Initial History Questionnaire

A LAS VEGAS MEDICAL GROUP

DATE/TIME		Form completed by:		Referred by:		Page no.	
CHILD'S NAME				DOB		ACCT NO.	
	Last	*First*	*M.I.*	**AGE**	*mm/dd/yy*	SEX	☐M ☐F
Previous/Referring M.D.		Referring OB-GYN (mother)		Prev. Shot Record:	☐ Present ☐ N/A		

HOUSEHOLD

Father's Name		☐ Single ☐ Married
Mother's Name		☐ Sep. ☐ Divorced
Address		

Home #		Office #		Mobile #		Email	

Please list all those living in the child's home

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names and ages and where they live. ______________________________________

____

If mother and father are not living together or if child does not live with parents, what is the child's custody status? _______________

____

If one or both parents are not living in the home, how often does he/she see the parent/parent? ____________________________

____

BIRTH HISTORY

Birth weight: ______________ Height: ________________ Birth Time _____________

Was the baby born at term? __________ Early? ___________ Late? ______________

If early, how many weeks' gestation? ______________________________________

Did mother have any illness or problem with her pregnancy?

☐ Yes ☐ No Explain ____

____

During pregnancy, did mother

Smoke? ☐ Yes ☐ No Drink Alcohol? ☐ Yes ☐ No

Use drugs or medications? ☐ Yes ☐ No

What _______________________________ When ____________________________

Was the delivery ☐ Vaginal? ☐ Cesarean?

If cesarean, why? _______________________

Did your baby have any problems right after birth?

☐ Yes ☐ No Explain ____

____

Was initial feeding ☐ Breast? ☐ Bottle?

Did your baby go home with mother from the hospital?

☐ Yes ☐ No Explain ____

____

OB-GYN :_________________

Hospital of Birth :___________

Referred by: _______________

GENERAL

Do you consider your child to be in good health? ☐ Yes ☐ No Explain ____________________________

Does your child have any serious illness or medical condition? ☐ Yes ☐ No Explain ____________________________

Has your child had serious injuries or accidents? ☐ Yes ☐ No Explain ____________________________

Has your child had any surgery? ☐ Yes ☐ No Explain ____________________________

Has your child ever been hospitalized? ☐ Yes ☐ No Explain ____________________________

Is your child allergic to any medicines or drugs? ☐ Yes ☐ No Explain ____________________________

DEVELOPMENT

Are you concerned about your child's physical development? ☐ Yes ☐ No Explain ____________________________

Are concerned about your child's mental or emotional development? ☐ Yes ☐ No Explain ____________________________

Are you concerned about your child's attention span? ☐ Yes ☐ No Explain ____________________________

If your child is in school:

How is his/her behavior in school? ____

Has he/she failed or repeated a grade in school? ____

How is he/she doing in academic subjects? ____

Is he/she in special or resource classes? ____

FAMILY HISTORY

Have any family members had the following:

Deafness	☐ Yes	☐ No	Who ______________________	Comments ______________________
Nasal allergies	☐ Yes	☐ No	Who ______________________	Comments ______________________
Tuberculosis	☐ Yes	☐ No	Who ______________________	Comments ______________________
Heart disease (before 50 years old)	☐ Yes	☐ No	Who ______________________	Comments ______________________
High blood pressure (before 50 years old)	☐ Yes	☐ No	Who ______________________	Comments ______________________
High cholesterol	☐ Yes	☐ No	Who ______________________	Comments ______________________
Anemia	☐ Yes	☐ No	Who ______________________	Comments ______________________
Bleeding disorder	☐ Yes	☐ No	Who ______________________	Comments ______________________
Liver disease	☐ Yes	☐ No	Who ______________________	Comments ______________________
Kidney disease	☐ Yes	☐ No	Who ______________________	Comments ______________________
Diabetes (before 50 years old)	☐ Yes	☐ No	Who ______________________	Comments ______________________
Bed-wetting (after 10 years old)	☐ Yes	☐ No	Who ______________________	Comments ______________________
Epilepsy or convulsions	☐ Yes	☐ No	Who ______________________	Comments ______________________
Alcohol abuse	☐ Yes	☐ No	Who ______________________	Comments ______________________
Drug abuse	☐ Yes	☐ No	Who ______________________	Comments ______________________
Mental illness	☐ Yes	☐ No	Who ______________________	Comments ______________________
Mental retardation	☐ Yes	☐ No	Who ______________________	Comments ______________________
Immune problems, HIV, or AIDS	☐ Yes	☐ No	Who ______________________	Comments ______________________

Additional family history ____

____

PAST HISTORY

Does your child have, or has he/she ever had:

