New Pediatric Patient History

Patient's Name: ______________________________ Date of Birth: ______________
Form Completed By: ________________________________ Relationship to patient: _______________

Birth History

Birth weight _____lbs_____ounces

The baby was born: ☐ On time ☐ Early ☐ Late

If early or late, how many weeks gestation?___weeks.

Did mother have any illness or problem with her pregnancy? ☐ No ☐ Yes,______________________

____

During pregnancy, did mother:

☐ Smoke ☐ Drink Alcohol ☐ Use drugs __________

How much? ______________________________

When?__________________________________

Did Mother take any prescription medications?

☐ No ☐ Yes, _____________________________

____

Was the delivery ☐ Vaginal? ☐ Cesarean?

If cesarean, why?_________________________

Did the baby have any problems right after birth?

☐ No ☐ Yes, _____________________________

____

____

____

Did the baby have to stay in the NICU?

☐ No ☐ Yes because,_______________________

______________________How long?__________

Did the baby go home with mother from hospital?

☐ Yes ☐ No, because_______________________

____

Medical History

Do you consider this child to be in good health? ☐ Yes ☐ No, because ____________________________

____

Please list any serious injuries or accidents:

____date:_______________
____date:_______________
____date:_______________
____date:_______________

Please list any surgeries:

____date:_______________
____date:_______________
____date:_______________
____date:_______________

Please list any hospitalizations not included above:

____date:_______________
____date:_______________
____date:_______________
____date:_______________

Please list any allergies:

Substance: ___________________________ Rash? ☐ Yes ☐ No. Life-threatening reaction? ☐ Yes ☐ No

Substance: ___________________________ Rash? ☐ Yes ☐ No. Life-threatening reaction? ☐ Yes ☐ No

Substance: ___________________________ Rash? ☐ Yes ☐ No. Life-threatening reaction? ☐ Yes ☐ No

Substance: ___________________________ Rash? ☐ Yes ☐ No. Life-threatening reaction? ☐ Yes ☐ No

Please list all medicines this child takes regularly:

_______________________________________ dose: ______________________ frequency: ___________________
_______________________________________ dose: ______________________ frequency: ___________________
_______________________________________ dose: ______________________ frequency: ___________________
_______________________________________ dose: ______________________ frequency: ___________________
_______________________________________ dose: ______________________ frequency: ___________________

New Pediatric Patient History

Has this child had any of the following problems? If so, how old were they at diagnosis? Circle the problem.

	Age		Age
ADHD		Hearing problems	
Anxiety		Heart problems or murmur:	
Asthma		Hypertension (high blood pressure)	
Bedwetting or Daytime accidents		Learning problems:	
Bladder or Kidney infection		Seizures	
Concussion		Skin problems:	
Depression		Speech problems:	
Diabetes		Stroke	
Ear infections		Vision problems:	
Headaches:		Other:	

Are this child's immunizations up to date? □ Yes □ No (Please provide records)

Family History

Please list all people who live with the child, their age, and any health problems. Also list any siblings or parent who do not live in the same household.

Name	Relationship	Age	Health Problems

Social History

Does the child live with both biological parents? □ Yes □ No – please explain:____________________________

____

Does this child attend daycare or Mother's Day Out? □ No □ Yes. How often?___________________________

Does anyone smoke inside the house or outside the house? □ Yes □ No

Are there any pets? □ No □ Yes. What kind?____

Has there been any history of abuse? □ No □ Yes, □ physical, □ emotional, □ sexual, when?_______________

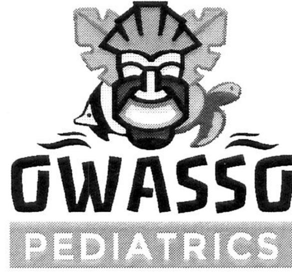
Has this child ever been homeless, a resident of a shelter, or group home? □ No □ Yes, when?_____________

Does this child attend school? □ No □ Yes. What grade?_______ Name of school________________________

Homeschooled? □ No □ Yes

Any other information you would like this child's physician to know? ____________________________________

____
____
____
____



Owasso Pediatric and Adolescent Medicine
Patient Profile

Doctor:_______________________________

PATIENT INFORMATION

Name: ____ Sex: [ ]M [ ]F
Last First Middle

Address: ____ Date of Birth:_____________

____ Race:__________________

City,State: ____ Primary Language :_________________________

Email:____ Social Security #: ______________________________

Phone: ____ [ ]Home [ ]Work [ ]Other [ ]Cell (**PREFERRED CONTACT NUMBER)**

Phone: ____ [ ]Home [ ]Work [ ]Other [ ]Cell

Phone: ____ [ ]Home [ ]Work [ ]Other [ ]Cell

Mother's Full Name: ____ Father's Full Name ____

Mother's Date of Birth : ____________________ Father's Date of Birth : ____________________

Mother's Social Security #: ________________________ Father's Social Security #: ______________________________

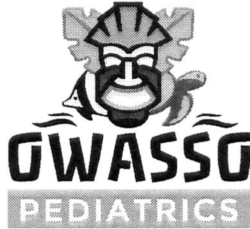
GUARANTOR **(Provider of Insurance and Payments)**

Name: ____

Relationship to Patient: ____

I authorize direct payment to be made to the office of Owasso Pediatric and Adolescent Medicine for any and all medical or surgical services rendered. I understand that if any of services or charges are not covered, or if Owasso Pediatric and Adolescent Medicine is unable to verify eligibility, that I am responsible for all charges incurred for services rendered. I also authorize the release of any medical records for the purpose of healthcare operations.

