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 Onset Frequency Severity

\*Please rank in priority ie. June 1997 ie. 4x/week 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:

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

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?*

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?

**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 theprovision 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

**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:

**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**