Sunnyside Collaborative Care

16144 SE Happy Valley Town Center Drive, Suite 214 Happy Valley, OR 97086
Ph: 503 658 7715 Fax: 503 658 7181

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Date of Birth: _____ **Age:** _____ **Gender:** *circle one* **M** **F**

PARENT OR GUARDIAN:

Father: _____ **Mother:** _____ **Guardian:** _____

Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

Home #: _____ **Work #:** _____ **Cell #:** _____

Email: _____

Name of Insurance Carrier: _____

Policy Holder Name: _____ **DOB:** _____

Relationship to Patient: _____

A L L R E S P O N S E S W I L L B E K E P T C O N F I D E N T I A L

Reason for today's office visit: _____

Other Health Concerns *Please rank in priority	**Onset** ie. June 1997	**Frequency** ie. 4x/week	**Severity** ie. mild/mod/severe
1.			
2.			
3.			
4.			

MEDICATIONS:
Now = medications currently being taken. Past = medications take at one time or another

Substance	**Now**	**Past**	**Substance**	**Now**	**Past**
Aspirin	☐	☐	Asthma Meds	☐	☐
Ibuprofen	☐	☐	Decongestants	☐	☐
Inhalers	☐	☐	Topical Steroids	☐	☐
Antibiotics	☐	☐	Anti-histamine	☐	☐
Other	☐				

SUPPLEMENTS:
Please list all supplements your child is taking: _____

_____

_____

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SPECIAL STUDIES:

Special Studies	Normal	Results	Not Tested
Hearing Test	**Y**	**N**	Not Tested
Vision Test	**Y**	**N**	Not Tested
Speech Impediments	**Y**	**N**	Past
Learning Impediments	**Y**	**N**	Don't Know

MEDICAL HISTORY:

Does your child have any allergies to foods, drugs or other allergens in your environment *(cats, mold, dust)?* **Y** **N**

If Yes, list and explain: _____

_____

Has your child ever had: *Check those that are applicable.*

_____ Chicken Pox _____ Measels _____ Frequent Colds
_____ Tonsillitis _____ Scarlet Fever _____ Pneumonia
_____ Eczema _____ Ear Infections _____ Bronchitis
_____ Rubella _____ Croup _____ Asthma
_____ Mumps _____ Other

Injuries/Surgeries/Hospitalizations: *Please list below.*

_____

_____

BIRTH HISTORY:

Mother's age at birth: _____

Mother's health during pregnancy:

_____ Bleeding _____ Nausea _____ Physical or Emotional Trauma _____ Illness
_____ Hypertension _____ Diabetes _____ Thyroid Problems
_____ Cigarettes, alcohol, drugs

Term: _____ Full _____ Premature _____ Late
_____ Weight at Birth _____ Length of Labor _____ Complications: **Y** **N**

As a newborn, did your child have any of the following problems?

_____ Jaundice _____ Rashes _____ Cerebral Palsy _____ Seizures _____ Diarrhea
_____ Colic _____ Birth Injuries _____ Birth Defects _____ Fever _____ Blue Baby
_____ Allergies _____ Other

Feeding:

_____ Breast Fed _____ How Long? **Formula:** _____ Milk or _____ Soy

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Age Began:

_____ Solid Foods _____ Sitting _____ Crawling _____ Walking _____ First Words

What were your child's sleep patterns the first year: _____

_____

IMMUNIZATIONS:
Please fill in with the appropriate letter: **U = UP TO DATE** **P = PARTIAL** **N = NOT DONE**

Pre-School:

_____ HBV(hepatitis B) _____ Hib(hemophilus influenza type B _____ HAV(hepatits A)
_____ IPV(polio) _____ MMR(measles, mumps, rubella) _____ Varicella (chicken pox
_____ PCV(pneumococcal bacteria) _____ DTap(diphtheria, tetanus, pertussis)

School Age:

_____ Td (tetanus, diphtheria) _____ MCV4 (meningitis)

Other:

_____ Influenza _____ Travel Vaccines

Reactions to immunizations: _____

SOCIAL HISTORY:

Are parents divorced/separated (circle one)? **Y** **N** Whom does the child live with?_____

How would you describe the child's…

Personality?_____

Intelligence?_____

Temper?_____

Sociability?_____

LIFESTYLE:

Does your child watch TV? **Y** **N** *How many hours per day?* _____

Does your child read? **Y** **N** *How many hours per day?* _____

Play video games? **Y** **N** *How many hours per day?* _____

Does your child play sports? **Y** **N** *How many hours per week?* _____

Is your child attending: *circle one* **Daycare** **School** **Home School** *What Grade Level?* _____

