FAMILY AND INSURANCE INFORMATION

Father/Guardian's Name _____ DOB __/____/____ Relation: _____

Address _____ SS# _____-_____-_____

City: _____ State: _____ Zip Code: _____

Home Phone (___) _____-_____ Work Phone (___) _____-_____ Cell Phone (___) _____-_____

Employer: _____ **Email Address:** _____

Mother/Guardian's Name _____ DOB ____/____/_____ Relation: _____

Maiden Name: _____

Address _____ SS# _____-_____-_____

City: _____ State: _____ Zip Code: _____

Home Phone (___) _____-_____ Work Phone (___) _____-_____ Cell Phone (___) _____-_____

Employer: _____ **Email Address:** _____

Children/Patients (Full Name) DOB Sex SS#

1_____

2_____

3_____

4_____

Child lives with: Both Parents Mother Father Other: _____

Emergency Contact: _____ Phone (___) _____-_____ Relationship: _____

INSURANCE (**Please present insurance card so copy may be obtained)**

Insurance Company _____ ID# _____

Address of Company _____ Group# _____

City/State/Zip _____ Effective Date ____/____/_____

Subscriber's Name _____ DOB ___/____/_____ Relation: _____

It is the member's responsibility to obtain referrals for specialty care in advance of services being rendered if the insurance is a managed care plan. I understand that I am responsible for services not authorized by my PCP. I hereby authorize payment directly to the provider of services and I understand that I am financially responsible for charges not covered by this authorization. I hereby authorize the release of any medical information necessary to process my insurance.

****

It is the policy of this office that the person who accompanies the child for care will be responsible for payment of services rendered. Individuals other than parents/guardians bringing children to the office will be expected to present payment and/or insurance information. Payment required at the time of service-unless prior arrangements have been made.

****

I UNDERSTAND AND GIVE AUTHORIZATION TO ALL ABOVE STATEMENTS.

I HAVE BEEN GIVEN A NOTICE OF PRIVACY PRACTICES OF NASSIM McMONIGLE & MESCIA.

Signed_____ Date ____/_____/_____

Nassim McMonigle & Mescia

APPOINTMENT GUIDELINES

It is the policy of Nassim McMonigle & Mescia to give the best medical care available while trying to work with our families' busy schedules. Hopefully, these guidelines will help when scheduling needed appointments.

Sick appointments are scheduled as same-day appointments. If you require a sick appointment for the following day, please call on the day the appointment is needed (sick only). We prefer not to schedule late appointment if daytime appointments are available. We try to reserve the later appointments for those parents arriving home from work to discover their child is sick and needs to be seen. Please note that our same-day appointments may not be with your child's preferred physician.

Check-Up appointments should be scheduled in advance, we do try to utilize all available appointments for the day and may be able to accommodate you in scheduling a well visit on a same-day basis with limited availability. Well visits are usually scheduled 4-6 weeks in advance. We recommend that you schedule your child's next appointment prior to leaving the office. As always, we will try to accommodate families with unusual circumstances.

Medication rechecks should be scheduled in advance to avoid problems arising regarding refills.

Missed appointments are documented and can result in dismissal from the practice.

Cancellation policy: In order to serve other sick patients, we request adequate notice to be given when cancelling an appointment. We understand that extreme issues such as weather or car trouble may prohibit enough notice. Appointments cancelled at or after the scheduled time may be considered a missed appointment.

Please contact our office coordinator or front office team leader for questions or concerns regarding these guidelines.

Notice of Privacy Practices

As Required by the Privacy Regulations Promulgated Pursuant to the Health Insurance
Portability and Accountability Act of 1996(HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your identifiable health information. In conducting your business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and privacy practices concerning your identifiable health information. By law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

To summarize, this notice provides you with the following important information:

- How we may use and disclose your identifiable health information
- Your privacy rights in your identifiable health information
- Our obligations concerning the use and disclosure of your identifiable health information.

