Pediatric History Form

Patient Name: ______________________ **Date of Birth:** ______________ **Sex:** __________

Birth History: (Circle One)

Type of Delivery: Vaginal C-Section

Was child born: On Time Early Late How early/late? ______________________

Any Delivery Problems? ______________________

Any Pregnancy Problems? ______________________

Birth Weight: ______Lbs. ______Oz. Length: __________ Did newborn pass hearing test? ______________

Hospital Name: ______________________

Patient History: (Please Circle)

Smoke Exposure: Yes No Explain: ______________________

Please circle if your child has had any of the following:

Allergies Strep Seizures Ear Infection Scarlet Fever Croup Pneumonia ADHD

Rotavirus Chicken Pox Asthma RSV Eczema Whooping Cough UTI Mono

General Health/Medical Problems: ______________________

Surgeries: ______________________

Hospitalizations: ______________________

Medications: ______________________Medication Allergies: ______________________

Grade: ____________ School/Daycare:______________________

Family Medical History:

Mother's Name: ______________________ Date of Birth: __________ Occupation: ______________

Medical Problems: ______________________

Father's Name: ______________________Date of Birth: __________ Occupation: ______________

Medical Problems: ______________________

Siblings: Name: ______________________ Age: __________ Sex: __________

Medical Problems: ______________________

Siblings: Name: ______________________ Age: __________ Sex: __________

Medical Problems: ______________________

Patient lives with: ____

Parent's Marital Status (*please circle one*):

Married Single Divorced Widowed

Please mark with an X if your families have/had any of the following:

( ) Genetic Disorder? Who/Type: ____

( ) Diabetes? Who/Type: ____

( ) Heart Disease? Who/Type: ____

( ) Cancer? Who/Type: ____

( ) High Blood Pressure ( ) Sudden Infant Death ( ) Seizures ( ) Depression ( ) Anemia

( ) Allergies ( ) ADHD ( ) Asthma ( ) Kidney Disease ( ) Psychiatric Problems ( ) Migraines

( ) Other: ____

Parent/Guarantor Signature: ______________________________ Date: ________________

Carol Swartz, M.D. Ronna Alcartado, APRN
1701 County Rd Ste. H ~ Minden NV 89423
(775) 782-3933 – Phone ~ (775) 782-1127 – Fax

PATIENT INFORMATION FORM – CHILD

List ALL of your children on this form:

Last Name, First ______________________ Date of Birth ______________ M ◯ F ◯

Social Security # ______________________ Nickname ______________

Last Name, First ______________________ Date of Birth ______________ M ◯ F ◯

Social Security # ______________________ Nickname ______________

Last Name, First ______________________ Date of Birth ______________ M ◯ F ◯

Social Security # ______________________ Nickname ______________

Last Name, First ______________________ Date of Birth ______________ M ◯ F ◯

Social Security # ______________________ Nickname ______________

Patient's Address:

Mailing Address ______________________ City ____________ State ______ Zip Code __________

Home Address ______________________ City ____________ State ______ Zip Code __________

Home Phone ______________________ Cell Phone ______________________

OK to leave detailed message at home? Yes No OK to leave detailed message on cell? Yes No

Mother's Name ______________________ Father's Name ______________________

Date of Birth ______________________ Date of Birth ______________________

Social Security # ______________________ Social Security # ______________________

Email Address ______________________ Email Address ______________________

OK to email appointment confirmation? Yes No

Pharmacy Name ______________________ Phone # ______________________

In case of an emergency:

Please contact (other than above) Name: ____

Relationship_____________________ Phone #___________________________________

Insurance:

Name of Primary Insurance: _______________

Address______________________________

City____________ State_____ Zip Code_______

Policy #______________________________

Group #______________________________

Insured Name__________________________

Relationship to Patient___________________

Co-Pay Amount $___________

Name of Secondary Insurance: _____________

Address ______________________________

City ____________State _____Zip Code_______

Policy #______________________________

Group #______________________________

Insured Name__________________________

Relationship to Patient___________________

Co-Pay Amount $___________

Please circle the appropriate answer:

Race: Asian Native Hawaiian African American White Hispanic Pacific Islander Other

Ethnicity: Hispanic/Latin Not Hispanic

Primary Language: English Spanish Indian (including Hindi and Tamil) Russian Other

Translator Required: Yes No

Mountainview Medical Associates
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AUTHORIZATION FOR EVALUATION AND/OR TREATMENT OF A MINOR CHILD

A parent or legal guardian must accompany a child younger than 18 years of age to consent for all medical and/or surgical treatment provided by Mountainview Medical Associates. Please complete this form if your child will be coming for a visit, treatment, or procedure, without a parent or legal guardian. This consent is valid for the specified time period with a maximum of one year from date signed.

