Dignity Health Medical Group Nevada

Dear Patient,

Welcome to the Dignity Health Medical Group Nevada –Henderson Clinic. You are scheduled to see: ○ Dr. Emily Peterson

On (today's date) _____ **At** (Appointment time) _____am/pm

Co-Payment Policy

Your co-payment, if applicable, is due at the time of your visit. We accept cash, check, MasterCard, Visa, American Express and Discover.

Cancellation Policy

Our office requires a 24 hour notification if you need to change or cancel your appointment. Failing to do so will result in a $25.00 charge.

Patient Appointment

For the convenience of our patients, we request that only *one family member per patient* accompany you during your appointment. There are circumstances where more members of the family are needed, and we understand this. However, due to limited seating in our reception area we ask that you comply with our request. Thank you for your attention to this information, and we look forward to providing your medical care.

I acknowledge I have read and understand the terms and policies for the Henderson Clinic.

Patient Name (Print) _____ Date: ___/____/____

Parent or Guardian's Signature _____

Patient Information

Patient's Name: _____ Today's Date: _____
Date of Birth: _____ Age: _____ Gender: Male ___ Female ___
Social Security #: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Race/Ethnicity: _____ Religion: _____
Primary Language: _____ Need an Interpreter? Yes __ No __

Patient Lives with:
Mother: ___ Father: ___ Both: ____

Mother's/Parent 1 Name: _____
Date of Birth: _____
Social Security #: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone Number: _____
Work Phone Number: _____
Cell Phone Number: _____
Occupation: _____

Father's/Parent 2 Name: _____
Date of Birth: _____
Social Security #: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone Number: _____
Work Phone Number: _____
Cell Phone Number: _____
Occupation: _____

Name of Legal Guardian, if other than parents: _____
Date of Birth: _____
Social Security#: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone Number: _____
Work Phone Number: _____
Cell Phone Number: _____
Occupation: _____

Patient's Name:_____ D.O.B. _____ Today's Date _____

Insurance Coverage

Primary Insurance Name: _____
Subscriber's Name: _____Social Security #: _____
Group #: _____ ID #: _____ Telephone Number: _____
Insurance Effective From: _____ To: _____ Subscriber's DOB: _____
Type of Plan (circle): HMO PPO POS EPO Other: _____

Secondary Insurance Name: _____
Subscriber's Name: _____Social Security #: _____
Group #: _____ ID #: _____ Telephone Number: _____
Insurance Effective From: _____ To: _____ Subscriber's DOB: _____
Type of Plan (circle): HMO PPO POS EPO Other: _____

Person Responsible for Payment ("Guarantor")

Responsible Party Name: _____
Relationship to Patient: _____
Date of Birth: ___/____/____ Social Security #: _____ Employer: _____
Street Address: _____ City: _____ State: ___ Zip: _____
Work Telephone #: ( ) _____ Home Telephone #: ( ) _____
Cell Phone #: _____

Additional Responsible Party Name: _____
Relationship to Patient: _____
Date of Birth: ____/____/____ Social Security #: _____ Employer: _____
Street Address: _____City: _____ State: ___ Zip: _____
Work Telephone #: ( ) _____Home Telephone #: ( ) _____
Cell Phone #: _____

Emergency Contact Name: _____Relationship:_____
Home Phone Number: _____ Work Phone Number: _____
Mobile Phone Number: _____
Is it ok to leave message on voicemail of above provided numbers? ○ Yes ○ No
(Telephone message may contain personal health information)

Previous Primary Care Physician Information

Name of Previous Pediatrician/Primary Care Physician: _____
Telephone Number: _____ Fax Number: _____

NEW PATIENT QUESTIONNAIRE

Please fill this out. The Physician and Medical Assistant will go over this during the visit

Child's Name | Age | Date

Accompanied by | Relationship to child

If you need to continue your answer, please use the space provided at the end of end of this form.

Previous Pediatrician/Primary Care Provider:

Name: | Phone:

Address: | Fax:

Past Medical History (Please list where/when illness/hospitalization/surgery took place. For allergies, list allergy and reaction)

Birth History: Birthdate: _____

Is this the mother's 1st, 2nd, 3rd pregnancy? _____

How many weeks pregnant were you when you delivered? _____

Mother's age at patient's birth: _____ Father's age: _____

Birth Method? ☐ Vaginal delivery ☐ Caeserian section

Any problems during the pregnancy, labor or delivery? _____

Birth Hospital? _____

How many days did the baby stay in the hospital? _____

Birth weight? _____

Passed newborn hearing screen? ☐ Yes ☐ No

Any problems in the first month? (Jaundice, feeding problems, infections?)

