SIGHT OF HAND

CHILD MEDICAL AND HEALTH HISTORY

A. Identification

Child's Name:_____ Age:_____ Birthdate:____/____/_____ Sex: M / F
Address:_____ City:_____ State:_____ Zip:_____
Phone: (H)_____ (W)_____ (C)_____ (F)_____ Parent's email: _____
Social Security #_____ How did you hear of us?_____
Mother's Name:_____ Father's Name:_____
Parent's Family Status: Married / Divorced / Separated / Never Married (circle one)
Emergency Contact:_____ Phone:_____

B. Insurance Information

Primary Insurance:_____ Policy #:_____ Group ID:_____
Patient's relationship to insured: Child / Other
Insured's Name (holder of policy):_____ Insured's DOB:_____
Secondary Insurance:_____ Policy #:_____ Group ID:_____
Patient's relationship to insured: Child / Other
I AM THE PARENT OR LEGAL GUARDIAN AND AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS THIS AND RELATED CLAIMS. I REQUEST PAYMENT TO MYSELF OR TO THE PARTY WHO PROVIDED THE CARE.
Signature_____ Date_____

C. Chief Complaint

Please list your child's major problems and/or symptoms and the approximate dates they began (if none, please write your reason for seeking this consultation). Please rank in order of severity.

PROBLEM AND/OR SYMPTOM	DATE PROBLEM BEGAN

If you have seen other practitioners for these problems, indicate the results of these evaluations:

_____

_____

D. Family Medical History

Please indicate if you, the parents have had any of the following problems in the past. Please note years affected and if mother or father has particular problem.

Alcoholism		Depression		Herpes		Lyme Disease		Smoker	
Allergies		Diabetes		HIV		Mental Illness		Thyroid Disease	
Anemia		Digestive Disease		Hypoglycemia		Migraine Headache			
Arthritis		Drug Problems		Hepatitis		Multiple Sclerosis			
Asthma		Eating Disorder		High Blood Pressure		Prostate Disease			
Cancer		Eczema		Irritable Bowel		Rheumatic Fever			
Celiac Disease		Emphysema		Kidney Disease		Seizures			
Crohn's Disease		Heart Disease		Lupus/AutoImmune		Stomach/Intestinal Ulcers			

How many siblings does the child have?_____
Please list names, ages and any medical problems.

Name	Age	Medical Problems?

E. Prenatal History (For mother to complete)

Did you smoke during pregnancy? Yes / No Did you drink during pregnancy? Yes / No
Did you receive immunizations for flu or tetanus? Yes / No Did you receive rhogam? Yes / No
Did you have gestational diabetes? Yes / No Did you have pre-eclampsia (high blood pressure)? Yes / No
Did you have any serious illnesses? Yes / No
If so, please explain:_____
_____

F. Perinatal Period (For mother to complete)

Was your child born prematurely? Yes / No if so, how many weeks?_____
Did you experience any complications during delivery? Yes / No If so, please detail and note any medications you may have been given:_____
_____

Did your child need any special care after delivery? Yes / No If so, please explain:_____
_____

G. Early Childhood

Has your child been diagnosed with any chronic medical conditions to date? Yes / No If so, please list and note who diagnosed condition:

DIAGNOSIS	DOCTOR

Was your child breastfed? Yes / No If so, for how long?_____
Has your child frequently been treated with antibiotics for respiratory or ear/throat infections? Yes / No If so, approximately how many times? _____ Were there any delays in developmental milestones? Yes / No
If so, please explain:_____

H. Immunizations: Specify when received if known (or attach copy of immunization schedule):

IMMUNIZATION	DATES RECEIVED	IMMUNIZATION	DATE RECEIVED
Polio (oral / shot)		Hemophilus Influenza (HIB)	
Measles / Mumps / Rubella		Pnemococcus (PCV)	
Diphtheria/Pertussis/Tetanus			
Hepatitis B			
Chicken Pox			

I. Hospitalization / Surgical History: Dates and reasons:

DATE	REASON

J. Current Medications / Supplements

Please write name, dosage and how often taken.