Chickenpox	☐ Yes	☐ No	When ______________________
Frequent ear infections	☐ Yes	☐ No	Explain ______________________
Problems with ears or hearing	☐ Yes	☐ No	Explain ______________________
Nasal allergies	☐ Yes	☐ No	Explain ______________________
Problems with eyes or vision	☐ Yes	☐ No	Explain ______________________
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	Explain ______________________
Any heart problem or hear murmur	☐ Yes	☐ No	Explain ______________________
Anemia or bleeding problem	☐ Yes	☐ No	Explain ______________________
Blood transfusion	☐ Yes	☐ No	Explain ______________________
Frequent abdominal pain	☐ Yes	☐ No	Explain ______________________
Constipation requiring doctor visits	☐ Yes	☐ No	Explain ______________________
Bladder or kidney infection	☐ Yes	☐ No	Explain ______________________
Bed-wetting (after 5 years old)	☐ Yes	☐ No	Explain ______________________
(For girls) Has she started her menstrual periods?	☐ Yes	☐ No	Explain ______________________
(For girls) Are there problems with her periods?	☐ Yes	☐ No	Explain ______________________
Any chronic or recurrent skin problem	☐ Yes	☐ No	Explain ______________________
Frequent headaches	☐ Yes	☐ No	Explain ______________________
Convulsions or other neurologic problem	☐ Yes	☐ No	Explain ______________________
Diabetes	☐ Yes	☐ No	Explain ______________________
Thyroid or other endocrine problem	☐ Yes	☐ No	Explain ______________________
Any other significant problem	☐ Yes	☐ No	Explain ______________________
Use of alcohol of drugs	☐ Yes	☐ No	Explain ______________________

Patient Information - Please print clearly (Informacion de Paciente – Escriba Claro, Por Favor)

Name of Child and Siblings *Nombre de Nino y Hijos*	**Date of Birth** *Fecha De Nacimiento*	**Sex** *Sexo*
	- -	☐ M ☐ F
	- -	☐ M ☐ F
	- -	☐ M ☐ F
	- -	☐ M ☐ F
	- -	☐ M ☐ F

Address and Contact Information (Informacion de Direccion y Telefono)

Address *Direcion*		**Apt / Unit #**		**City** *Ciudad*	
State *Estado*		**Zip Code** *Zona Postal*		**Home Phone** *Telefono de Casa*		**Mobile Phone** *Telefono Cellular*	

MAY WE COMMUNICATE MEDICAL/BILLING INFORMATION VIA TEXT MESSAGE?	**YES**	**NO**
LE PODEMOS COMUNICAR INFORMACIÓN MEDICA Y FACTURACIÓN VIA TEXTO	***SI***	***NO***

Parent / Responsible Party Information (Informacion De Padres O Persona De Responsible)

Father's Name *Nombre de Padre*		**Social Security** *Numero de Seguro Social*	
Date of Birth *Fecha de Nacimiento*	- -	**Occupation** *Ocupacion*	
Employer *Nombre del lugar de Empleo*		**Work Phone** *Telefono del lugar de empleo*	
Mother's Name *Nombre de Madre*		**Social Security** *Numero de Seguro Social*	
Date of Birth *Fecha de Nacimiento*	- -	**Occupation** *Ocupacion*	
Employer *Nombre del lugar de Empleo*		**Work Phone** *Telefono del lugar de empleo*	

Marital Status *Estado Marital* ☐ Married *Casado* ☐ Divorced *Divorciado* ☐ Separated *Seperado* ☐ Single *Soltero*

Nearest Friend (Not living with you) *Aimgo Sercano (Que no vive con usted)*		**Phone** *Telefono*	
Nearest Relative (Not living with you) *Pariente Sercano (Que no vive con usted)*		**Phone** *Telefono*	

Insurance Information – Please bring cards to window for copies (Informacion De Aseguranza – Por favor, lleva tarjeta seguro a ventana para copias)

Father's Insurance *Aseguranza del Padre*		**Effective Date** *Fecha de Effectiva*	- -	☐ **Primary** *Primaria*	☐ **Secondary** *Secundaria*
Claims Address *Direcion de Aseguranza*		**Telephone** *Telefono*			
Policy Number or SSN # *Numero poliza o SSN #*		**Group Number** *Numero del Grupo*			
Mother's Insurance *Aseguranza del Madre*		**Effective Date** *Fecha de Effectiva*	- -	☐ **Primary** *Primaria*	☐ **Secondary** *Secundaria*
Claims Address *Direcion de Aseguranza*		**Telephone** *Telefono*			
Policy Number or SSN # *Numero poliza o SSN #*		**Group Number** *Numero del Grupo*			

Treatment Authorization

I authorize A Las Vegas Medical Group to provide any emergency care for my child named above including hospitalization, if necessary in my absence.
Yo autorizo a A Las Vegas Medical Group proveer cualquier cuidado de emergencia a mi-nino arriba menciado si es necesario en mi absencia.

Signature of Parent / Guardian *Firma del Padre / Guardian* **X**

I authorize ____________________________ to bring my child to A Las Vegas Medical Group for medical care.
Yo autorizo ____________________________ que traiga a mi hijo(a) a A Las Vegas Medical Group para cuidado medico.