_____

Any problems with: ☐ sleep ☐ urination ☐ stooling ☐ weight ☐ height ☐ behavior problems

Feeding History (complete if child is under 2 years of age)

☐ Brestmilk ☐ Formula ☐ Breast and Formula

Feeding Issues or Intolerance?_____

Age started solid foods? _____

Any special diet? _____

Serious Injuries or Illness:

Hospitalizations:

Surgeries:

Allergies: Drugs? ☐ Yes ☐ No _____

Food? ☐ Yes ☐ No _____

Latex? ☐ Yes ☐ No _____

Environmental? ☐ Yes ☐ No _____

Allergy Testing? ☐ Yes ☐ No _____

Contagious diseases: Has your child had the following and at what age?

☐ Chickenpox ☐ Measles ☐ Scarlet Fever ☐ Mumps ☐ Other:

Family History

There is a family history of the following: Please list the relationship of the family member to the patient next to the diagnosis

☐ diabetes ☐ convulsions ☐ cancer ☐ tuberculosis

☐ allergies ☐ asthma ☐ heart disease ☐ other

Family Profile

	Name	Age	Health
Parent			
Parent			
Sibling			
Sibling			
Sibling			
Sibling			

Child's parents are ☐ married ☐ separated ☐ divorced ☐ other

Highest school grade? | Occupation

Highest school grade? | Occupation

Number of people living in your house? _____

Anyone smoke in the house? ☐ Yes ☐ No Oustside? ☐ Yes ☐ No

Pets? ☐ Yes ☐ No What kind?_____

How many siblings does your child have?_____

How many people live with your child?_____ How long has your family lived in this area?_____

Does your child have frequent contact with anyone who is receiving chemotherapy, on medications regularly such as steroids or has had an organ transplant? ☐ Yes ☐ No

NEW PATIENT QUESTIONNAIRE CONTINUED

Name Age Date

Accompanied by Relationship to child

If you need to continue your answer, please use the space provided at the end of end of this form.

Immunizations

Are your child's immunizations up to date? ☐ Yes ☐ No If possible, please show us your child's vaccine record

Did your child receive BCG vaccine as infant/child? ☐ Yes ☐ No

Habits and Safety

Does your child do **regular exercise**? ☐ Yes ☐ No. Is the exercise ☐ Inactive ☐ Light ☐ Moderate ☐ Heavy

Frequency of exercise? Type of exercise?

☐ Yes ☐ No. Does your child use **seatbelts/carseats** regularly? Does you child use **helmets** regularly? ☐ Yes ☐ No

☐ Yes ☐ No. Are there any **guns** in the home?

☐ Yes ☐ No. Drinks **milk**? How much per day? _____ oz/day What kind of **milk**? ☐ whole ☐ 2% ☐ soy

☐ Yes ☐ No. **Caffeine** use? If yes, how much per day? _____ cans/day ☐ Other

☐ Yes ☐ No. **Sugary drinks** per day (soda, fruit juice)? _____ oz/day

Has your family **traveled** in the last year? ☐ Yes ☐ No If yes, where?

Development

Age when your child first: (complete if child under 5 years of age)

Rolled _____ Walked _____

Sat _____ First teeth _____

Crawled _____ Toilet trained _____

First word _____ Talked _____

School History: My child is in: ☐ Daycare ☐ Preschool ☐ public school ☐ private school ☐ home school

School Name:

Year in school:

School Problems? ☐ Yes ☐ No

Has your child ever been seen by a Psychologist, Speech Therapist or Special Teachers? ☐ Yes ☐ No

Does your child have any discipline or behavior problems? ☐ Yes ☐ No

Is your child in any special classes? ☐ Yes ☐ No

If you answered yes, please explain:

Current medications - prescription, over-the-counter and vitamins/supplements

Name	dose (mg)	times/day	Name	dose	times/day

Preferred pharmacy? Address

Phone Fax

Health Maintenance

Has your child had the following? Not all of the below are for every child at every age.

Newborn Metabolic Screening	☐ Yes ☐ No	Influenza Vaccine Annually	☐ Yes ☐ No
Lead Screening	☐ Yes ☐ No	Developmental Screening	☐ Yes ☐ No
Hemoglobin Screening	☐ Yes ☐ No	Autisim Screeining	☐ Yes ☐ No
Tuberculin Test Screening	☐ Yes ☐ No	Behavioral Screening	☐ Yes ☐ No
Dyslipidemia Screening	☐ Yes ☐ No	Alcohol and Drug Screening	☐ Yes ☐ No
STI Screening	☐ Yes ☐ No	Oral Health Sreening	☐ Yes ☐ No
Vision Screening	☐ Yes ☐ No	Hearing Screening	☐ Yes ☐ No

NEW PATIENT QUESTIONNAIRE CONTINUED

Name | Age | Date

Accompanied by | Relationship to child

If you need to continue your answer, please use the space provided at the end of end of this form.

