Staying Healthy Assessment

9 – 11 Years

Child's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	Grade in School:
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Other (Specify)			School Attendance Regular? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

Clinic Use Only:

					Nutrition
1	Does your child drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	
2	Does your child eat fruits and vegetables at least two times per day?	Yes	No	Skip	
3	Does your child eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Yes	Skip	
4	Does your child drink more than one cup (8 oz.) of juice per day?	No	Yes	Skip	
5	Does your child drink soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once per week?	No	Yes	Skip	
					Physical Activity
6	Does your child exercise or play sports most days of the week?	Yes	No	Skip	
7	Are you concerned about your child's weight?	No	Yes	Skip	
8	Does your child watch TV or play video games less than 2 hours per day?	Yes	No	Skip	
					Safety
9	Does your home have a working smoke detector?	Yes	No	Skip	
10	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	
11	Does your child always use a seat belt in the back seat (or use a booster seat if under 4'9")?	Yes	No	Skip	
12	Does your child spend time near a swimming pool, river, or lake?	No	Yes	Skip	
13	Does your child spend time in a home where a gun is kept?	No	Yes	Skip	
14	Does your child spend time with anyone who carries a gun, knife, or other weapon?	No	Yes	Skip	
15	Does your child always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	Skip	
16	Has your child ever witnessed or been a victim of abuse or violence?	No	Yes	Skip	
17	Has your child been hit or has your child hit someone in the past year?	No	Yes	Skip	

18	Has your child ever been bullied, felt unsafe at school or in your neighborhood (or been cyber-bullied)?	No	Yes	Skip	
19	Does your child brush and floss her/his teeth daily?	Yes	No	Skip	Dental Health
20	Does your child often seem sad or depressed?	No	Yes	Skip	Mental Health
21	Does your child spend time with anyone who smokes?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
22	Has your child ever smoked cigarettes or chewed tobacco?	No	Yes	Skip	
23	Are you concerned your child may be using drugs or sniffing substances, such as glue, to get high?	No	Yes	Skip	
24	Are you concerned that your child may be drinking alcohol, such as beer, wine, wine coolers, or liquor?	No	Yes	Skip	
25	Does your child have friends or family members who have a problem with drugs or alcohol?	No	Yes	Skip	
26	Has your child started dating or "going out" with boyfriends or girlfriends?	No	Yes	Skip	Sexual Issues
27	Do you think your child might be sexually active?	No	Yes	Skip	
28	Do you have any other questions or concerns about your child's health or behavior?	No	Yes	Skip	

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Mental Health	☐	☐	☐	☐
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐
☐ Sexual Issues	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

SHA ANNUAL REVIEW

PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:

Black Ink Only

DATE _____

CHART NO. _____

Riverwalk Pediatric Clinic, Inc.

HASMUKH C. AMIN, M.D.
MARIA C. RUERAS, M.D.
MARISSA Q. DeLEON, M.D.
VALERIE J. CAYABYAB-GARCIA, M.D.
MARILOU D. VELOSO, M.D.
JENNIFER HENNICK, FNP
JESSICA PRATHER, FNP

9508 STOCKDALE HWY., SUITE 150~ BAKERSFIELD, CA 93311
PHONE: (661) 663-7500~ FAX : (661) 663-3063

Primary Language Spoken
- ☐ English
- ☐ Spanish
- ☐ Other_____

- ☐ American Indian
- ☐ Asian
- ☐ Black
- ☐ Flipino
- ☐ Mex. Amer/Hisp
- ☐ White
- ☐ Other
- ☐ Pacific Islander

PATIENT INFORMATION

LAST	FIRST	MIDDLE	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER
NAME					

NUMBER AND STREET	CITY	STATE/ZIP	PHONE
ADDRESS			

SECTION II – INFORMATION REQUIRED IF PATIENT IS A MINOR – INDICATE RESPONSIBLE PARTY BY (X)

FATHER'S NAME	MOTHER'S NAME
DATE OF BIRTH SOC. SEC. NO.	DATE OF BIRTH SOC. SEC. NO.
ADDRESS	ADDRESS
PHONE	PHONE
CELL	CELL
EMAIL	EMAIL
EMPLOYER'S NAME	EMPLOYER'S NAME

SECTION III – INSURANCE INFORMATION

PRIMARY INSURANCE	**SECONDARY INSURANCE**
SUBSCRIBER'S NAME	SUBSCRIBER NAME
I.D. # GROUP #	I.D. # GROUP #

RESPONSIBLE PARTY

REFERRED BY

IN CASE OF EMERGENCY CONTACT (Other than Parent)

NUMBER AND STREET	CITY, STATE ZIP	PHONE / CELL

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize Riverwalk Pediatric Clinic, Inc. to furnish information concerning this illness and I hereby assign to them all payments for medical services rendered. A copy of this authorization is valid as the original. I understand that I am financially responsible for the charges not covered by this authorization.

SIGNED (INSURED PERSON) _____ DATE _____

Medical Record: _____

Riverwalk Pediatric Clinic, Inc. 9508 Stockdale Hwy # 150, Bakersfield Ca, 93311, 661-663-7500

CAIR California Immunization Registry

Immunization Registry Notice to Patients and Parents

Immunizations or 'shots' prevent serious diseases. Keeping track of shots you have received can be hard. It's especially hard if more than one doctor gave them. Today, doctors use a secure computer system called an *immunization registry* to keep track of shots. If you change doctors, your new doctor can use the registry to see the shot record. It's your right to choose if you want shot records shared in the *California Immunization Registry.*

How Does a Registry Help You?