The terms of this notice apply to all records containing your identifiable health information that are created or retained by our practice. We reserve the right to revise or amend our notice of privacy practices. Any revision or amendment to this notice will be effective for all of your records our practice has created or maintained in the past, and for any of your records we may create or maintain in the future. Our practice will post a copy of our current notice in our offices in a prominent location, and you may request a copy of our most current notice during any office visit.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

NASSIM McMONIGLE & MESCIA
(812) 949-0405

C. WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION IN THE FOLLOWING WAYS:

The following categories describe the different ways in which we may use and disclose identifiable health information.

1. **Treatment.** Our practice may use your identifiable health information to treat you. For example, we may ask you to undergo laboratory test (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We use your identifiable health information in order to write a prescription for you, or we might disclose your identifiable health information to a pharmacy when we call and order a prescription for you. Many of the people who work for our practice - including doctors and nurses – may use or disclose your identifiable health information in order to treat you or to assist others in your treatment. Additionally, we may disclose your identifiable health information to others who may assist in your care, such as your spouse, children or parents.

2. **Payment.** Our practice may use and disclose your identifiable health information in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to

determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your identifiable health information to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your identifiable health information to bill you directly for services and items.

3. **Health Care Operations.** Our practice may use and disclose your identifiable health information to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your health information to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.

4. **Appointment Reminders.** Our practice may use and disclose your identifiable health information to contact you and remind you of an appointment.

5. **Treatment Options.** Our practice may use and disclose your identifiable health information to inform you of potential treatment options or alternatives.

6. **Health-Related Benefits and Services.** Our practice may use and disclose your identifiable health information to inform you of health-related benefits or services that may be of interest to you.

7. **Release of Information to Family/Friends.** Our practice may release your identifiable health information to a friend or family member that is helping you pay for your health care, or who assists in taking care of you.

8. **Disclosures Required By Law.** Our practice will use and disclose your identifiable health information when we are required to do so by federal, state or local law.

D. <u>USE AND DISCLOSURE OF YOUR IDENTIFIABLE HEALTH INFORMATION IN CERTAIN SPECIAL CIRCUMSTANCES</u>

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public Health Risks.** Our practice may disclose your identifiable health information to public health authorities that are authorized by law to collect information for the purpose of :

    - ❑ Maintaining vital records, such as births and deaths
    - ❑ Reporting child abuse or neglect
    - ❑ Preventing or controlling disease, injury or disability
    - ❑ Notifying a person regarding a potential risk for spreading or contracting a disease or condition
    - ❑ Reporting reactions to drugs or problems with products or devices
    - ❑ Notifying individuals if a product or device they may be using has been recalled
    - ❑ Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of a patient(including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
    - ❑ Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. **Health Oversight Activities.** Our practice may disclose your identifiable health information to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions, civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your identifiable health information in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your identifiable health information in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. **Law Enforcement.** We may release identifiable health information if asked to do so by a law enforcement official:

    - ❑ Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
    - ❑ Concerning a death we believe might have resulted from criminal conduct
    - ❑ Regarding criminal conduct at our offices
    - ❑ In response to a warrant, summons, court order, subpoena or similar legal process

- ❑ To identify/locate a suspect, material witness, fugitive or missing person
- ❑ In an emergency to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. **Deceased Patients.** Our practice may release identifiable health information to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. **Organ and Tissue Donation.** Our practice may release your identifiable health information to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. **Research.** Our practice may use and disclose your identifiable health information for research purposes in certain limited circumstances. We will obtain your written authorization to use your identifiable health information for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a privacy Board; (b) we obtain the oral or written agreement of a researcher that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your identifiable health information is solely to prepare a research protocol or for similar preparatory research, and (iii) the researcher will not remove any of your identifiable health information from our premises; or (c) the identifiable health information sought by the researcher only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research and if we request it, to provide us with proof of death prior to access to the identifiable health information of the decedents.

8. **Serious Threats to Health or Safety.** Our practice may use and disclose your identifiable health information when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. **Military.** Our practice may disclose your identifiable health information if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate military command authorities.

