McKenzie Pediatrics

Patient Information

(please print)

Date: _____

Acct #_____

Child's Name: _____Birthdate: _____
(First) (Middle) (Last)

Home Phone _____

Soc. Sec #_____ Male ☐ Female ☐ Cell/Pager: _____

Home Address: _____ City: _____State: _____ Zip: _____

If Patient Is A Student, Please Give Name of School: _____

RESPONSIBLE PARTY: (Name of person or person's responsible for this account.)

☐ Parent ☐ Guardian ☐ Foster Parent

Mother's Name: _____ Employer: _____
(First) (Last)
Birthdate: _____ Soc.Sec.# _____ Work Phone: _____

Father's Name: _____ Employer: _____
(First) (Last)
Birthdate: _____ Soc.Sec.# _____ Work Phone: _____

Check Appropriate Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Whom May We Thank For Referring You To Us? _____

Person To Contact In Case Of Emergency: _____Phone: _____
☐ **Friend** ☐ **Relative**

I authorize the following people to bring _____in for treatment:
Child's Name

_____	_____	_____
Name	**Relationship To Child**	**Phone / Cell**

INSURANCE INFORMATION:

Name of Insurance/Address: _____

_____Phone: _____

Please provide a copy of your current insurance card.

*****OVER FOR SIGNATURE *****

McKenzie Pediatrics, PC.

Office Policy

Our office policies represent our constant attempt to maintain fairness to each and every one of our patient families.

All Lane OHP and Omap Identification / Eligibility forms are required at "time of service". If you do not present this form you may be asked to re-scheduled the appointment.

Please give us **24-hour notice of any cancellation**, to allow for other patients to be scheduled in that appointment slot. A cancellation at the time of the appointment is considered by us as a "No Show" since we cannot use the time to see another patient in your place. Once 2 appointments have been "**No-Showed",** you will receive a warning letter. After a **3rd "No-Show" appointment you may be terminated from McKenzie Pediatrics and asked to find another physician.**

Please remember that we care for many children at our office, and we strive to treat each child and family with **equal** consideration and respect.

Credit Policy

Co-payments if required by your insurance are due at time of service. Federal law requires that we not waive any patient co-payment, regardless of ability to pay, as this can be a form of discrimination.

We realize there are many families in a state of change. Our policy is that the parent or caregiver who requests treatment and brings the child in, will be responsible for payment (co-payment due at time service included) of services rendered.

Full payment is expected within 30 days of the service rendered unless otherwise arranged. If you are unable to pay your commitment within the 30 days of services rendered, **please** discuss this with our office staff to set up regular monthly payment arrangements. We do reserve the right to impose a 1.5% service charge (or 18% annual rate) on any balance outstanding more than 90 days past service rendered. After 90 days, if you have not made specific payment arrangements, or have not made any payments, necessary collection proceedings will be initiated. Maximum credit limit is $500.

I consent to treatment. I authorize release of any information concerning my child's health care advice for the purpose of evaluating and administering claims for insurance benefits. I hereby authorize payment of insurance benefits payable direct to McKenzie Pediatrics, PC. Or Direct to the Physician.

I have read the above Office/Credit Policy, and agree to abide by its principles. I have been advised and or offered a copy of the Privacy Policy.

_____ _____

Signature of Responsible party required: Parent/Guardian) Today's Date

McKenzie Pediatrics
New Patient Health Questionnaire

Welcome to our office! Please take the time to complete this short questionnaire in order to assist us in providing the best care possible for your child. Thanks!

Child's Name: _____ Child's Date of Birth: _____

Today's Date: _____

Birth History:

1. Was your child born full-term (37 weeks or greater)? Yes No (if not, when: _____)
2. Did you have any complications to your pregnancy? No Yes
   If yes, please describe: _____
3. Were there any complications to your delivery? No Yes
   If yes, please describe: _____
4. What was your baby's birth weight? _____lbs_____ounces
5. Did your baby go home with you? Yes No
   If not, why not? _____

Siblings:

Please list all of your child's siblings: _____Birthdate_____
_____Birthdate_____
_____Birthdate_____
_____Birthdate_____

Family History:

Please circle if any family history of:

juvenile diabetes	birth defects	ADD/hyperactivity
cystic fibrosis	mental retardation	drug dependency
heart disease	childhood cancers	epilepsy/seizures
tuberculosis	sickle cell anemia	anemia/"low blood"
bleeding disorders	asthma	hayfever
eczema	depression	dyslexia

Please mention any other important family history: _____

Lead Risk Factors:

Please circle if can be answered "yes":

1. Has child lived or spent significant time in, now or past, any home built before 1960 undergoing renovation?
2. Has child lived or spent significant time in, now or past, any home with peeling paint (walls, sills, or exterior)?
3. Do any of the child's caregivers have hobbies such as lead jewelry, battery repair, home car repair, ceramics, stained glass, welding?
4. Has child lived, now or past, near any major highway, smelter, or battery factory?
5. Does child exhibit "pica", the eating of dirt or rocks?
6. Does child have sibling or playmate with blood lead level above 20?

Tuberculosis Risk Factors:

Please circle if can be answered "yes":

1. Has child been exposed to anyone with known TB?
2. Has child lived with, or spent significant time with anyone who has recently immigrated from a "3rd-World" country?
3. Has child himself/herself recently immigrated from, or traveled to a "3rd-World" country?
4. Has child lived with, or spent significant time with anyone who has been incarcerated, homeless, an IV drug abuser, or who has HIV?

(please continue to complete other side)

Cholesterol Risk Factors:

Please circle if can be answered "yes":

1. Does child have parent or grandparent who died of a heart attack or stroke before age 50?
2. Does child have parent with serum cholesterol level above 240?

Vaccine Risk Factors:

Please circle if can be answered "yes". Please remember that only **certain** vaccines can't be given if one or several of these risk factors are positive. **Most** vaccines can be safely administered under virtually **any** circumstance. Thanks!

1. Is anyone currently pregnant with close contact to your child?
2. Is anyone currently HIV (+) with close contact to our child?
3. Does anyone currently suffer from cancer, and on chemo- or radiation therapy, with close contact to your child?
4. Is anyone currently on immunosuppressive drugs (such as oral steroids/Prednisone, cytoxan/Imuran, or methotrexate) with close contact to your child?
5. Does your child suffer from any known immunodeficiency, cancer, AIDS, or rheumatoid disease?
6. Has your child ever had any severe, life-threatening reaction to any vaccine? Please note: _____

Development and School Performance Questions: (Complete Only Relevant Questions)

1. **Do you have any concerns about your child's learning or school performance?** No Yes
   Explain: _____
2. **Do you have any concerns about your child's attention, concentration, and/or overactivity?** No Yes
   Explain: _____
3. **Do you have any concerns about your child is doing in certain subjects at school?** No Yes
   Explain: _____
4. **Do you have any concerns about how much your child is enjoying school compared to his/her friends or classmates?** No Yes
   Explain: _____
5. **Does your child have any problems completing his/her homework?** No Yes
   Explain: _____
6. **Do you have any concerns about your young child's development?** No Yes
   Explain: _____
7. **Do you have any concerns about your young child's social skills?** No Yes
   Explain: _____

For Moms Only:

1. **Have you been hit, kicked, punched, threatened or otherwise hurt by someone within the past year?**
   No Yes Explain: _____
2. **Do you feel safe in your current relationship?** No Yes
   Explain: _____
3. **Is there a partner from a previous relationship who is making you feel unsafe now?** No Yes
   Explain: _____