Signature of Parent / Guardian *Firma del Padre / Guardian* **X**

Insurance Assignment & Medical Release (Asignacion de la Aseguranza & Aprovacion para entregar espedientes medicos)

I the undersigned, do hereby authorize my insurance carrier(s) to pay A Las Vegas Medical Group directly, the insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for any charges NOT covered by the said insurance carrier(s), including co-pay and / or deductible amounts. I also undersigned that I give my permission to A Las Vegas Medical Group to furnish any and all necessary medical records to any entity for emergencies or payment of claims.
Yo autorizo a mi aseguranza que le pague a A Las Vegas Medical directamente, los beneficios, si habra alguno que si no fueran pasados mi para servicios rindados. Yo entiendo que you estoy financieramente responsable para las cargas NO CUBIERTOS por la aseguranza, eso incluye co-pagos y o deducibles. Yo tambien le doy permiso a A Las Vegas Pediatrics para entregar todos y qualquier expediente medico a lugar necesarios en caso de emergencias o para pagos.

Date *Fecha*		**Signature of Parent / Guardian** *Firma del Padre / Guardian*	**X**

A LAS VEGAS MEDICAL GROUP FINANCIAL POLICY

The goal of A LAS VEGAS MEDICAL GROUP is to provide you with the best quality care at a reasonable cost. In order to achieve these goals, your assistance is needed in understanding your insurance policy and benefits. We do verify eligibility and get a brief summary of benefits from your insurance company, **it is very important that you read and understand your benefits.**

If your insurance company cannot be contacted to verify eligibility, you will be asked to pay for the visit via cash, credit or check at the time of service, until the eligibility can be verified.

Payment is due at the time of service and includes all co-pays and deductibles per your insurance company and their contract with our facility.

A charge of $25 will be applied to your account for FMLA, disability forms, etc. This fee will also be charged for writing letters to schools, attorneys, etc.

A charge of $10 will be applied to your account for sports forms (If not filled out during Well Check-Up)

A charge of $25 will be applied to your account for missed or cancelled appointments without 24 hours advanced notice.

A charge of $30 will be applied to your account for all returned checks, This fee, plus the amount of your check must be paid in cash or money order within 24 hours of notification unless prior arrangements have been made.

Should your account become delinquent, all late fees, collection fees and court fees will become your responsibility.

A LAS VEGAS MEDICAL GROUP requests that you respond to all inquiries from your insurance company on your pending claims in a timely manner. We appreciate your continued cooperation and assistance in dealing with your insurance company, which leaves us more time to give the best care to your child.

By signing this agreement, I understand and agree to abide with the policies of A LAS VEGAS MEDICAL GROUP. I also understand that I am financially responsible for any charges not covered by my insurance carrier. I also authorize A LAS VEGAS MEDICAL GROUP to release medical information to my insurance company in connection with my medical claims.

Patient full name	______________	**Date of birth**	______________
Parent name or guardian	______________	**Signature**	**X** ______________
Relationship to patient (if signed by personal representative of patient)	______________	**Date**	______________

No Show / Late Arrival Policy

NO SHOW POLICY

- First occurrence – Patient/parent will receive a phone call advising of our policy and offering to reschedule the missed appointment.
- Second occurrence – Patient/parent will receive a formal letter and may be subject to a $25.00 no show fee.
- Third and subsequent occurrences – May result in dismissal from practice and additional $25.00 no show fee for each occurrence.

LATE ARRIVAL POLICY

Any patient arriving late for their appointment may be subject to reschedule or cancellation.

______________________________ ______________

Patient/Parent/Guardian Signature Date

Patient(s) DOB

___________________________________ ______________

___________________________________ ______________

___________________________________ ______________

___________________________________ ______________

___________________________________ ______________

MEDICATION REFILL POLICY

It is the responsibility of the patient to contact the office at least **FIVE (5) DAYS IN ADVANCE** of the medication running out. For your convenience, you may leave a voicemail on the "refills" option when you contact the main office.

THE PRACTICE WILL NOT DO SAME DAY REFILLS UNLESS IT IS DURING AN OFFICE VISIT

I, ____________________________________, have read the medication refill policy above and understand that I have to contact the office FIVE (5) DAYS IN ADVANCE for any medication refills. I also understand that the office WILL NOT DO SAME DAY REFILLS.

Patient Name:____

PatientSignature:_____________________________

PatientDOB:_____________**Date:**_________

FORMS POLICY

We understand that at times, various forms or letters may be required to assist you with your healthcare needs. The staff at A Las Vegas Medical Group will be happy to complete forms and write medical letters as necessary upon your request. However, because this can be time consuming, please allow **7-10 BUSINESS DAYS FOR COMPLETION** of requested forms/letters. Also, note that a $25 fee may be applied for the completion of forms.

I, ______________________________, understand that completion of forms may take 7-10 business days. I also understand that **SAME DAY OR NEXT DAY FORM COMPLETION WILL NOT OCCUR**. As such, I understand it is my responsibility to turn in forms with enough time before their due date in order to be completed. I also understand a $25 fee may be applied for completion of forms.

_____________________________________ ___________

Patient/Responsible Party signature Date