10. **National Security.** Our practice may disclose your identifiable health information to federal officials for intelligence and national security activities authorized by law. We also may disclose your identifiable health information to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. **Inmates.** Our practice may disclose your identifiable health information to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. **Workers' Compensation.** Our practice may release your identifiable health information for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IDENTIFIABLE HEALTH INFORMATION

You have the following rights regarding the identifiable health information that we maintain about you:

1. **Confidential Communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to the Office Manager of Nassim and Associates, PSC, 2305 Green Valley Road, New Albany, IN 47150, specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your identifiable health information for treatment, payment or health care operations. Additionally, you have the right to request that we limit our disclosure of your identifiable health information to individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when disclosure of your identifiable health information, you must make your request in writing to the Office Manager of Nassim and Associates, PSC, 2305 Green Valley Road, New Albany, IN 47150. Your request must describe in a clear and concise fashion: (a) the information you wish restricted: (b) whether you are requesting to limit our practice's use, disclosure or both; and (c) to whom you want the limits to apply.

3. **Inspection and Copies.** You have the right to inspect and obtain a copy of the identifiable health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Office Manager of Nassim and Associates, PSC, 2305 Green Valley Road, New Albany, IN 47150 in order to inspect and/or obtain a copy of your identifiable health information. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the Office Manager, Nassim and Associates, PSC at 2305 Green Valley Road, New Albany, IN 47150. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is: (a) accurate and complete; (b) not part of the identifiable health information kept by or for the practice; (c) not part of the identifiable health information which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. **Accounting of Disclosures.** All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain disclosures our practice has made of your identifiable health information. In order to obtain an accounting of disclosures, you must submit your request in writing to the Office Manager, Nassim and Associates, PSC, 2305 Green Valley Road, New Albany, IN 47150. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. **Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the Office Manager, Nassim and Associates, PSC, (812) 949-0405.

7. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Office Manager, Nassim and Associates, PSC, 2305 Green Valley Road, New Albany, IN 47150. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. **Right to Provide an Authorization for Other Uses and Disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your identifiable health information may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your identifiable health information for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact the Office Manager, Nassim and Associates, PSC at (812) 949-0405.

Revised 11/01/2014

NASSIM AND ASSOCIATES, PSC

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Nassim and Associates, PSC may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Nassim and Associates, PSC Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review your Notice of Privacy Practices prior to signing this consent. Nassim and Associates reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices any be obtained by forwarding a written request to our Privacy Officer at 2305 Green Valley Road, New Albany, IN. 47150.

With my consent, Nassim and Associates, PSC may call my home or office and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO such as appointment reminders, insurance items and any call pertaining to your clinical care, including laboratory results among others.

With my consent, Nassim and Associates, PSC may mail to my □ home or □ office any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Nassim and Associates, PSC may e-mail to my □ home or □ office any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements.

I have the right to request that Nassim and Associates, PSC restrict how Nassim and Associates, PSC uses or discloses my PHI to carry out TPO. However, Nassim and Associates, PSC is not required to agree to my requested restrictions, but if Nassim and Associates, PSC does, they are bound by our agreement.

By signing this form, I am consenting to Nassim and Associates, PSC's use and disclosure of my PHI to carry out TPO. This consent may be revoked in writing except to the extent that Nassim and Associates, PSC has already made disclosures in reliance upon my prior consent. If I decline to sign this consent, Nassim and Associates, PSC may decline to provide treatment to my child/children.

_____ _____

Signature of Parent/Legal Guardian Date

_____

Print Name of Parent/Legal Guardian

_____ _____

Patient's Name Patient's Name

_____ _____

Patient's Name Patient's Name

NASSIM AND ASSOCIATES, PSC.
POLICIES AND PROCEDURES

Thank you for choosing us as your health care provider. We are committed to providing you with the best possible care and to your treatment being successful. Your clear understanding of our financial policy is important to our professional relationship. Please understand that payment of your bill is considered part of your treatment. We accept CASH, CHECK, MONEY ORDER, VISA, and MASTERCARD.

