

Evergreen Natural Health Center
6610 SW Capitol Hwy • Portland OR, 97239
503-977-0500 • www.drssamantha.com
PEDIATRIC PATIENT INFORMATION SHEET

PATIENT:

Last Name: _____ First Name: _____ Middle initial: _____

Prefer to be called: _____

Gender: M F Date of Birth: ___ / ___ / _____ Age: _____ SS#: _____

Primary Guardian/s Name and Relationship to Child _____

Home Address: _____ Apt # _____

City _____ State _____ Zip _____

Phone: (h) _____ (w) _____ (c) _____

Email _____ What is the best way to contact you? _____

May we send you our e-newsletters? Y N We never share info. You may request removal at any time.

Employer Name: _____ Occupation: _____

Work Address: _____

Guardian Relationship status: Married ___ Separated ___ Partner ___ Single ___

Living in home with child: Parents ___ Siblings ___ Other ___

How did you hear about our clinic? _____

2nd PARENT OR OTHER GUARDIAN INFORMATION

Last Name: _____ First Name: _____ Middle initial: _____

Phone: (h) _____ (w) _____ (c) _____

Other information we may need: _____

Other guardian at different address? Y N

EMERGENCY: *Name and address of relative or friend not living with child:*

Last Name: _____ First Name: _____ Middle initial: _____

Phone: (h) _____ (w) _____ (c) _____

Relationship to Patient: _____

INSURANCE: *Please present your insurance card(s) to the receptionist if you wish us to bill your insurance. Please see our financial policy for details.*

Name of insured: _____ Date of birth of insured: _____

RESPONSIBLE PARTY: *Fill out if you are not responsible for the bill.*

Responsible Party: _____ Relationship to the patient: _____

Home Address: _____ Apt # _____

City _____ State _____ Zip _____

Phone: (h) _____ (w) _____ (c) _____

Email _____ What is the best way to contact you? _____

SIGNATURE: (Patient, Parent, Legal Guardian or Responsible Party)

I request services X _____ Date _____

Date: _____ Child's Name: _____

Prefers to be called: _____ Age: _____ Date of Birth: _____ Gender M F

Parent/Legal Guardian Name and Relationship: _____

2nd Parent/Legal Guardian Name and Relationship: _____

Please note if living at different address.

Sibling Names and Ages: _____

How did you hear about our clinic? _____

Pediatrician Name and Clinic _____

Medical History:

What are your current concerns regarding your child's health?

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Please circle: **Y= a medication your child takes now; N= has never taken ; P= has taken in the past.**

| | | | | | | | |
|---------|-------|---------------|-------|------------------|-------|-------------|-------|
| Aspirin | Y N P | Antibiotics | Y N P | Decongestant | Y N P | Ibuprofen | Y N P |
| Tylenol | Y N P | Antihistamine | Y N P | Topical Steroids | Y N P | Asthma Meds | Y N P |

Any other medications? _____

Known allergies to medications? _____

Does your child take supplements? Y N If yes, which ones? _____

Can your child swallow pills? Y N

Do you regularly put sunscreen on your child? Y N

Injuries/Surgeries/Hospitalizations?

1. _____
2. _____
3. _____

Has your child had any of the following special studies (please circle)?

| | | | | | |
|--------|----------|-----------------|--------------------|-----------------|-------------|
| MRI | CT scan | X-ray | Hearing assessment | EEG | EKG/ECG |
| Speech | Language | Reading/Writing | Psych eval | Allergy testing | Other _____ |

Has your child been immunized to the CDC recommended schedule? Y N

Has your child had any adverse reactions to immunizations? Y N

If you have chosen an alternative vaccination schedule, or have chosen not to vaccinate, please specify here:

Guardian's Initials _____

General Medical History

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

| | | | | | |
|--------------------|-------|---------------------|-------|------------------------|-------|
| Baby acne | Y N P | Sore throat | Y N P | Blood in urine | Y N P |
| Eczema | Y N P | Cough | Y N P | Bladder infection | Y N P |
| Hives | Y N P | Ear infections | Y N P | Frequent urination | Y N P |
| Chronic rash | Y N P | Frequent colds | Y N P | Sleep problems | Y N P |
| Easy bruising | Y N P | High fevers | Y N P | Nightmares | Y N P |
| Night sweats | Y N P | Asthma | Y N P | Excessive fatigue | Y N P |
| Stomach aches | Y N P | Wheezing | Y N P | Nervous | Y N P |
| Decreased appetite | Y N P | Hearing loss | Y N P | Cries easily | Y N P |
| Increased appetite | Y N P | Frequent headaches | Y N P | Unusual fears | Y N P |
| Diarrhea | Y N P | Bleeding gums | Y N P | Depression | Y N P |
| Constipation | Y N P | Nose bleeds | Y N P | Motion or car sickness | Y N P |
| Gas | Y N P | Mouth sores | Y N P | Sensitive to light | Y N P |
| Vomiting spells | Y N P | Body or breath odor | Y N P | Dizzy spells | Y N P |
| Flat feet | Y N P | Hair loss | Y N P | Bleeding tendency | Y N P |
| Joint pains | Y N P | Heart murmur | Y N P | Physical trauma | Y N P |
| "Growing pains" | Y N P | Jaundice | Y N P | Emotional trauma | Y N P |
| Seizures | Y N P | Anemia | Y N P | Abuse | Y N P |

Anything else not mentioned: _____

Family medical history (if known.)