PRESCRIPTION/OVER THE COUNTER MEDICATIONS	SUPPLEMENTS

Please list any medications your child may have an allergy to and the type of reaction:_____
_____

Environment

Are there any pets in the house? Yes / No If yes, please list type(s)_____
Is the child's room carpeted? Yes / No Does any family member smoke in the house? Yes / No

Please complete primary care provider or pediatrician information:
Name:_____ Address:_____ Phone:_____

If you have a specialist, please complete:
Name:_____ Address:_____ Phone:_____
Specialty_____

K. Review of Systems

Please check next to the symptoms that you have experienced over the past 6 months.

	General		Skin		Eyes		Ears		Nose
	Fevers		Dryness		Eye Pain		Excessive Wax		Runny Nose
	Night Sweats		Rashes		Redness		Discharge		Nasal Discharge
	Insomnia		Itching		Discharge		Itching		Sneezing
	Frequent Colds/Flu		Nail Fungus		Itching		Ringing / Tinnitus		Frequent Bleeding
	Fatigue		Brittle Nails		Excessive Tearing		Decreased Hearing		Frequent Snoring
					Dryness				
					Blurred Vision				
					Poor Night Vision				
	Mouth		**Throat**		**Endocrine**		**Cardio/Pulmonary**		**Gastrointestinal**
	Oral Sores		Frequent Soreness		Intolerance to Heat		Shortness of Breath		Heartburn
	Funny Taste		Difficulty Swallowing		Intolerance to Cold		Palpitations		Bloating/Gas
	Bad Breath		Painful Swallowing		Shakiness		Cough		Nausea
	Coating on Tongue		Change in Voice		Fatigue		Chest Pain		Vomiting
			Frequent Clearing Throat		Increased Appetite		Leg Cramps when Walking		Hemorrhoids
			Hoarseness		Decreased Appetite		Leg Cramps at Night		Black or Dark Stools
					Weight Gain/Loss		Varicose Veins		Blood in Stools
					Sweat Easily		Lightheadedness		Constipation
					Cold Hands/Feet		Passed Out		Diarrhea
					Hair Loss/Thinning		Leg Swelling		Thin Stools
					Excess Facial Hair				
					Eyebrows Thinning				
	Neurological		**Mental/Emotional**		**Musculoskeletal**		**Genitourinary**		**Men Only**
	Numbness of a Limb		Anxiety		Joint Pain		Difficulty Urinating		Testicular Lumps
	Weakness of a Limb		Depression		Muscle Aches		Cloudy Urine		Penile Discharge
	Tension Headaches		Suicidal Thoughts		Back Pain		Involuntary Loss of Urine		Penile Lesions
	Migraine Headaches		Panic Attacks		Morning Stiffness		Frequent Urination		Impotence
	Room Spinning		Nervousness				Nighttime Urination		Breast Enlargement
	Head Trauma								
	Memory Loss								

L. Diet Survey

Please check all the following statements, being careful to use the appropriate box related to the frequency of your personal habits.

Frequent = at least once per day Often = several times/week Occasional = once/week or less Seldom = once or twice/month or less
Never = almost total avoidance

