CHILDREN'S OASIS PEDIATRICS
HEALTH HISTORY

Name: _____ DOB: _____

Sex ☐ Male ☐ Female Race/ethnicity: _____

PLEASE LIST ALL PEOPLE IN THE HOUSEHOLD:

Name	Date of Birth	Occupation	Education
Father			
Mother			

Have there been any recent major changes or stresses in the child's life? ☐Yes ☐No

If Yes, explain _____

Does the child go to: ☐ Daycare Center ☐Home Daycare ☐Relative ☐Sitter

BIRTH HISTORY: BIRTH WEIGHT _____ LENGTH _____

Place: ☐ Chandler Regional ☐Mercy Gilbert ☐ Banner Hospital ☐Other

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

☐ During the pregnancy, did mother: (if YES, please 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 or delivery?	☐ YES ☐NO	_____

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

Does the child have any allergies? ☐YES ☐ NO Explain: _____

Is the child taking any medications? ☐YES ☐ NO Explain: _____

BACKSIDE TO BE DONE

PAST MEDICAL HISTORY: Is the child's general health ☐ GOOD ☐ FAIR ☐ POOR

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	_____
Heart	☐ YES ☐ NO	_____
Lungs	☐ YES ☐ NO	_____
Skin	☐ YES ☐ NO	_____
Neurological/Seizures	☐ YES ☐ NO	_____
Joints	☐ YES ☐ NO	_____
Teeth	☐ YES ☐ NO	_____

Please list any hospitalizations, surgeries, or serious illness with age or date:

_____ Age/Date _____

_____ Age/Date _____

FAMILY HISTORY:

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

If yes, please give cause. _____

Check the box if any of the child's blood relatives had the following diseases?

	NO	Father	Mother	Paternal Grandpa	Paternal Grandma	Maternal Grandpa	Maternal Grandma	Other
Heart Disease:								
High Blood Pressure:								
Kidney Disease:								
Allergies:								
Asthma:								
Diabetes:								
Depression:								
Anxiety:								
Any Emotional or Behavioral diagnosis:								
Sickle Cell:								
Seizures:								
Cancer:								

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: Patient Name: _____ Date of Birth: _____ PCC#: _____

I understand and I consent to the following:

Regarding Health Information:

- 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 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 prior to signing this consent that describes uses and disclosures of my child's Protected Health Information (medical record). Children's Oasis Pediatrics' may use and disclose my children(s) Protected Health Information in order to carry out treatment, payment and health care operations.
- 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 understand that Children's Oasis Pediatrics has the right to change its notice and practices.

Regarding Financial Policies:

- I give permission and request that Children's Oasis Pediatrics bill my child's insurance for services.
- **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 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. If not paid then, there is an additional $20 admin fee added to the balance.
- 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. **A No Show will apply to visits that are missed with a $50 fee. If I No Show for a Saturday Appointment there will be no more Saturday Appointments scheduled for your child in the future.**
- I understand there are procedure codes for holiday/Saturday appointments, telemedicine, phone advice, digital communication and longitudinal primary care services that are used as defined by AMA CPT rules. These have fees and are billed to insurance. The insurance may not pay them or may "cover them" but assign responsibility to the patient. In these cases, the cost is due to the patient. A list of these charges can be provided to you on request.

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.

Parent/Guardian Name (print) _____

Signature _____ Date _____

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[redacted]

Children's Oasis Pediatrics

KATHERINE KRIEG, M.D. * SHARON NOVY, M.D.

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Phone: 480-792-1012 Fax: 480-792-1013

Children's Oasis Pediatrics

Consent for Family Member or Non Guardian to bring your child(~~ren~~) to our office

Patient Name: _____ Date of Birth: _____ PCC #: _____

Do you wish to have someone OTHER THAN BIOLOGICAL MOM OR BIOLOGICAL DAD bring your child to our office?

Choose One (1) below.

- ☐ No
- ☐ Yes List them below.

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:
_____	_____
_____	_____
_____	_____

Parent/Guardian Name (print) _____

Signature _____ Date _____

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.

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Children's Oasis Pediatrics

Patient Consent For Media Services

Patient Name:_____ Date Of Birth:_____

I agree to the following:

- Children's Oasis Pediatrics may contact me by phone (including leaving voicemail messages), text message, email, or mail regarding items that assist the practice in carrying out treatment, payment, and health care operations.
- These communications may include, but are not limited to, appointment reminders, normal laboratory results, insurance matters, and other information related to my child's care.
- I understand that I may change my communication preferences (phone, text, or email) at any time through the patient portal.
- 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.

Preferred Email for communication and for logging into the patient portal.

_____

Preferred Cell phone number to receive text message appointment reminders and pertinent office notifications.

1. _____ 2. _____

Parent/Guardian Printed Name: _____ Relationship to Patient(s): _____

Parent/Guardian Signature _____ Date: _____

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