional Issues | <input type="checkbox"/> NO | <input type="checkbox"/> FATHER | <input type="checkbox"/> MOTHER | <input type="checkbox"/> OTHER | _____ |
| Sickle Cell | <input type="checkbox"/> NO | <input type="checkbox"/> FATHER | <input type="checkbox"/> MOTHER | <input type="checkbox"/> OTHER | _____ |
| Seizures | <input type="checkbox"/> NO | <input type="checkbox"/> FATHER | <input type="checkbox"/> MOTHER | <input type="checkbox"/> OTHER | _____ |
| Cancer | <input type="checkbox"/> NO | <input type="checkbox"/> FATHER | <input type="checkbox"/> MOTHER | <input type="checkbox"/> OTHER | _____ |

IMMUNIZATIONS

Up to date? YES NO

Patient Consent for Use and Disclosure of Protected Health Information and Office Policy

As parent/guardian of _____, I understand that as part of my child/children's health care Children's Oasis Pediatrics originates and maintains health records. These records describe history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment. I also give my consent for the patient(s) to receive medical evaluation and treatment by the providers at Children's Oasis Pediatrics. (I have been provided the opportunity to view the Notice of Information Practices that describes uses and disclosures of my child's Protected Health Information (medical record). I understand that I have the right to review the notice prior to signing this consent.)

With my consent, Children's Oasis Pediatrics may call (including leaving voice mail messages) or mail my home regarding items that assist the practice in carrying out treatment, payment, and health care operations, such as an appointment reminders, normal laboratory results and insurance items.

Permission to Treat

I give permission for Children's Oasis Pediatrics to provide medical treatment for my child.

I understand that Children's Oasis Pediatrics has the right to change its notice and practices. I understand that I have the right to request restrictions as to how my child's health information may be used or disclosed to carry out treatment, payment, or health care operations and that Children's Oasis Pediatrics is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that Children's Oasis Pediatrics has already taken action. If I do not sign this consent or revoke it, Children's Oasis Pediatrics may decline to provide treatment to my child.

I am aware that according to my insurance plan I am responsible for all co-payments, deductibles, and co- insurance. **Co-pay/deductibles/Co-Ins are due at the time of the service. Not all services are covered by every plan.** It is my responsibility as the guarantor/parent/guardian to understand and have knowledge of my insurance plan. **Any service not covered by my plan will be my responsibility.** I am aware if my account is not paid and sent to collections, the patient(s) will be asked to find another provider. The office does ask that I give a 24 hour notice if I need to cancel or reschedule. **No Show will apply to visits that are missed with a \$25 fee. Also if you No Show for a Saturday Appointment there will be no more Saturday Appointments scheduled for your child in the future.**

Phone advice and Tele Medicine will have associated charges and if insurance does not cover the patient will be responsible.

I fully understand and I consent to Children's Oasis Pediatrics' use and disclosure of my children(s) Protected Health Information in order to carry out treatment, payment and health care operations. I also fully understand and consent to Children's Oasis Pediatrics' office policy.

Health Information Exchange

I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding my provider's participation in the statewide Health Information Exchange (HEI), or I previously received this information and decline another copy."

In My Absence:

I, being the parent/legal guardian of the above named minor(s), do hereby give permission to the following individual(s) to act on my behalf in authorizing medical care for the above named minor(s) during my absence. I also authorize Children's Oasis Pediatrics to discuss my child(s) care with the following people.

Name	Relationship to child	Phone Number	Date of Birth

Parent/Guardian (print)	Signature	Date
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Phone #: _____



Children's Oasis
Pediatrics

KATHERINE KRIEG, M.D., F.A.A.P. • SHARON NOVY, M.D., F.A.A.P.

1425 W. Elliot Rd., Suite 204 • Gilbert, Arizona 85233 • 480-792-1012 • Fax 480-792-1013

Patient Consent For Media Services

Patient Name: _____ Date Of Birth: _____

Patient Name: _____ Date Of Birth: _____

Patient Name: _____ Date Of Birth: _____

Patient Name: _____ Date Of Birth: _____

I have read, fully understand, and consent to the information provided in the most recent version of the Media Consent. Any questions have been answered to my satisfaction. I hereby give my informed consent for the services I have checked below to be used in my child's medical care and consent to the instructions and conditions outlined above. I agree not to hold the provider liable for any electronic messaging charges/fees by these services. I will inform my provider of any changes in my email or phone number in a timely manner.

I hereby authorize Dr. Krieg/Dr. Novy to use **TELEMEDICINE** in the course of my diagnosis and treatment.

Please **sign me up to receive email** messages at the following email when the service is available. **This will be the same email you use for the portal.**

Email: _____

Please **sign me up to receive text message appointment reminders** and pertinent office notifications when the service is available.

Mobile Number: _____

Signature of Authorized Signer to Patient(s)

Date:

Relationship to Patient(s)

Financial Agreement

- New Born
 New Patient
 Established Patient – Yearly Update

I am the parent/guardian of _____
(name of patient)

DOB: _____ and I am requesting that the providers at Children's Oasis Pediatrics see the above named child for New Born Check/Well Child Check/Acute Care.

The above named patient has:

Private Insurance No / Yes

If Yes: Primary Ins: _____

Secondary Ins: _____

State Fund Insurance No / Yes Primary or Secondary

If Yes: Ins: _____

New Born: By signing this form I am being made aware that my newborn needs to be added to insurance policy PRIOR to the end of the 30 days. If I, the parent/guardian, fail to do this within the 30 days then I will owe the full amount of this and any visits to Children's Oasis Pediatrics.

New Patient / **Established Patient:** By signing this form I'm telling Children's Oasis Pediatrics that this child has the insurance listed above and no other. I am aware that this office will not be held accountable if found that the parent/guardian has falsified the above insurance information and after claims have been submitted. If it's found later that the insurance information was incorrect, the patient will responsible for the original decision by the insurance that was billed.

Signature of Parent/Guardian

Date



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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name _____ Date of Birth _____

Request health information from:

Request health information to:

Name of Person/Provider/Facility: _____

Address: _____

Phone: _____ Fax: _____

This request and authorization applies to:

All records regarding treatment of the patient.

All records regarding treatment for the following condition: _____

Immunization records only

Other: _____

This authorization expires: On this date ____/____/____ or one year from the date signed.

Authorization:

Signature _____ Date _____

Print Name _____ Phone _____

Relationship: Parent Guardian Patient

To Patients:

Please allow 24-48 hours for the release of immunization records and 2 weeks for the release of all other healthcare information, unless an earlier date is requested and approved.

