Welcome To Our Clinic!

Patient

Name: ______________________ P. O. Box/Mail to: ______________________

First Middle Last Street Address: ______________________

Birthdate: ________ ☐Male ☐Female City, State ZIP: ______________________

SSN: ______________________ Home Phone: (   ) ______________________

Please list the names and ages of those living with patient: ______________________

____

In Case Of Emergency First Call Phone: (   ) ____________ Name: ______________________

Relation to Patient: ______________________

If No Answer: Then Call Phone: (   ) ____________ Name: ______________________

Relation to Patient: ______________________

Guarantor / Person Financially Responsible For Patient

Name: ______________________ P. O. Box/Mail to: ______________________

First Middle Last Street Address: ______________________

☐Male ☐Female City, State ZIP: ______________________

SSN: ______________________ Home Phone: (   ) ______________________

Cell Phone: (   ) ______________________

☐Employed ☐Student Work Phone: (   ) ______________________

Birthdate: ____________ ☐Retired ☐Other Employer: ______________________

Primary Insurance *(attach copy back & front of card)*

Insurance Company: ______________________

Mailing Address: ______________________

City, State Zip: ______________________

Telephone: (   ) ______________________

Insured Name: ______________________

Insured's Employer: ______________________

Relationship of Patient to Insured: ☐Self ☐Child ☐Spouse ☐Other

Policy #: ____________ Insured's

Group: ____________ Birthdate: ________

Secondary Insurance *(attach copy back & front of card)*

Insurance Company: ______________________

Mailing Address: ______________________

City, State Zip: ______________________

Telephone: (   ) ______________________

Insured Name: ______________________

Insured's Employer: ______________________

Relationship of Patient to Insured: ☐Self ☐Child ☐Spouse ☐Other

Policy #: ____________ Insured's

Group: ____________ Birthdate: ________

How did you learn about our practice? ______________________

Our office will file insurance claims for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, copay, and non-covered service amounts. Monthly interest in the amount of 1.5% will accrue on all unpaid balances.

By signing this form, I authorize the release of any medical information necessary to process my claim.

I also authorize payment of insurance benefits directly to Mazen Dahan, M.D.

Signed: ______________________ ____________

Patient / Responsible Party Date

NOTICE OF PRIVACY PRACTICES —ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Mazen Dahan, M.D.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

____
Patient or legally authorized individual signature

____
Date Time

____
Printed name if signed on behalf of the patient

____
Relationship
(parent, legal guardian, personal representative)

(Notation, if any, by staff)

This form will be retained in your medical record.

Last Update: 4 / 14 / 03

PATIENTS WITH NO MEDICAL INSURANCE or SELF BILLING

1. It is the policy of our clinic to ask for payment at the time services are rendered unless prior arrangements are made. Our clinic does understand that there are circumstances that do not allow our patients to pay their medical services in full at the time services are rendered and a regular monthly payment schedule can be arranged if necessary.

PATIENTS WITH MEDICAL INSURANCE

1. Our office has contracted with certain Insurance Carriers to submit claims directly to the carrier. The patient is responsible for furnishing our office with a copy of their Insurance Identification Card. The agencies are:

Regence Health Plan	**Premera Blue Cross**
First Choice	**United Healthcare**
Pacificare	**Aetna US Healthcare of WA**
Aetna US Healthcare	**Cigna Healthcare**

PATIENTS WITH DSHS OR HEALTHY OPTIONSs: IT IS THE POLICY OF OUR OFFICE TO ASK THAT YOU PROVIDE US WITH A DSHS COUPON ON A MONTHLY BASIS.

FOR PATIENTS COVERED BY MEDICAL INSURANCE OUR CLINIC POLICY IS TO REQUEST PAYMENT AT THE TIME OF SERVICE FOR THE CO-PAY, AND ANY NON-COVERED SERVICE PORTION OF THE BILLING.

WE ALSO REMIND YOU THAT ALTHOUGH WE WILL MAKE EVERY EFFORT TO ASSIST YOU IN SUBMISSION OF YOUR INSURANCE CLAIMS TO YOUR CARRIER FOR REIMBURSEMENT, OUR OFFICE CANNOT ACCEPT RESPONSIBILITY FOR COLLECTION OF PAYMENT FROM YOUR INSURANCE CARRIER OR FOR NEGOTIATING A SETTLEMENT ON A DISPUTED CLAIM. THE AGREEMENT OF YOUR INSURANCE COMPANY TO PAY YOUR MEDICAL CLAIM IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE CARRIER AND PAYMENT TO OUR OFFICE REMAINS YOUR RESPONSIBILITY.

