

WELCOME TO GREEN MOUNTAIN PEDIATRICS

Date: _____

Patient Name:

Last _____ First _____ Middle _____
(Please Print)

Address: _____ Apt # _____ City _____

State _____ Zip Code _____ Home Phone # _____ Cell # _____

Email Address: _____

Date of Birth: _____ Sex: F ____, M ____

Parent Name: _____ SS# _____

Address: _____ Phone # _____

(If different)

Place of Employment: _____

Work Address: _____ Work Phone _____

Parent Name: _____ SS# _____

Address: _____ Phone # _____

(If different)

Place of Employment: _____

Work Address: _____ Work Phone _____

Insurance Information:

Primary Insurance _____ Effective Date _____

Primary Insured Name _____ DOB _____

ID # _____ Policy # _____

Secondary Insurance _____ Effective Date _____

Secondary Insured Name _____ ID # _____ Policy # _____

Emergency Contact Name: _____ Phone # _____

I authorize payment of medical benefits to physician or supplier for these services and all future claims. I understand that I am responsible to pay for services rendered including reasonable attorney's fees and cost of collection in the event of default. I understand that I may be charged \$30 for each missed appointment that was not canceled prior. I also understand that I may be charged \$30 for each applicable co-payment not made at the time of service. I authorize the release of any medical information necessary to process this claim and all future claims.

Signature _____ Date: _____
(Parent or Guardian if Patient of Minor)

**Consent for the Use or Disclosure of
Protected Health Information**

Green Mountain Pediatrics
255 Union Blvd. #120
Lakewood, CO 80228
Effective Date: 4/14/2002

As required by the Health Information Portability and Accountability Act of 1996, Green Mountain Pediatrics may not use your personal health information for the purposes of treatment, payment or health care operations without your consent. The specific uses and disclosures that we intend to make are described in our Notice of Information Practices. You have the right to review the Notice of Information Practices prior to signing this consent form. You may request restrictions on the uses and disclosures described in the notice of information practices by describing the requested restrictions in the "restriction request" section of this form. You may revoke this consent at any time by signing and dating the revocation section of this form.

CONSENT SECTION

I, _____, hereby consent to the use and disclosure of my dependent's, (name), _____, personal health information for the purposes of treatment, payment and health care operations. My signature below indicates that I have been given an opportunity to read Green Mountain Pediatrics's Notice of Information Practices and to have any questions answered before signing.

I understand that I may request **restrictions** on the uses and disclosures of my dependent's health information at any time by completing and signing the restriction request section of this form. I further understand that Green Mountain Pediatrics is not required to accept my restriction request.

I understand that I may **revoke** this consent at any time by signing a revocation policy form. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this consent.

Restriction Request Section

I am requesting the following restrictions on my dependent's health information:

Name: _____

- The entire record, or
- Specific information regarding: _____
From (date) _____ To (date) _____

Print

Signature

Date

Initial History Questionnaire

FORM COMPLETED BY _____

DATE COMPLETED _____

Name _____

BIRTH DATE _____

AGE _____

M

F

Home

Please list all those living in the child's home

Name	Relationship to child	Birthdate	Health Problems

Are there siblings not listed? If so, please list their names, ages, and where they live.

What is the child's living situation if not with both biological parents?

- Lives with adoptive parents Joint custody Single custody
- Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent (s) not in the home?

Birth History

Don't know birth history

Birth weight _____ Was the baby born at term? _____ OR _____ weeks Was the delivery Vaginal Cesarean If cesarean, why? _____

Were there any prenatal or neonatal complications?

Yes No Explain _____

Was a NICU stay required? Yes No Explain _____

During pregnancy, did mother

Use tobacco Yes No Drink alcohol Yes No

Use drugs or medications Yes No Used prenatal vitamins

What _____ When _____

Was initial feeding Formula Breast milk How long breastfed? _____

Did your baby go home with mother from the hospital?

Yes No Explain _____

General

DK = don't know

Do you consider your child to be in good health? Yes No DK Explain _____

Does your child have any serious illnesses or medical conditions? Yes No DK Explain _____

Has your child had any surgery? Yes No DK Explain _____

Has your child ever been hospitalized? Yes No DK Explain _____

Is your child allergic to medicine or drugs? Yes No DK Explain _____

Do you feel your family has enough to eat? Yes No DK Explain _____

Biological Family History

DK = don't know

Have any family members had the following?

Childhood hearing loss	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Nasal Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Heart disease (before 55 years old)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
High cholesterol/takes cholesterol medication	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Bleeding disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Dental decay	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Cancer (before 55 years old)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____

Initial History Questionnaire (Continued from front side)

Biological Family History DK = don't know

Have any family members had the following?

Liver disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Kidney disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Diabetes (before 55 years old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Bed-wetting (after 10 years old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Obesity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Epilepsy or convulsions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Alcohol abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Drug abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Mental illness/depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Developmental disability	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Immune problems, HIV, or AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Tobacco use	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Additional family history _____					

Past History DK = don't know

Does your child have, or has your child ever had

Chickenpox	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	When _____	
Frequent ear infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____	
Problems with ears or hearing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____	
Nasal allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____	
Problems with eyes or vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____	
Asthma, bronchitis, bronchiolitis, or pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____	
Any heart problem or heart murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____	
Anemia or bleeding problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____	
Blood transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____	
HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____	
Organ transplant	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____	
Malignancy/bone marrow transplant	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____	
Chemotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____	
Frequent abdominal pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____	
Constipation requiring doctor visits	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____	
Recurrent urinary tract infections and problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____	
Congenital cataracts/retinoblastoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____	
Metabolic/Genetic disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____	
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____	
Kidney disease or urologic malformations	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____	
Bed-wetting (after 5 years old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____	
Sleep problems; snoring	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____	
Chronic or recurrent skin problems (eg, acne, eczema)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____	
Frequent headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____	
Convulsions or other neurologic problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____	
Obesity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____	
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____	
Thyroid or other endocrine problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____	
High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____	
History of serious injuries/fractures/concussions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____	
Use of alcohol or drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____	
Tobacco	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____	
ADHD/anxiety/mood problems/depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____	
Developmental delay	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____	
Dental decay	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____	
History of family violence	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____	
Sexually transmitted infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____	
Pregnancy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____	
For girls: Problems with her periods	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____	
Has had first period	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Age of first period _____	
Any other significant problem _____					