Minor Patient:

Name: ______________________________ DOB: ______________________________

Address: ____

City: __________________ State: ____________ Zip: ____________ Phone: ______________

Time Frame:

Written consent is valid for the time period of: ___________ to___________. (Not to exceed one year) at which time a new consent form would be required. This consent may be revoked by me at any time in writing.

Authorization for other individuals to accompany minor patients under 18 years of age:

I authorize ______________________________ ______________________________
Name of person(s) being authorized Relationship to Patient

______________________________ ______________________________
Name of person(s) being authorized Relationship to Patient

______________________________ ______________________________
Name of person(s) being authorized Relationship to Patient

to give consent to medical treatment by Mountainview Medical Associates on behalf of my child listed above.

The above-named individual(s) may also receive test results and additional information pertinent to the care and treatment of this minor child. ***I understand that I am still financially responsible for all medical expenses incurred by my child during these appointments.***

____
Parent/Legal Guardian Date Signed Phone number (in case of emergency)

Please note for emergencies we will accept a verbal approval from an authorized individual.

Mountainview Medical Associates

Patient Name: ______________________________ Date: ____________________

E-PRESCRIBE CONSENT

ePrecribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

- **Formulary and benefit transactions** — Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Mountainview Medical Associates can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. Understanding all of the above, I hereby provide informed consent to Mountainview Medical Associates to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

FINANCIAL AGREEMENT:

I understand that although I may own one or more insurance policies, I, not the insurance companies, am responsible for payment of all charges incurred in my treatment by Mountainview Medical Associates, and any co-payment will be paid TODAY.

I hereby authorize the release of any information acquired in the course of my examination or treatment to legal counsel, the insurance companies I have insurance through, and/or physicians to who I may agree to see at the request of Mountainview Medical Associates. I further authorize Mountainview Medical Associates to obtain medical information from any source deemed necessary for my treatment.

I hereby authorize and assign any payments directly to Mountainview Medical Associates for any surgical and/or medical benefits otherwise payable to me for services, not to exceed the contracted rate for those services. My consent in hereby granted to use this original or a copy as equally valid authorization.

In an effort to serve you better, it is important that you understand that it is your responsibility:

- **To know your insurance.**
- **To know if Mountainview Medical Associates is a contracted provider for your insurance.**
- **To know if you need prior authorization for procedures.**
- **To know if procedures (x-rays, labs, etc.) have to be done at a specific facility.**
- **To know if you have a co-payment, a yearly deductible, and if that deductible has been met.**

There are hundreds of insurance companies and it is not possible for our staff to know the specific requirements of each policy.

HIPAA

I, ______________________ (print patient/guarantor name) hereby acknowledge that I have access to a paper copy of practice's notice of privacy practices.

If a family member or friend calls or comes into the office requesting information regarding your current condition or any account related issues, who may we release this information to?

Name: ____________________ Relationship: ____________________ Phone: ______________

Name: ____________________ Relationship: ____________________ Phone: ______________

Patient/Guarantor Signature ______________________________ **Date:**____________________

For Office Use Only

□ Acknowledgment refused:

Describe efforts to obtain signature:

State patient's reason for refusal:

Employee Signature: ____________________ Date: ______________

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Name: ____ **Date of Birth:** ____________________

Last First Middle

Authorization for Use/Disclosure of Information: I voluntarily authorize and direct my health care provider:

Name: ____

Address: ____

Fax Number: ______________________________ Phone Number: ____________________________

to disclose my health information during the term of this Authorization to the recipient that I have identified.

Recipient: Name of person or class of persons to whom my health care provider may disclose my health information:
Mountainview Medical Associates 1701 County Rd Ste. H, Minden, NV 89423 (P) 775-782-3933 (F) 775-782-1127.

Purpose: I understand that the specific purpose of the Authorization is at the request of the patient.

Information to be disclosed: This authorization permits the above provider to disclose the following medical records:

☐ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental, or physical condition and any treatment received by me **

☐ All of my health information described above except for the following:

____

☐ Only the following records or types of health information: (Insert dated of treatment, types of treatment, or other designation:

____

Terms: This authorization is to remain in place until the provider fulfills this request.
Refusal to sign/right to revoke: I may refuse to sign or may revoke this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation, or quality of my treatment by my health care provider.
Revocation: I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider's Privacy Officer at the address listed above. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Patient/Guardian Signature: ____________________________________ **Date:** ________________

Patient/Guardian Print Name: ____

Signature of Witness: ____

**** NOTE: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law or mental health records that are protected by the Lanterman-Petris-Short Act.**