INSURANCE

Our practice is committed to providing the best treatment for our patients. We must emphasize that as Medical Care providers, our relationship is with our patient, not with your insurance company. We cannot accept the responsibility of negotiating the claims with insurance companies or any other persons. While filing of insurance claims is a "courtesy" that we extend to our patients, all charges are your responsibility from the date of the services rendered.

Your insurance is a contract between you and the insurance company. It is very important that you understand the provisions of your policy. We cannot guarantee payment of claims. If your insurance company pays only a portion of the bill or rejects your claims, any contact or explanation should be made to you, the policyholder. Reduction or rejection of your claim by your insurance company does not relieve you of your financial obligation.

Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Some of the services may be considered "non-covered" services and not medically necessary under some medical insurance programs. Please remember that professional services are rendered and charged to the patient, not the insurance company.

We charge what is usual and customary for our area. The patient is responsible for payment in full within a reasonable time-regardless of the status of the claim or any insurance company's arbitrary determination of usual customary rates. Our fees are considered to fall within the acceptable range of most companies and therefore are covered up to maximum allowance determined by each carrier.

The physician is required to report services using a variety of diagnostic ICD and CPT management and treatment codes. Different insurance companies and plans may initiate co-pay or additional charges to your account based on the illness or preventive codes used.

If you have a managed care medical insurance with which we participate, your payment of deductibles, non-covered services and co-payments are due when services are rendered. If we do not participate with your insurance company or if you do not have health insurance coverage, payment in full for services is due at the time of services are rendered.

Although an insurance claim is filed, you will receive a monthly statement if your account has a patient balance due. This office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. The patient is responsible for payment.

We realize that temporary financial problems may affect timely payment on your account. We encourage you to contact our billing manager for assistance in the management of your account. In the event that your account becomes delinquent and you have not responded to our collection efforts, your account may be turned over to an outside source of collecting the balance due on the account at which time you will be asked to seek care elsewhere. You are responsible for all charges including any agency fees and interest assessed to the account.

If you do not provide us with the complete and accurate insurance information for each visit (within the timely filing limits set by your insurance company(ies)), you will be held responsible for any outstanding balances.

CREDIT CARD POLICY

As a small business operating on decreasing insurance reimbursements with rising costs and expenses, we must do everything possible to reduce the length of time that we extend credit to our patients. We are giving you the opportunity to provide us with a credit card at the time of service. A separate authorization form has been presented to you for completion.

RETURNED CHECKS

Any returned checks are subject to a $25.00 service fee. Any returned check must be resolved before any future appointments can be arranged.

BANKRUPTCY

It is policy of this office that when any bankruptcy case notices are received which list the debtor as the guarantor of any active patient account, appointments will be allowed on a CASH BASIS ONLY. All charges incurred must be paid at the time services are rendered regardless of insurance status. If a payment is then received from your insurance company, a refund will be issued.

MISSED APPOINTMENTS

We understand that an emergency occasionally occurs and that you must cancel your appointment. Please let us know as soon as possible; this will help one of our other patients to use the open appointment. Thank you!

FORMS

Please bring any form (school, sports, daycare, etc) that requires completion with you for your child's appointment. It will be completed "no charge" as part of the office visit. There will be a $5.00 charge to complete any other form not presented at your appointment payable in advance. This fee will not be billed to your insurance company. FMLA forms will be completed; however there will be a $25.00 fee payable in advance and will not be billed to your insurance.

Medical Records

In accordance with the Indiana State Statute IC 16-39-9-4, Nassim & Associates will provide copies of records for the following fees:

- Twenty dollar ($20.00) labor fee which includes the first 10 pages
- Fifty cents ($.50) per page for pages eleven (11) through fifty (50)
- Twenty five cents ($.25) per page for pages fifty one (51) and higher
- Actual mailing costs
- Ten dollar ($10.00) rush fee if records are to be provided within two (2) business days
- Twenty dollar ($20.00)certifying fee if requested

(One copy of the patient(s) medical records will be provided upon request, at no charge, released to parent or other physician's office)

MINOR AGE PATIENTS

We encourage that all patients be accompanied by an adult or that billing arrangements to be made with our office ahead of time. If treatment is rendered we resume, in good faith, that the parents or guardians are responsible for incurred charges.