____
Signature of patient or guardian Date



OWASSO PEDIATRIC AND ADOLESCENT MEDICINE
AUTHORIZATION FOR TREATMENT TO MINOR

______________________________ ______________________________
MINOR'S NAME IN FULL DATE OF BIRTH

I/we, the undersigned parent(s)/legal guardian(s), of the minor person listed above do authorize the physicians of OPAM to provide health services to this minor in the absence of a parent or legal guardian. This health service may include, but is not limited to: examination, preventative and/or curative treatment, x-ray, laboratory examination, anesthetic, medical or surgical diagnosis, and any consultation deemed necessary at the physician's discretion. Services shall not include research or experimentation.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required and is given to encourage the physician to exercise his or her best judgment as to the requirements of such diagnosis or medical treatment in my/our absence.

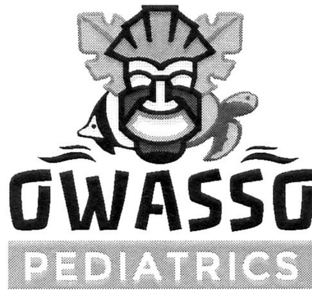
NOTE: Not used as permission for vaccines.

This consent shall remain in effect until revoked, in writing, by parent(s) or legal guardian(s),or until child may legally consent for him or herself.

______________________________ ______________________________
SIGNATURE - PARENT OR LEGAL GUARDIAN DATE

I declare under penalty of perjury under the laws of the State of Oklahoma that the foregoing is true and correct.

______________________________ ______________________________
SIGNATURE - PARENT OR LEGAL GUARDIAN DATE



ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a written copy of the **Owasso Pediatric and Adolescent Medicine's** Notice of Privacy Practices. I also acknowledge that I have been allowed to ask questions concerning this notice and my rights under this notice. I understand that this form will be a part of my record until such time as I may choose to revoke this acknowledgement. If I am not the patient, I represent that I am authorized by law to act for and on the patient's behalf.

________________________________ ________________

Signature of Patient or Authorized Agent Date

TO BE COMPLETED BY OWASSO PEDIATRIC AND ADOLESCENT MEDICINE IF NO ACKNOWLEDGEMENT CAN BE OBTAINED:

Good faith efforts were made to obtain acknowledgement from the patient or patient's authorized agent. The good faith efforts made, and the reason acknowledgement could not be obtained, were:

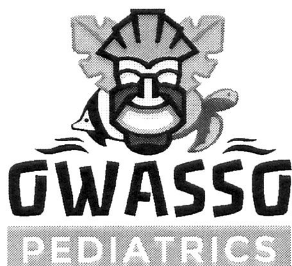
_____ Patient (or authorized agent) refused to sign after being requested to do so.

_____ Minor presented without parent or authorized agent. Notice of Privacy Practice, acknowledgement form, and self addressed envelope sent home with patient.

_____ Other: (please describe)____
____

____ ___________________

Signature of Owasso Pediatric and Adolescent Medicine Date



Guardian Consent Form

I,___________________________, give Owasso Pediatric and Adolescent Medicine permission to speak with the following people regarding my child's health status, including diagnosis, treatment options, and plans and payment for health services from Owasso Pediatric and Adolescent Medicine.

This consent is valid until such time as I provide Owasso Pediatric and Adolescent Medicine written revocation of it.

Patient Name:____

Patient's DOB:____

Owasso Pediatric and Adolescent Medicine may speak with:

Name:____

Relationship:____

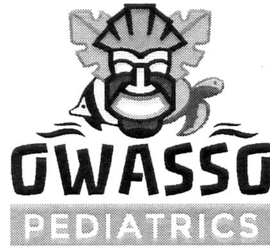
Name :____

Relationship:____

Name:____

Relationship:____

Patient/Guardian Signature:________________________ Date:_________



No Show and Late Show Policy

No-show Policy

A no-show is defined as missing a scheduled appointment without calling us in advance to cancel the appointment. A patient who no-shows three times in a calendar year is subject to dismissal from the practice. We understand that situations occasionally arise when an appointment cannot be kept, and adequate notice is not possible. These situations will be considered on a case by case basis. If the appointment is not cancelled prior to the scheduled appointment time, a $20 no-show fee will be billed directly to the patient's account. The guardian will then be responsible for this charge and it must be paid prior to scheduling another appointment.