Review of symptoms:

Within the last week, has your child had any of the following symptoms:

General
- ☐ Yes ☐ No. Fever
- ☐ Yes ☐ No. Night sweats/chills
- ☐ Yes ☐ No. Decreased appetite
- ☐ Yes ☐ No. Increased crying

Skin
- ☐ Yes ☐ No. Itching
- ☐ Yes ☐ No. Rash
- ☐ Yes ☐ No. New lesion
- ☐ Yes ☐ No. Excessive sweating

HEENT
- ☐ Yes ☐ No. Red eye(s)
- ☐ Yes ☐ No. Excessive tearing
- ☐ Yes ☐ No. Eye discharge
- ☐ Yes ☐ No. Earache
- ☐ Yes ☐ No. Ear discharge
- ☐ Yes ☐ No. Runny nose
- ☐ Yes ☐ No. Nasal congestion
- ☐ Yes ☐ No. Sore throat

Neck
- ☐ Yes ☐ No. Neck stiffness
- ☐ Yes ☐ No. Swollen glands

Respiratory
- ☐ Yes ☐ No. Cough
- ☐ Yes ☐ No. Wheezing
- ☐ Yes ☐ No. Difficulty breathing

Cardiovascular
- ☐ Yes ☐ No. Shortness of breath
- ☐ Yes ☐ No. Chest pain
- ☐ Yes ☐ No. Difficulty breathing on exertion
- ☐ Yes ☐ No. Sweating while feeding if infant

Gastrointestinal
- ☐ Yes ☐ No. Abdominal pain
- ☐ Yes ☐ No. Vomiting
- ☐ Yes ☐ No. Diarrhea
- ☐ Yes ☐ No. Constipation
- ☐ Yes ☐ No. Difficulty swallowing

Musculoskeletal
- ☐ Yes ☐ No. Decreased range of motion
- ☐ Yes ☐ No. Muscle weakness
- ☐ Yes ☐ No. Joint pain/swelling

Neurologic
- ☐ Yes ☐ No. Headaches
- ☐ Yes ☐ No. Seizures
- ☐ Yes ☐ No. Weakness

Psychiatric
- ☐ Yes ☐ No. Change in sleep pattern
- ☐ Yes ☐ No. Fussiness

Endocrine
- ☐ Yes ☐ No. Changes in hair

Hematology
- ☐ Yes ☐ No. Easy bruising
- ☐ Yes ☐ No. Enlarged lymph nodes

Urologic
- ☐ Yes ☐ No. Pain with urination
- ☐ Yes ☐ No. Blood in urine

Other:

Comments/Concerns/Extra Space

Any special comments or concerns about your child?

Patient's Name:_____ D.O.B. _____ Today's Date _____

Dignity Health Medical Group Nevada

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I authorize:

_____
_____
_____

To disclose **all** information concerning my treatment history to:

☐ Emily Peterson, DO

Dignity Health Medical Group Nevada
10001 S. Eastern Ave. Suite 203
Henderson, NV 88052
(Ph) 702-616-5870
(Fax) 702-616-5895

Patient Name (print): _____

Date of Birth: _____ Social Security #: _____

Patient/Guardian Signature: _____

Witness: _____

Patient's Name:_____ D.O.B. _____ Today's Date _____

JOINT NOTICE OF PRIVACY PRACTICES FOR MEDICAL INFORMATION

Effective April 14, 2003, the law requires that Dignity Health Medical Group give patients a copy of its Notice of Privacy Practices for Health Information. We will give you a copy at the time of first treatment and, if we change our notice, thereafter at the next treatment visit.

Parent/Guardian Initials _____

CONSENT AND ASSIGNMENT OF BENEFITS

Dignity Health Medical Group is contracted to various health insurance programs, including Medicare, and accepts assignments only for those health insurances. If a contract exists between my insurance company and Dignity Health Medical Group, Dignity Health will file my health insurance. I request that payment be made by my insurance on my behalf to Dignity Health Medical Group, LLC. I agree to pay any portion of my charges rendered by Dignity Health Medical Group that my contracted health insurance determines is my responsibility. In the event a charge is determined to be cosmetic, I agree to pay for the cosmetic services in full at the time service is rendered.

If I do not have a health insurance plan that Dignity Health Medical Group is contracted with, I agree to pay all fees in full at the time services are rendered.

I understand that I am ultimately responsible for payment of my medical bill. If it becomes necessary for Dignity Health Medical Group to collect payment, I understand that I will be responsible for legal costs, including attorney's fees.

I understand that as a result of refusal to sign this form, or if I have altered this form in any way, Dignity Health Medical Group may refuse to diagnose and treat me. I have the right to revoke this consent and assignment of benefits in writing except for services that have already occurred.

Parent/Guardian Initials _____

By initialing above each section and signing below, you acknowledge receipt of the Joint Notice of Privacy Practices for Medical Information and understand the Assignment of Benefits as the patient, the patient's personal representative, the patient's authorized agent or an individual involved in the patient's medical care.

Parent/Guardian Name: _____ Witness Signature: _____

Acknowledgement Signature: _____ Date: _____

Print Name: _____ Relationship to Patient: _____