	Frequently	Often	Occasional	Seldom	Never
Alcoholic Beverages					
Eat at Restaurants					
Eat at Fast Food Restaurants					
Pastries, Cookies, Candies, Ice Cream, Other Sweets					
Add Sugar to Coffee, Tea, Cereals, Other Foods					
Colas or Other Soft Drinks					
Instant Breakfasts, Pop Tarts, Doughnuts, Muffins					
Cold Breakfast Cereals					
Caffeine Drinks (Coffee, Tea, Cola, Chocolate)					
Deep Fried Food					
Margarine of any Type					
Whole Grain Hot Cereals (Oatmeal, Wheatena, etc.)					
Meat (Beef or Veal, Pork or Ham, Lamb, Liver)					
Chicken or Turkey – Regular or Free Range?					
Fresh Fish					
Processed Meat (Bologna, Turkey Roll, Sausage, etc.)					
Fresh Raw Fruit					
Fresh Vegetables, Raw or Cooked					
Salads					
Whole Grains or Whole Grain Breads					
White Bread or White Flour Products					
Beans and Legumes (Lentil, Kidney, Chickpea, etc.)					
Yogurt – Whole or Lowfat, Plain or Flavored (circle)					
Milk – Whole, Lowfat, or Skimmed (circle)					
Cheese					
Eggs – Regular or Free Range (circle)					
Salt					
Herbs, Fresh and Dried, or Spices					
Drink Adequate Water – Tap, Filtered, Bottled (circle)					
Eat Excessively if Bored or Depressed					
Swallow Food Before Chewing Well					
Hurried or Rushed Meals					
Stuff Yourself					
Read and Understand Food Labels					
Sneak or Hide Foods					
Adequate Fiber or Roughage in Diet					
Artificial Sweeteners (Saccharin, Nutrasweet, etc.)					
Shop at Health Food Stores					

SIGHT OF HAND FINANCIAL POLICY

It is our office policy to inform you of our patient payment procedure. Please review the section below that is applicable to you, as checked and initial it.

____ Patient with Insurance: You are responsible for deductibles, copays, non-covered services, coinsurance, and items considered "not medically necessary" by your insurance company. Co-payment amounts will be collected at the time services are rendered. The remaining balance should be paid within 30 days of receipt of statement. If payment cannot be made at each visit, notify the front desk staff prior to visit to meet with our billing specialist.

____ Patient without Insurance (Private Pay): Please make payment for your care at each patient visit. If payment cannot be made at each visit, notify the front desk prior to visit to meet without billing specialist.

____Personal injury (accident): If you are a personal injury/automobile accident patient, our office will bill the appropriate insurance companies. If we are unable to obtain payment, the charges for services rendered will be your responsibility. Please give all information needed for billing. If statements are to be sent to your attorney instead of to an insurance company, a lien must be signed by your attorney guaranteeing payment for services rendered.

____Medicare: Our office will submit your Medicare charges to Medicare and your secondary insurance, if applicable. You are responsible for deductibles, copays and any non-covered services.

____ Patient without proof of Insurance: If you do not have evidence of health insurance, or complete information regarding your worker's compensation claim or personal injury claim at the time of visit, cash payment will be required at the time of visit. If we then receive the appropriate insurance/claim information and obtain payment, your cash payment will be refunded promptly.

____Non-participating provider: We do not participate with _____. If we do not participate with your individual insurance, payment for your care should be made at each patient visit. If payment cannot be made at each visit, notify the front desk staff prior to first visit to meet with our billing specialist.

SIGHT OF HAND, LLC

GUARANTEE OF PAYMENT

Please initial each section on the line provided.

____ I understand that I am responsible for payment of all fees and services rendered, irrespective of insurance coverage or other responsibilities.

NOTE: The guarantor of each account is ultimately responsible for payment in full of the account. Current, accurate information regarding guarantor and insurance coverage must be provided.

____ I have been advised that if my health insurance carrier/HMO/Medicare plan claims that the services I received today are not considered reasonable and medically necessary for my care, I will be responsible for payment of these services.

____ I understand that if I am participating in an HMO plan, my primary care physician (PCP) must authorize services that I requested and received today. I have been advised that if I did not notify my PCP in adavance for a referral authorization, my HMO plan may deny payment for services and thus, I will become responsible for payment of all services.

____ I authorize payment of benefits from my insurance carriers directly to SIGHT OF HAND. [If I choose not to initial this item, the benefit payments will be paid to me and I will be responsible for paying SIGHT OF HAND].