PLEASE SIGN BELOW THAT YOU DID READ AND DO AGREE TO THE FINANCIAL POLICY AS INDICATED ABOVE AND TO THE RELEASE AND ASSIGNMENT OF BENEFITS AND THAT YOU DID RECEIVE AND REVIEW OUR PRIVACY POLICY.

____

SIGNATURE OF PATIENT OR GUARDIAN

PEDIATRIC HEALTH CARE

Pediatric Health History (11 years & under)

Name *(Nombre)*:______________________________ Date *(Fecha)*:__________

BIRTH HISTORY: *(DATOS DEL NACIMIENTO)*

Birth date *(Fecha de nacimiento)*:__________ Birth weight *(Peso al nacer)*:__________ Birth length *(Medida al nacer)*:__________

Was child's birth on time? *(¿Nació a tiempo su niño?)*

☐ Yes*(Sí)* ☐ Early by ___ weeks *(Temprano por ___ semanas)* ☐ Late by ___ weeks *(Tarde por ___ semanas)*

Problems during pregnancy or delivery? *(¿Tuvo problemas durante el embarazo o el parto?)* ______________________

Problems after delivery? *(¿Tuvo problemas después del parto?)* ______________________

Feeding *(Alimentación)*:

Breast milk? *(¿Leche de pecho?)* ☐ Yes*(Sí)* ☐ No For how long? *(¿Por cuánto tiempo?)*__________

Formula? *(¿Fórmula?)* ☐ Yes*(Sí)* ☐ No For how long? *(¿Por cuánto tiempo?)*__________

Any feeding problems or food allergies? Please describe: *(¿Algún problema con la alimentación o alergias a algún alimento? Favor de describir*

____

DEVELOPMENT AND SOCIAL HISTORY: *(HISTORIAL SOCIAL Y DE DESAROLLO)*

Please note the age for when your child first took the following milestones: *(Favor de anotar la edad en que su niño alcanzo las siguientes etapas)*:

Sat up *(Se sentó)* __________ First tooth *(Primer diente)*__________ Toilet trained *(Dejo el pañal)*__________

Walked *(Caminó)* __________ First words *(Primeras palabras)*__________ Short phrases *(Frases cortas)* __________

Any problems with speech? *(¿Algún problema con el habla?)* ☐ Yes*(Sí)* ☐ No __________

Any problems with behavior? *(¿Algún problema con la conducta?)* ☐ Yes*(Sí)* ☐ No __________

School or preschool problems? *(¿Problemas en la escuela o pre-escuela?)* ☐ Yes*(Sí)* ☐ No __________

List family members and ages: mom, dad, brothers, sisters. *(Aliste a los miembros de su familia y sus edades: madre, padre, hermanos/as.)*

____

Who lives with child? List names of household members, related or not: *(¿Quién vive con el/la niño/a? Apunte los nombres de todas las personas vivan en la casa, parientes o no.)*:______________________

GENERAL HISTORY: *(HISTORIAL GENERAL)*

Prior physician or clinic *(Médico o clínica anterior)*:______________________

Medicine allergies *(Alergias a medicamentos)* ☐ Yes*(Sí)* ☐ No Describe reaction *(Describa la reacción)*: __________

Hospitalizations *(Hospitalizaciones)* ☐ Yes*(Sí)* ☐ No When?*(¿Cuándo?)* ______ For what?*(Por qué razón?)* __________

Surgeries *(Cirugías)*: ☐ Yes*(Sí)* ☐ No When? *(¿Cuándo?)*__________ What type?*(¿Qué tipo?)*__________

Major accidents, head injuries, poisonings, stitches, or broken bones? Describe: __________
(¿Accidentes graves, lesiones a la cabeza, envenenamientos, puntadas, o huesos quebrados? Describa)

Current medications: include any vitamins, fluoride, or over-the-counter medications. __________
(Medicamentos actuales: incluya vitaminas, flúor, o medicamentos sin receta.)

