CHILDREN'S OASIS PEDIATRICS
HEALTH HISTORY

NAME _____ DATE OF BIRTH _____

SEX ☐ MALE ☐ 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 hosptial 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	☐ YES	☐ NO	_____
Digestion/Nutrition	☐ YES	☐ NO	_____
Ears/Hearing	☐ YES	☐ NO	_____
Urine/Kidneys	☐ YES	☐ NO	_____
Joints	☐ YES	☐ NO	_____
Skin	☐ YES	☐ NO	_____
Lungs	☐ YES	☐ NO	_____
Teeth	☐ YES	☐ NO	_____
Heart	☐ YES	☐ NO	_____
Seizures	☐ YES	☐ 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	☐ NO	☐ FATHER	☐ MOTHER	☐ OTHER	_____
High Blood Pressure	☐ NO	☐ FATHER	☐ MOTHER	☐ OTHER	_____
Kidney Disease	☐ NO	☐ FATHER	☐ MOTHER	☐ OTHER	_____
Allergies	☐ NO	☐ FATHER	☐ MOTHER	☐ OTHER	_____
Asthma	☐ NO	☐ FATHER	☐ MOTHER	☐ OTHER	_____
Diabetes	☐ NO	☐ FATHER	☐ MOTHER	☐ OTHER	_____
Mental/Emotional Issues	☐ NO	☐ FATHER	☐ MOTHER	☐ OTHER	_____
Sickle Cell	☐ NO	☐ FATHER	☐ MOTHER	☐ OTHER	_____
Seizures	☐ NO	☐ FATHER	☐ MOTHER	☐ OTHER	_____
Cancer	☐ NO	☐ FATHER	☐ MOTHER	☐ OTHER	_____

IMMUNIZATIONS

Up to date? ☐ YES ☐ NO

Children's Oasis Pediatrics - 1425 W Elliot Road, Suite 204, Gilbert, Arizona 85233

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 reminder, 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 $50 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

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: _____

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)

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Children's Oasis Pediatrics

Financial Agreement

(If left blank then we will charge you as a cash patient)

☐ 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 Is ALWAYS Primary)***

Private Insurance *(Employer Ins, Self-Funded, Ins you pay for)* **No / Yes**

If Yes: Primary Ins: _____

Secondary Ins: _____

State Fund Insurance *(Medicaid, AHCCCS)* **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.