Please specify: M=mother, F=father, PA/PU= paternal aunt or uncle, MA/MU= maternal aunt or uncle, MGF/MGM= maternal grandfather or grandmother, PGF/PGM= paternal grandfather or grandmother.

| | | | |
|-----------|---------------|----------------|-----------------|
| Allergies | Hypertension | Diabetes | Thyroid disease |
| Arthritis | Heart Disease | Mental Illness | Asthma |
| Cancer | Eczema | Other | |

Mother's Prenatal History (if known.)

Mother's age at child's birth _____ Was your child adopted? Y N

Health issues for mother during pregnancy, please circle Y or N.

| | | | | | |
|---------------|-----|------------------|-----|------------------|-----|
| Bleeding | Y N | Diabetes | Y N | Alcohol/Drugs | Y N |
| Nausea | Y N | Thyroid problems | Y N | Physical trauma | Y N |
| Severe stress | Y N | Cigarettes | Y N | Emotional trauma | Y N |

A few final questions:

- How does your child's state of health affect his or her daily life?
- On a scale of 1-10 how committed are you to working to improve your child's health? _____
- On a scale of 1-10 how much change are you willing to make to improve your child's health? _____

"The doctor of the future will give no medicine but will interest his patients in the care of the human frame and in the cause and prevention of disease." –Thomas Edison

Guardian's Initials _____

Insurance & Financial Policies
PLEASE READ THOROUGHLY AND INITIAL BELOW

If you have questions about any of our financial policies please contact the office. We appreciate that you have chosen us for your health care and are glad to be of service to you.

Insurance:

In many cases we will be able to call to verify your coverage during your first visit. **If benefits cannot be determined at the time of service and/or if there is any doubt regarding your coverage, payment in full is expected.** If your insurance company remits payment you will be reimbursed when we receive payment. It is important to understand that a verbal confirmation of coverage over the phone from the insurance company does *not* guarantee payment as it is possible for an insurance company to misquote coverage. We strongly recommend reviewing your policy to confirm that the information we received is correct. In some cases, care agreed to be medically indicated by the physician and the patient may not be covered by insurance (for example: lab tests, well child and annual exams, pre-existing conditions, etc.) Please check with your insurance company to find out if there are any exclusions in your policy.

Initial here _____

It is the patient's responsibility to pay for visits and procedures not paid by insurance within a usual and customary time frame (60-90 days). If we are having trouble getting payment within this time frame and you would like us to continue to pursue billing your insurance company, we will require payment for the visit, verbal confirmation from you, and a \$15 per claim fee in order to help defray the costs of completing the payment.

Initial here _____

Supplements:

Most insurance companies do not cover supplements. Payment in full is expected at time of purchase. We are happy to take a return if the safety seal has not been broken, and it is within 60 days of date of purchase. Please note that there is no requirement to purchase recommended supplements from our office; there are several local stores or web stores that may carry similar products.

Initial here _____

Late Cancellation/Missed Appointments:

There will be a \$50.00 charge for all no-show and/or appointment cancellations with less than 24 hours notice. After two missed appointments, you will be charged for the entire time reserved for you on the schedule. If you are scheduled for naturopathic and acupuncture on one day, this is considered two appointments as two slots have been reserved on the schedule. Please note that we place appointment reminder calls as a courtesy. If you do not receive a reminder call prior to your appointment, the missed appointment fee still applies.

Initial here _____

Methods of Payment:

We accept cash, checks, debit, Visa, and MasterCard. There is a \$25.00 fee for returned checks to cover bank fees. We understand that on occasion, financial problems may affect timely payment of your account. If such a situation arises, please contact our office promptly so payment arrangements can be made.

Authorizations:

- I have read the above information and agree regardless of my insurance status to be responsible for the balance of my account. I agree to pay the co-pay, co-insurance, any remaining balance my insurance deems to be patient responsibility, and any fee for services rendered that are not covered by my insurance. I agree to notify this office should there be any change in my insurance coverage.

- I authorize the release of any medical or other information necessary to process any claims.
- I authorize payment of benefits to Evergreen Natural Health Center for all services rendered.

Patient's or Authorized Person's Signature:

Name (please print): _____

Signature: _____ Date: _____

PATIENT NOTICE OF PRIVACY POLICY

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION MAY BE USED OR DISCLOSED,
AND HOW YOU CAN ACCESS YOUR MEDICAL INFORMATION.**

Patient Rights, Uses and Disclosures of Health Information:

During the course of your care with Evergreen Natural Health Center we may use or disclose personal and health-related information.

- Personal health information and clinical records may be disclosed to another health care provider or hospital.
- Health care and billing records may be disclosed to another party, such as an insurance carrier, or your employer, if they are responsible for payment of your services.
- Name, address, phone number, and health care records may be used to contact you regarding appointment reminders, or your care. (If you are not at home to receive an appointment reminder, we may leave a message. You have the right to refuse authorization to contact you. If you do not provide us with this authorization it will not affect the care provide to you or the reimbursement avenues associated with your care.)

Under federal law, we also may disclose your health information without consent under these circumstances:

- In providing health care services based on the orders of another health care provider.
- In an emergency.
- If we are required by law to provide care, and are unable to obtain your consent.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information other than as outlined above will only be made upon your written authorization. You have the right to inspect and/or copy your health information. You have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided in writing.

Physician Legal Duties:

We are required by state and federal law to maintain the privacy of your patient file and the protected health information. We are also required to provide you with this notice of our privacy practices. We are further required by law to abide by the terms of this notice while it is en effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible.

Complaints and Questions:

If you have a complaint regarding our privacy notice or privacy practices, or if you would like more detailed information, please contact us at 503.977.0500. This notice and any alterations or amendments will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Patient Name (please print) Signature Date

If patient is a minor, or if patient is being represented by another party, your representative signs below:

Personal Representative (please print) Personal Representative Signature Date