Last dental checkup *(Ultimo examen dental)*: __________ Problems? *(¿Problemas?)*: __________

Last physical exam or well-child checkup *(Ultimo examen físico o control)*: __________

Age at last shot *(Edad de la última vacuna)*: ______ Up-to-date?*(¿Todo-al-día?)* ☐ Yes*(Sí)* ☐ No What is missing? *(¿Que le falta?)* ______

Check any that your child has had: *(Marque cualesquiera de los siguientes que su niño/a ha tenido)*:

- ☐ Acne *(Acné)*
- ☐ Anemia *(Anemia)*
- ☐ Asthma *(Asma)*
- ☐ Bed wetting after age 7 *(Moja la cama después de 7 años)*
- ☐ Chicken pox *(Varicela)*
- ☐ Ear infections [How many?______] *(Infecciones a los oidos [¿Cuántas?________])*
- ☐ Eczema/skin problems *(Problemas a la piel / eczema)*
- ☐ Eye problems/glasses *(Problemas a los ojos / lentes)*
- ☐ Headaches *(Dolor de cabeza)*
- ☐ Hearing problems *(Problemas de audición)*
- ☐ Heart murmur *(Soplo cardiaco)*
- ☐ Hepatitis or jaundice *(Hepatitis o ictericia)*
- ☐ Leg or foot problems *(Problemas a las piernas o pies)*
- ☐ Pneumonia *(Neumonía)*
- ☐ Seizures *(Convulsiones)*
- ☐ Stomach aches *(Dolores de estómago)*
- ☐ Undescended testicles *(Testículos que no han descendic*
- ☐ Urinary tract infection/bladder *(Infecció en las vías urinarias / vejiga)*
- ☐ Other *(Otro)*: __________ __________

FAMILY HISTORY – Check any that a relative has had: *(HISTORIAL FAMILIAR – Marque cualesquiera que haya tenido algún pariente)*

- ☐ Asthma *(Asma)*
- ☐ Alcoholism/drug abuse *(Alcoholismo / abuso de drogas)*
- ☐ Bleeding problems *(Problemas de hemorragia)*
- ☐ Cancer *(Cáncer)*
- ☐ Diabetes *(Diabetes)*
- ☐ Heart attack *(Ataque cardiaco)*
- ☐ High blood pressure *(Presión alta)*
- ☐ Seizures *(Convulsiones)*
- ☐ Sickle cell anemia *(Anemi drepanocítica)*

Is there a smoker in your household? *(¿Hay alguien en la casa que fume?)* ☐ Yes*(Sí)* ☐ No Who? *(¿Quién?)*__________

Office use: Provider initials: __________ Date reviewed: __________

For Your Convenience:

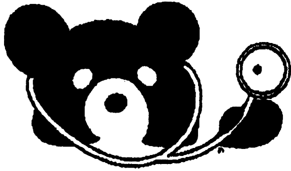
Does your child play any sports? Or Take any Medications at school?

School Name:______________________________
Address:______________________________
Phone Number:______________________________
Fax Number:______________________________

Pharmacy Information
Name:______________________________
Address:______________________________
Phone Number:______________________________
Fax Number:______________________________

Medication (If your child is on any)
Name:______________________________
Dosage:______________________________

*All medication/ Vaccine forms take 24-48 hours to process.



Pediatric Healthcare

1420 3RD STREET SOUTH EAST SUITE 200 PUYALLUP, WA 98372
PHONE: (253) 848-7660 FAX: (253) 841-1801

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patients Name: ______________________________ Date of Birth: ______________

Previous Name (if applicable): ______________________________ Phone Number: ______________

INFORMATION TO BE RELEASED BY:	INFORMATION TO BE RELEASED TO:
☐ Pediatric Healthcare	☐ Pediatric Healthcare
☐ ______________________ Organization / Person Name	☐ ______________________ Organization / Person Name
______________________ Address	______________________ Address
______________________ City / State / Zip	______________________ City / State / Zip
______________________ Phone Fax	______________________ Phone Fax

Type of Medical Information to be Released:

☐ Complete medical record

☐ Healthcare information related to the following treatment or dates:

____

☐ Other: ____

Reason for Request:

☐ Personal ☐ Insurance

☐ Transfer of Care ☐ Legal

☐ Other: (please explain) ______________________________

This authorization includes the release of the following sensitive information unless specifically excluded. Please check if you do NOT want this information included in the release of your medical record.

