Partners in Pediatrics
NATURALLY HEALTHY KIDS

South Metro Office: 9785 Maroon Circle St, Englewood, CO 80112 (303) 779-1172
Denver Office: 919 Jasmine Denver, CO 80220 (303) 388-4256

PATIENT INFORMATION:

Patient Name: Last _____ First _____ Middle _____

Nickname: _____

Date of Birth: ____/____/____ **Sex: M/F** Phone: _____

Address: _____ Apt. No. _____

City: _____ State: _____ ZIP _____

List all Siblings, name and date of birth: 1) _____ M/F ____/____/_____

2) _____ M/F ____/____/_____ 3) _____ M/F ____/____/_____

4) _____ M/F ____/____/_____ 5) _____ M/F ____/____/_____

6) _____ M/F ____/____/_____ 7) _____ M/F ____/____/_____

Parent/Guardian Information: Spouse:

Name: _____ _____

Employer: _____ _____

Occupation: _____ _____

Social Security #: _____ _____

Date of Birth: _____ _____

Primary Tel #: _____ _____

Cell Phone#: _____ _____

Email address: _____ _____

Name of Parent not living with child (if applicable): _____

Address: _____ Primary Phone: _____

_____ Cell Phone: _____

Emergency Contact not living in the household:

Name: _____ Telephone #: _____

Referred to Partners In Pediatrics by: _____

INSURANCE INFORMATION:

Primary Insurance: _____

Insured's Name: _____ Insured's Birth Date: ____/____/_____

Subscriber ID: _____ Copay Amount: _____

Secondary Insurance:: _____ Group #: _____

Insured's Name: _____ Insured's Birthdate: ____/____/_____

Subscriber ID: _____ Copay Amount: _____

Email address: _____ _____

You are responsible for payment of services at the time they are rendered. If we are a "Plan Provider" on your insurance and can bill your insurance company, we will do so, but co-payment is always due at the time of service.

Parent / Guardian Signature: _____ **Date:** ____/____/____

Partners in Pediatrics

NATURALLY HEALTHY KIDS

Partners in Pediatrics Health History Form

(Please complete one form for each child)

Childs Name:_____ **Date of Birth:**_____

Is your child up to date on well care? ☐ Yes ☐ No ☐Unknown

Is your child up to date on immunizations? ☐ Yes ☐ No ☐Unknown

Does your child have any allergies or sensitivities? ☐ Yes ☐ No ☐Unknown
Please list:_____ ***Reaction:***_____
_____ _____

Does your child take Medications, vitamins, or supplements? ☐ Yes ☐ No
Please list:_____ ***Dose:***_____
_____ _____

Has your child been hospitalized other than birth? ☐ Yes ☐ No
Has your child ever had surgery? ☐ Yes ☐ No

Please list hospitalizations/surgeries and date:_____
_____

Number of persons who live in household with patient: _____
Parents marital Status?_____
Lives with both parents? ☐ Yes ☐ No _____
Adopted? ☐ Yes ☐ No
Does your child go to daycare? ☐ Yes ☐ No
Child cared for by a babysitter/nanny? ☐ Yes ☐ No
Do any household members smoke? ☐ Yes ☐ No
Any pets in the household? ☐ Yes ☐ No _____
School Name:_____Grade:_____
Sports/Exercise:_____
How often?_____(Days/Hours)
Hobbies:_____
Is there anything else you would like us to know about your child?_____
_____
_____

Partners in Pediatrics
NATURALLY HEALTHY KIDS

Patient Name:_____ **Date of Birth:**_____

(Please complete one form for each child)

Patient Past Medical history

Please mark any of the following that apply to your child: ***(Do not complete if your child is under 6 months of age)***

ADHD	☐ Yes	☐ No	Eating Disorder	☐ Yes	☐ No
Anemia/Blood Disorders	☐ Yes	☐ No	Digestive Problems	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No	GYN Problems	☐ Yes	☐ No
Asthma/Breathing Issues	☐ Yes	☐ No	Head Injury or Concussion	☐ Yes	☐ No
Autism	☐ Yes	☐ No	Headaches	☐ Yes	☐ No
Bedwetting	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No
Behavior Issues	☐ Yes	☐ No	Immune System Problems	☐ Yes	☐ No
Bladder or Kidney Problems	☐ Yes	☐ No	Mental Health Problems	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Muskuloskeletal Problems	☐ Yes	☐ No
Congenital Problems	☐ Yes	☐ No	Prematurity	☐ Yes	☐ No
Constipation	☐ Yes	☐ No	Respiratory Problems	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Seizure Disorder	☐ Yes	☐ No
Developmental Problems	☐ Yes	☐ No	Skin Problems	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Ear or Hearing Problems	☐ Yes	☐ No	UTI's	☐ Yes	☐ No
Ear Infections			Vision or Eye problems.	☐ Yes	☐ No

Other:_____

Family Medical History

Do any family members of the patient have any of the following conditions:					Maternal	Maternal	Paternal	Paternal
Condtion:	Mother	Father	Brother	Sister	Grandmother	Grandfather	Grandmother	Grandfather
ADD/ADHD								
Allergies								
Asthma/Respiratory Problem								
Anema/ Blood Disorder								
Cancer								
Depression								
Developmental Delay								
Diabetes								
Headache/Migraines								
Heart Problems								
High Blood Pressure								
Immune Problems								
Kidney Disease								
Liver Disease								
Mental Health								
Seizure/Neurological Disorder								
Substance Abuse								
Thyroid Problems								
Other								

Please explain any of the above:_____

_____

_____

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OUR OFFICE POLICIES

For your most comfortable and efficient health care experience, we have established the following policies for our medical practice. Please be aware of these policies and know that they have been created with your best interest in mind.