____ **Cancellation Policy:**

I understand that there is a $50 charge for all missed or cancelled appointments with less than 24 hours notice (business day). This fee must be paid prior to scheduling another appointment.

____**Minor Patients only:**

The adult accompanying a minor or the parents/guardians are responsible for payment at the time of service.

PAYMENT IS REQUIRED AT TIME OF SERVICE

THERE WILL BE A $25.00 FEE FOR RETURNED CHECKS

I have read and understand my financial responsibilities as outlined in both pages of this SIGHT OF HAND Financial Policy document.

X_____ _____

Patient's Signature Date

_____

Patient's Printed Name

_____ _____

Printed name of person signing on behalf of patient Relationship to patient

SIGHT OF HAND CONSENT FORM / PRIVACY NOTICE

Please initial each section on the line provided.

____ Consent for Treatment:

I consent to diagnostic procedures and medical care as necessary in the judgment of my doctor. I understand that my doctor will explain to me the purpose of, the benefits, and the usual risks and hazards involved in the diagnosis and treatment of any illness or injury, as well as alternative courses of treatment. I further understand that I have the right to refuse any suggested examinations, tests, or treatment. I acknowledge that no guarantees have been made to me as to the results of treatment or examination.

____ Medical Release Authorization:

With my consent, SIGHT OF HAND may use and disclose protected health information about me to carry out treatment, payment and healthcare operations as noted below.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN ACCESS THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

SIGHT OF HAND is required by law to protect the privacy of patient information and to provide notice to individuals of our privacy practices. We must abide by the terms of this notice. We reserve the right to change this notice. If we make changes to this notice we will provide patients with a revised notice.

Practice Privacy Policy

At SIGHT OF HAND your privacy is one of our top priorities. Our doctors and staff are bound to honor and respect the patient information entrusted to us.

We must commit to protecting your privacy by abiding by the policies we have established. This notice outlines how we will use or disclose your protected health information.

Patient Health Care Information Use & Disclosure

Your protected health information will be used to treat you, to work with your insurance company for payment purposes, and to carry out healthcare operations. Healthcare operations may include uses and disclosures necessary to manage our practice and assure quality health care.

Otherwise we will not release your health information to other people, unless you specifically authorize us to do so, in writing. You may revoke this authorization at any time by submitting a request to us in writing.

____Consent for Contact:

With my consent, SIGHT OF HAND may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations (such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others). Such items may also be mailed to my home or other designated location.

SIGHT OF HAND

Practice Duties – Regarding your health care information

SIGHT OF HAND is required by law to maintain the privacy of protected health information and to provide patients with notice of its legal duties and privacy practices with respect to protected health information.

SIGHT OF HAND is required to abide by the terms of the notice in effect. We reserve the right to change these policies and we must inform you of these changes. We will inform you of these changes when you arrive at our practice for treatment.

If you have a concern about how your protected health information has been handled by our practice, the managing partner will review your complaint. You will receive written notification informing you of the action taken in response to your concern.

There will be no retaliation against a patient for filing a complaint. If you feel your complaint is not resolved, you may file a complaint with the Secretary of Health and Human Services.

Patient Rights – Regarding their health care information

The patient has the right to request the practice to restrict use and disclosure of protected health information. SIGHT OF HAND is not required to agree to the requested restriction.

The patient has the right to receive confidential communications of protected health information.

Generally, the patient has the right to inspect and request a copy of their protected health information (additional fees may apply).

The patient has the right to request an amendment to their protected health information in the practice medical record.

The patient has the right to receive a paper copy of this notice.

By signing this notice, I am consenting to SIGHT OF HAND's use and disclosure of my protected health information to carry out treatment, payment and healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, SIGHT OF HAND may decline to provide treatment to me.

X_____ _____ _____

Patient's Signature Date

_____

Patient's Printed Name

_____ _____

Printed name of person signing on behalf of patient Relationship to patient