- Keeps track of all shots, so you don't miss any or get too many
- Sends reminders when you or your child need shots
- Gives you a copy of the shot record from the doctor
- Can show proof about shots needed to start child care, school, or a new job

How Does a Registry Help Your Health Care Team?

Doctors, nurses, health plans, and public health agencies use the registry to:

- See which shots are needed
- Remind you about shots needed
- Prevent disease in your community
- Help with record-keeping

Can Schools or Other Programs See the Registry?

Yes, but this is limited. Schools, child care, and other agencies allowed under California law may:

- See which shots children in their programs need
- Make sure children have all shots needed to start child care or school

What Information Can Be Shared in a Registry?

- patient's name, sex, and birth place
- parents' or guardians' names
- limited information to identify patients
- details about a patient's shots

What's entered in the registry is treated like other private medical information. Misuse of the registry can be punished by law. Under California law, only your doctor's office, health plan, or public health department may see your address and phone number.

Patient and Parent Rights

It's your legal right to ask:

- not to share your (or your child's) registry shot records with others besides your doctor*
- not to get shot appointment reminders from your doctor's office
- to look at a copy of your or your child's shot records
- who has seen the records or to have the doctor change any mistakes

If you DO want your or your child's records in the registry, do nothing. You're all done.

If you DO NOT want your doctor's office to share your immunization information in the registry: Please request an "*Immunization Registry Refusal Form*" from your doctor's office.

For more information about your rights, call **(800) 578-7889**

Patient Name: _____ **D.O.B.** _____

* *By law, public health officials can also look at the registry in the case of a public health emergency.*

rev 1/08

California Child Health and Disability Prevention Program

CONSENT FORM

I hereby give my consent for _____ to receive the health screening tests and
(Name of patient)

immunizations recommended by the CHDP Program from _____.
(Name of provider)

I hereby authorize release of information concerning the results of these screening tests to CHDP Program personnel. I also authorize release of the information to the locations checked below.

I understand that information provided to CHDP Program personnel will be strictly confidential and will be used only to make the provision of health services easier and to permit statistical reporting on the results of screening.

☐ School

Name

Address (number, street)	City	State	ZIP code

☐ Health care provider

Name

Address (number, street)	City	State	ZIP code

☐ Other

Name

Address (number, street)	City	State	ZIP code

Name of parent, guardian, or emancipated minor

Signature of parent, guardian, or emancipated minor	Date

Screening Provider: This form, signed by parent, guardian, or emancipated minor, must be retained in patient's file.

FORM 15 -1

NOTICE OF PRIVACY PRACTICES:
Acknowledgement of Receipt

HASMUKH AMIN, M.D. ACKNOWLEDGEMENT OF RECEIPT

Patient Name: _____ Date of Birth: _____

By signing this form. you acknowledge receipt of the *Notice of Privacy Practices* of Dr. Amin's office. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice by coming by the office at 9508 Stockdale Hwy., Suite 150 Bakersfield, CA 93311.

If you have any questions about our *Notice of Privacy Practices,* please contact:

Tina Lujan, Privacy Officer at: 661-663-7500
D'ln Brown at: 661-663-7500

I acknowledge receipt of the *Notice of Privacy Practices* of Dr. Amin's office.

Patient/Parent Name: _____

Signature: _____ Date: _____
(patient/parent/conservator/guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT

Complete only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

Patient's Name: _____

Reasons why the acknowledgment was not obtained:

- ☐ Patient refused to sign this acknowledgement even though the patient was asked to do so and the patient was given the *Notice of Privacy Practices*
- ☐ *Other:* _____

Signature of provider representative: _____ Date: _____

(5/12) KVP

Chart # _____

Riverwalk Pediatric Clinic, Inc.
9508 Stockdale Hwy, Suite 150
Bakersfield, CA 93311

Patient Name: _____ D.O.B _____

IMPORTANT INFORMATION REGARDING YOUR FINANCIAL RESPONSIBILITY

Riverwalk Pediatric Clinic, Inc. is contracted with most major health plans. Insurance coverage is an agreement between you and your insurance company. We will be happy to bill your insurance company directly for medical services rendered. It is your responsibility to contact the insurance company to verify coverage when being treated at Riverwalk Pediatric Clinic, Inc. If problems arise regarding coverage issues, we will attempt to work with you and your insurance company to resolve them.

It is your responsibility to keep your insurance and personal information current in our files. We ask that you present your insurance card at every visit. Copayments and coinsurance are due at time of service.

If you do not have medical insurance at time of service, you must pay in full before services are provided. We accept cash, personal checks, and Visa, Master Card, Discover, and American Express. If your financial situation is such that you are unable to pay in full, please contact our billing office to discuss possible payment options.

Cash Patients:
As a courtesy, we are able to provide information, which may assist you in obtaining specific medical services at a minimal/or no cost.

Riverwalk Pediatric Clinic, Inc. is committed to providing quality service. Thank you in advance for your cooperation and patience

_____ _____
Patient/Parent/or Guardian Name Date

_____
Patient/Parent/or Guardian Signature