What are your child's favorite activities? _____

Anyone in your house smoke? **Y** **N**

Are there pets at home? **Y** **N** *What kind?* _____

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TYPICAL DIET:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Drinks: _____

Does your child have any food intolerance's that you know of? **Y** **N**
If YES, please explain:

_____

FAMILY HISTORY:

_____ Heart Disease _____ Diabetes _____ Birth Defects _____ Cancer

_____ Mental Illnesss _____ Hypertension _____ Arthritis _____ Tuberculosis

_____ Allergies _____ Hay Fever _____ Eczema _____ Other

Please explain, if you chose 'other': _____

_____

SYMPTOMS:

Please circle: **Y =** *a condition your child has now* **N =** *never had* **P =** *has had in the past*

Hives	**Y P N**	**Burning of urine**	**Y P N**	**Bloody urine**	**Y P N**
Eczema	**Y P N**	**Frequent urination**	**Y P N**	**Cries easily**	**Y P N**
Bleeding gums	**Y P N**	**Heart murmur**	**Y P N**	**Nervous**	**Y P N**
Nose bleeds	**Y P N**	**Vomiting spells**	**Y P N**	**Sleep problems**	**Y P N**
Acne	**Y P N**	**Anemia**	**Y P N**	**Night sweats**	**Y P N**
High fever	**Y P N**	**Stomach aches**	**Y P N**	**Sensitive to light**	**Y P N**
Chronic rash	**Y P N**	**Jaundice**	**Y P N**	**Body/breath odor**	**Y P N**
Hearing loss	**Y P N**	**Easy bruising**	**Y P N**	**Motion/car sick**	**Y P N**
Diarrhea	**Y P N**	**Flat feet**	**Y P N**	**No appetite**	**Y P N**
Sore throats	**Y P N**	**Constipation**	**Y P N**	**Nightmares**	**Y P N**
Gas	**Y P N**	**Canker sores**	**Y P N**	**Wheezing**	**Y P N**
Joint pains	**Y P N**	**Cough**	**Y P N**	**Dizzy spells**	**Y P N**
Hair loss	**Y P N**	**Frequent headaches**	**Y P N**	**Frequent colds**	**Y P N**
Unusual fears	**Y P N**	**Bleeding tendency**	**Y P N**	**Excessive fatigue**	**Y P N**

Does your child have any other conditions not mentioned?

_____

_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of Sunnyside Collaborative Care

(Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

PATIENT CONSENT TO TREATMENT

Patient's Name _____ Date of Birth _____/_____/_____

A patient coming to Sunnyside Collaborative Care to see a provider gives his/her permission and authority for care by them in accordance with appropriate test, diagnosis, and analysis. The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I hereby consent to the provision of diagnosis, care, and/or treatment by **Sunnyside Collaborative Care Provider's** I hereby acknowledge and confirm that I am mentally capable of giving informed consent to the provision of the diagnosis, care and/or treatment and am not subject to duress or undue influence.

Right to Refuse Treatment: In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers.

_____ _____

Signature of Patient or Person Date

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PLEASE READ THIS DOCUMENT CAREFULLY. BY EXECUTING THIS CONTRACT, YOU AGREE TO ALL RIGHTS, DUTIES, AND RESPONSIBILITIES STATED HEREIN.

1. **If You Do Not Have Insurance.** All payments are to be paid at the time of services.

2. **If You Have Insurance.** All deductibles and co-payments are to be paid at the time of service.

3. **Cash Patient.** All payments are to be paid at the time of services. You are a cash patient until you submit insurance cards, and SCC qualifies and accepts your insurance coverage.

4. **Reasonable Fees.** SCC fees are usual, customary, and reasonable according to professional industry standard, and, therefore, are covered up to the maximum allowance determined by each carrier.

5**. Patient Financial Responsibilities:**

A. **Patient Responsibility for Uncovered Claims/Services.** If your carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance. If services are not covered by your insurance, patient is responsible for the non-covered services. It is your responsibility to know what your insurance does and does not cover.

B. **Patient Responsible for Cost of Recovery**. If your account with SCC is delinquent more than five months and no payments have to established, SCC will take legal action to recovery the full amount owed.

_____ _____

Patient Signature Date

_____ _____

Signature of Responsible Party or Guardian Date:

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Cancellation Policy/No Show Policy

1. **Cancellation/No Show Policy for Doctor Appointment**

   We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "Full" appointment book.

   If any appointment is not cancelled at least 24 hours in advance you will be charged a fifty dollar ($50) fee; this will not be covered by your insurance company

   _____ _____

   Signature Patient/Guardian **Date**