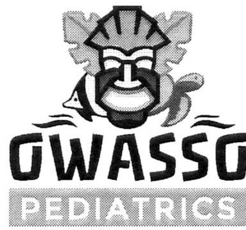
Late-show Policy

A patient who is more than 15 minutes late to his or her appointment will be informed that they have missed their appointment, and will need to reschedule the appointment for another time.

Please understand that the intent of these policies are to aid us in offering a high standard of care to our patients. They are not meant to be a burden. We also pledge to do our part to keep our schedule moving as efficiently as we possibly can.

Patient Name:____

Signature:________________________________ Date:____________________



Financial Policy

Thank you for choosing Owasso Pediatric & Adolescent Medicine for your pediatric needs. Our primary concern is providing quality of care to all of our patients.

Cash patients- payment is due at the time service is rendered.

Insurance patients- deductibles, co-payments, and or co-insurance amounts are due at the time of service. **It is the family's responsibly to know the terms of their specific insurance plan.**

We accept cash, check, Master Card, Visa, American Express, and Discover for you convenience. Returned checks will be charged a $25 fee.

We have made prior arrangements with most insurance carriers and to other plans to accept assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the copay/deductible/co insurance at the time of service.

If you have insurance coverage with a plan we do not have a prior agreement with, we will prepare and send the calm in for you on an unassigned basis. In the event your health plan determines services are "not covered," or you do not have authorization, you will be responsible for the complete charge. **Patients/guardians are responsible for contacting their insurance plans for clarification of benefits prior to services rendered.**

Patients with outstanding balances will be expected to sign a budget agreement and make a minimum payment equal or greater than 20% of the total amount due. The balance should be paid in full within 6 months from the date of the agreement. Failure to comply will result in further collection activity to the account.

Delinquent accounts will be turned over to a collections agency for collection. Accounts are considered delinquent if unpaid after 90 days. In the event your account is turned over to collections, you will be required to pay this outstanding balance in full prior to initiating additional treatment with the practice. Delinquent accounts are subject to dismissal from this medical practice.

All visits after 5pm M-F and on the weekends will have an additional $25 after hour convenience fee. This fee is billed to the insurance but in the case that it's not covered, the remaining balance will be written off.

All billing inquiries should be directed to the Billing Office at 918-274-9700 M-F 9am-5pm.

Patient Name:_______________________________________ DOB:_______________

Parent Signature:_____________________________________ Date:_______________

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Information:

_______________________________________ ________________ _________________
PRINT Patient Name In Full | Date of Birth | Social Security #

I hereby authorize Owasso Pediatric and Adolescent Medicine ("Provider) and its agents and employees to ___ **release** or ___ **obtain** (please check the appropriate space) information and copies or records pertaining to my medical care and treatment which could include information about communicable or venereal disease, mental health, or drug, substance or alcohol abuse.

Release to:	**Obtain from:**
Name of designated Facility or Provider	Name of designated Facility or Provider
Address	Address
City, State, Zip Code Phone Number	City, State, Zip Code Phone Number

Information to be Released:

___ All medical records
___ The most recent two years of pertinent information (chart notes, labs, x-rays, and special tests)
___ Specific information (please specify):____

Purpose for which request is being made (please check one of the following):

___ Physician ___ Medical Claims Processing ___ Self ___Attorney ___Other_____________________

I understand that if I am requesting records/information for release to me or a patient representative:

- laws may prevent certain records being released to the patient
- in certain situations, records denied for release to the patient may allow patient to request and obtain a review of the denial

Drug/Alcohol Abuse Treatment Records: This category of medical information/records is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit anyone receiving this information or records from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I, the undersigned, hereby authorize the release of my (or give relationship) ________________________________ medical record as specified above. This authorization includes the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug related conditions, alcoholism and/or psychiatric/psychological conditions to the above mentioned entity (s).

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE DISEASE OR NONCOMMUNICABLE DISEASE.

My Rights:
I understand that I do not have to sign this authorization in order to obtain health care benefits. I may revoke this authorization in writing by following the process described in the Notice of Privacy Practices posted in this office. I understand that Provider has no control over any information and records released to any other person, firm or agency under this Authorization and it is, therefore, possible that a release of this information or records may occur by such other party.

Reasonable Fee:
State law provides that a health care provider may charge a reasonable fee.

I release Provider, its employees and agents from any liability in connections with the use or disclosure of the information and records released to any party pursuant to this Authorization.

_______________________________________ ______________ __________
Signature of Patient or Patient's Authorized Representative | Date | Time

_______________________________________ ______________________
Reason Patient Unable to Sign | Relationship to Patient

This Authorization will expire in twelve (12) months or ________________________.