PREGNANCY

It is the policy of this office that if we have a patient who becomes pregnant or marries, we ask that they seek the care of an adult PCP. As a pediatrician, we treat only the child not the parent and the child.

MEDICAID AND PRIVATE INSURANCES

If you are covered by one of the above, or any other government sponsored program, you must present your current insurance card prior to services being rendered. If your card is not available, we will be happy to reschedule your appointment.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

_____ _____

Patient or responsible party Date

NASSIM
McMONIGLE
& MESCIA
PEDIATRIC AND ADOLESCENT MEDICINE

AUTHORIZATION FOR RELEASE OF PHI, PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize:

PHYSICIAN NAME: _____
ADDRESS: _____
_____
PHONE NUMBER: (_____) _____- _____

to disclose pertinent PHI including medical information, test results, x-rays, correspondence and surgical records about the child/children listed below to Nassim & Associates, PSC.

The PHI to be released (please specify):
□ Entire medical record (INCLUDING psychiatric, mental health, alcohol and/or drug abuse and sexually transmitted disease information)
□ Entire medical record (EXCLUDING psychiatric, mental health, alcohol and/or drug abuse and sexually transmitted disease information)
□ Specific portions: (Please list specific portions such as, service, level of detail, origin of information, dates etc.)
_____

Reason or need for release of records (please specify):
↑ Personal use ↑ Transfer of care ↑ Other (please specify) _____

Patient Name(s):
_____ DOB: _____
_____ DOB: _____
_____ DOB: _____
_____ DOB: _____

I understand that I may revoke this authorization by submitting a revocation in writing to the Privacy Officer at Nassim & Associates, PSC at the above named address except to the extent that Nassim & Associates, PSC has acted in reliance upon this authorization.

This authorization expires 60 days from receipt unless otherwise indicated.

Signature of Parent/Guardian: _____ Printed Name: _____

Relationship to Patient: _____ Date: _____/_____/_____ Time: _____ (am/pm)

Address: _____ City/State/Zip: _____

For office use only: Acct #:_____Witnessed by: _____ Date: _____/_____/____

New Patient Questionnaire

GENERAL INFORMATION:

1. Do you consider your child to be in good health? □ Yes □ No

2. Does your child have any serious illness or medical conditions? □ Yes □ No

    a. If yes, please list the illnesses and/or medical conditions:
    _____
    _____
    _____

3. Are these issues you would like to discuss at your first visit? □ Yes □ No
4. Has your child ever been hospitalized? □ Yes □ No
    a. If yes, please list all hospitalizations (When, Where, Why):
    _____
    _____
    _____

5. Has your child ever had surgery? □ Yes □ No
    a. If yes, please list all surgeries (When, Where, Why):
    _____
    _____
    _____

6. Is your child allergic to any medication or drug? □ Yes □ No

    a. If yes, please explain/describe the reaction to the medication or drug:
    _____
    _____
    _____

If not familiar with the child's birth history, please skip to the next page:

PREGNANCY AND BIRTH HISTORY:

1. During the pregnancy did mother use tobacco? □ Yes □ No
2. During the pregnancy did mother drink alcohol? □ Yes □ No
    a. If yes, how often? _____
3. During the pregnancy did mother use drugs or medications? □ Yes □ No
    a. If yes, what and when were they used? _____
    _____
4. During the pregnancy did mother use prenatal vitamins? □ Yes □ No
5. Did mother have any complications during the pregnancy? □ Yes □ No
    a. If yes, please explain: _____
    _____
6. Was your child born premature? □ Yes □ No
    a. If yes, how many weeks? _____
7. The delivery was: □ Vaginal □ Cesarean
    a. If cesarean, what was the reason? _____
    _____
8. Where there any complications during the delivery? □ Yes □ No
    a. If yes, please explain: _____
    _____
9. Was this child in the NICU? □ Yes □ No
    a. If yes, please explain: _____
    _____
    b. If yes, was the child on a ventilator? □ Yes □ No □ Not Sure
10. Did your child go home with mother from the hospital? □ Yes □ No
    a. If no, please explain: _____
    _____
11. Birth Weight: ____ (lbs) ____ (oz)
    a. Was initial feeding: □ Formula □ Breast Milk: If breast milk, how long? _____