☐ HIV/AIDS ☐ Reproductive Care

☐ Sexually Transmitted Diseases ☐ Other ______________

Minors Age 13-17: A minor patient's signature is required in order to release the following information: (1) Conditions relating to the minor's reproductive care including, but not limited to: contraception, pregnancy, pregnancy termination, sterilization, and sexually transmitted diseases, (2) alcohol and/or drug abuse. (3) and mental health conditions.

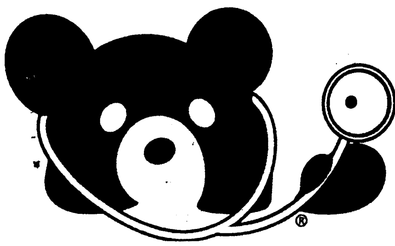
I hereby consent to the release of the specified information related to the diagnoses, testing, or treatment to the person or entity named above. I understand that such information cannot be released without my informed consent. I acknowledge I have fully reviewed and understood the contents of this authorization form. My signature below indicates that I herby agree to and authorize the release of patient health information to the above named person or entity. I understand that I have the right to revoke or cancel this authorization in writing at anytime.

There may be a charge for copies of your medical record unless the copies of your health record are being faxed to another physician or healthcare facility.

Patient Signature: ______________________________ Date: ______________

Parent/Legal Guardian Signature: ______________________________ Date: ______________

This authorization Expires 90 days from the date of signing. Federal laws prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.



Pediatric Healthcare

Authorization – Non-Parent/Guardian to Accompany Patient

Periodically there may be times when you are unable to bring your child to the office for an appointment and need to rely on a family member or friend. We understand these circumstances; however, we must have a written authorization letter allowing this person to accompany your child(ren). The person bringing your child will need to present a photo identification at time of service.

This authorization gives the person permission to bring your child(ren) in, speak to the doctor, given authorization for treatment, vaccinations, medication, certain procedures and make general health decisions.

I, ______________________________________, give the person(s) listed below permission to bring my child to Children's Pediatricians & Associates (CP&A) and to discuss and share medical information about my child. I further authorize them to see all necessary medical records and make health care decisions of a routine nature as determined at the sole discretion of the CP&A provider.

I also give them authority to make more serious or urgent health care decisions in the event I cannot be reached or where it is of an emergency nature where there is not enough time to seek out my specific consent.

Child's Name: ____________________________________ DOB: ______________________

Child's Name: ____________________________________ DOB: ______________________

Child's Name: ____________________________________ DOB: ______________________

(IF ONLY PARENTS ARE ALLOWED TO BRING CHILD IN, PLEASE INDICATE 'NONE')

____ ______________________

Name of Person (allowed to bring child)

Relationship ____ ______________________

Name of Person (allowed to bring child)

Relationship ____ ______________________

Do you use the Internet or a smartphone?

Would you like to be able to send your doctor's office a quick message in the evening or take a look at your lab results on-line? How about checking to see when your next appointment is or requesting a prescription refill? Great! Now you can . . .

Pediatric Health Care is offering a *FREE* secure on-line service linking you to our healthcare team. Use your computer or use your smartphone. It's a quick and easy way for you to communicate with our office staff or look-up information any time of day.

<u>What you will be able to do</u>:
Review your end of visit summary from your recent visits
View current and historical lab results
Securely message office staff
View medications/allergies and request prescription refills
Request and/or view your appointment information
Print and review practice forms and handouts
Monitor anticoagulation graphing and dosing
Review problem list details
Receive lab/radiology orders, clinical notes, etc. from provider office
Immediately receive follow-up letters electronically
Receive appointment reminder messages

Please complete the information below and give this to your nurse to get access today!

Print Name: ______________________________ Date of Birth: ____________

Select your Provider:

☐ Dr. Dahan

Would you like to receive this FREE service?

_____ Sign me up. _____ I do not have Internet or an e-mail address.

E-Mail Address: ______________________________

Our providers feel getting you connected on-line helps you stay informed and allows you to actively participate in your healthcare.