1. **All office visits must be scheduled.** If your child is ill, please call our office first before coming in. Some problems, especially emergencies, may be better handled in an emergency room than in our office. So, always call us first to determine the best way to handle an illness or emergency. Walk-in visits may result in unnecessary waits to see the doctor. There is an **additional fee** for **unscheduled walk-in visits.**

2. **Our answering service does not make office appointments.** Only our office staff can make appointments. Please call us between the hours of 8:30 A.M. to 12:00 P.M.: 1:00 P.M. to 5:00 P.M., Monday through Friday.

3. **We do not see children ONLY for sick care.** We treat ill children who also maintain their regular well-childcare exams or annual physical exams. Thus, we do not render second opinions for children who are not patients in our practice unless the child is transferring for full well-and-sick care to Partners in Pediatrics.

4. **Please be on time for your visits.** If you are more than 15 minutes late for a well-child exam, your appointment may be rescheduled at the discretion of the healthcare providers. This late policy is extremely important to us to continue prompt delivery of care to your children. Late arrivals created delays for all patients who follow. We make our best effort to stay on time. This policy is important for our successful on-time performance.

5. **We document all missed appointments,** which you have not personally cancelled by telephone.

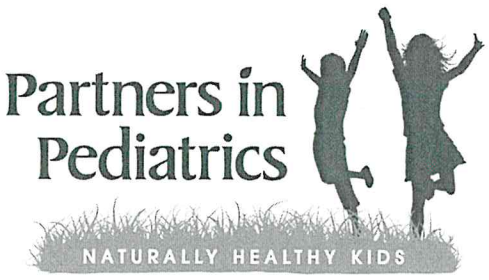
6. **There is a fee for missed Well Care/ADD appointments.** Ample doctor's time has been set aside for your visit. A "no-show" visit is time lost for the doctor and a **fee will be charged** to your account. Two "no-shows" warrant a double fee to be charged to your account. Three "no-shows" are grounds for dismissal from our practice. If you know that you will be unable to keep an appointment, you must speak with a Partners in Pediatrics staff member at least 24 hours ahead of your appointment time.

7. **Payment/co-payment for service is due at the time of your visit.** Should a bill be sent to you (such as for after- hours care), payment is due upon receipt of the bill. A service charge is assessed monthly to your account for any balance carried past 30 days. If you need special payment arrangements, please contact our billing manager to set up an alternate payment schedule. Any delinquent account that is turned over to a collection agency is grounds for dismissal of your children from our care.

8. **If we are a participating provider for your insurance company,** we will submit claims to your insurance company for you and your signature below will authorize payment of medical benefits to Partners in Pediatrics. You will be responsible for any charges not covered by your insurance.

_____ _____ ____/____/_____

Parent/Guardian Signature **Print Name** **Date**



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Partners In Pediatrics

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I,_____, have had an opportunity to read and review
Print Parent or Legal Guardian Name
a copy of Partners In Pediatrics Notices of Privacy Practices. Copies are available upon request.

_____ Date _____/_____/_____
Signature of Parent or Legal Guardian

Please print below the names of all children, first and last.

_____

_____

_____

_____

_____

_____

_____

_____

_____

Partners in Pediatrics

CONTACT AUTHORIZATION AND MEDICAL PRESCRIPTION HISTORY AUTHORIZATION

Consent to text – authorization to receive automated text alerts from our practice on your mobile phone. Text messages may be about appointments, test results and more.

YES ◯ NO ◯

Consent to access medication history – authorizes Partners in Pediatrics to download your child or children's prescription history through pharmacy benefit managers.

YES ◯ NO ◯

_____ Date_____

Signature of Parent or Legal Guardian

Please print below the names of all children, first and last.

_____

_____

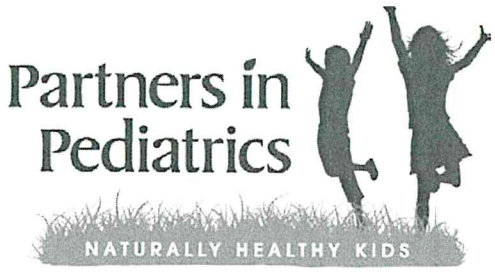
_____

_____

_____

_____

_____



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RELEASE OF MEDICAL RECORDS

I hereby request the release of medical record information for my child(ren):

Patient Name: _____ Date of Birth: ____/____/____

Patient Name: _____ Date of Birth: ____/____/____

Patient Name: _____ Date of Birth: ____/____/____

Patient Name: _____ Date of Birth: ____/____/____

Patient Name: _____ Date of Birth: ____/____/____

Transfer to/from:

☐ Partners In Pediatrics
919 Jasmine St.
Denver, CO 80220

☐ Partners In Pediatrics
9785 Maroon Circle
Englewood, CO 80112

Release to/from:

_____
_____
_____

_____
_____
_____

Reason for this request for release of records: _____

_____

Records will be sent in a reasonable amount of time:

☐ I will **HAND CARRY** the records to my new health care provider.
☐ **MAIL** the medical records to the above address.
☐ **MAIL** the medical records to my home address listed below.
☐ **FAX** the medical records . Attn: _____ Fax #_____

Parent/Guardian Signature: _____ Date:____/____/____

Patient Signature: _____ Date:____/____/____

NOTE: **ONLY** the patient may authorize disclosure relating to birth control, sexual disease or drug use/addiction, regardless of the age of the patient.

RELATIONSHIP TO PATIENT: _____

HOME or NEW ADDRESS: _____

CITY, STATE & ZIP CODE: _____

TELPHONE NUMBER: (____) _____