Does your child have or has ever had problems with any of the following:

PAST MEDICAL HISTORY:

□ Chickenpox

□ Frequent Ear Infections

□ Ears (Hearing or Other Problems)

□ Eyes (Vision or Other Problems)

□ Asthma/Pneumonia/Breathing Problems

□ Nasal Allergies

□ Blood Transfusion

□ Anemia/Bleeding Problem

□ Heart Problem (Any) or Heart Murmur

□ Abdominal Pain (Frequent)

□ Constipation (Requiring Doctor Visits)

□ Cancer

□ Urinary Tract Infection (UTI - Frequent/Problems)

□ Genetic/Metabolic Disorder

□ Kidney or Bladder Disease

□ Bed Wetting (After Age 5)

□ Sleep Problems; Snoring

□ Skin Problems; Acne/Eczema (Chronic or Frequent)

□ Headaches (Frequent)

□ Convulsions/Seizures/Other Neurologic Problems

□ Obesity/Weight Problems

□ Diabetes

□ Thyroid/Endocrine/Gland Problems

□ High Blood Pressure

□ History of Serious Injuries/Fractures

□ History of Concussions or Being Knocked Out

□ History or Drug or Alcohol Use

□ Tobacco Use

□ ADHD/Anxiety/Mood Problems/Depression

□ Autism Spectrum

□ Developmental Delay

□ Dental Decay/Cavities

□ History of Family Violence

□ Sexually Transmitted Infections

□ Pregnancy

Any other significant concerns or comments about the above choices: _____
_____
_____
_____

FEMALES ONLY:

□ Problems/Concerns with Periods

Has had first period? □ Yes □ No If yes, at what age? _____ yrs of age

HOUSEHOLD/SOCIAL HISTORY:

1. Please list all those living in the child's home: (Name, Relationship, Age, Any Health Concerns)

2. If there are siblings of the child not living in the home, please list their names, ages and where they live:

3. Does your child live with both biological parents? □ Yes □ No

   a. If no, what is the living situation at this time?

   b. If no, if one or both of the parents are not living in the child's home, how often does the child see the parent(s)?

   c. If no, are there any legal custody arrangements that we should be made aware of?

Have any family members had the following? If so, please list any biological family members below.

BIOLOGICAL FAMILY HISTORY:

□ Childhood Hearing Loss: _____
_____

□ Nasal Allergies: _____
_____

□ Asthma: _____
_____

□ Tuberculosis or Positive TB Test: _____
_____

□ Heart Disease: _____
_____

□ High Cholesterol/Taking Cholesterol Medication: _____
_____

□ Anemia or Bleeding Disorder: _____
_____

□ Dental Decay: _____
_____

□ Cancer (Before Age 55): _____
_____

□ Liver Disease: _____
_____

□ Kidney Disease: _____
_____

□ Diabetes (Before Age 55): _____
_____

□ Bed-Wetting (After Age 10): _____
_____

□ Obesity/Weight Problems: _____
_____

□ Epilepsy/Convulsions/Seizures _____
_____

□ Tobacco Use: _____
_____

□ Alcohol Abuse: _____
_____

□ Drug Abuse: _____
_____

□ Mental Illness/Depression: _____
_____

□ ADD/ADHD: _____
_____

□ Developmental Delay: _____
_____

□ Autism Spectrum Disorder: _____
_____

□ Immune Problems (HIV/AIDS): _____
_____

□ Additional Family History not mentioned above: _____
_____
_____
_____