Desert Valley Pediatrics

☐ West Valley Office	☐ At The Ball Park	☐ Surprise Office
4137 N. 108th Ave.	3802 N. 53rd Ave. Ste. 160	15264 W. Brookside Ln. Ste. 155
Phoenix, AZ 85037	Phoenix, AZ 85031	Surprise, AZ 85374
P 623-877-7337	P 623-877-7337	P 623-877-7337
F 623-772-0686	F 623-247-6537	F 623-214-3219

Patient Account #________________

Child's Last Name ________________ First ________________ MI ______

Birth Date________ Age _____ Sex: F M Primary Language ________________

Please list names of family members seen by DVP physicians: ________________

____

Guardian's/
Father's Name ________________

Address ________________

City________ State____ Zip______

Home/Message Phone________________

Business Phone ________________

Cell Phone ________________

SS# ________ Date of Birth________

Guardian's/
Mother's Name________________

Address ________________

City________ State____Zip ______

Home/Message Phone________________

Business Phone ________________

Cell Phone ________________

SS# ________ Date of Birth________

Insurance Information

Insurance Co. Name________________________________

Patient's Insurance ID #: ________________ Group:________

Include member number if applicable (01, 02, 03, etc.)

Insurance Policy Holder Name:________________________________

Insurance Policy Holder DOB: ________________ Relationship:________

Address To Send Claims: ________________________________

____

____

Release of Benefits and Information: I consent for medical treatment and I have verified the insurance listed on this form and authorize my insurance benefits be paid directly to the doctor. I am financially responsible for any balance due. I authorize Desert Valley Pediatrics to release any information required for this claim.

Signed:________________________________ **Date:**________________

DESERT VALLEY PEDIATRICS
PEDIATRIC HISTORY

Date (La fecha) ____________________ Child's Name (Nombre del Nino/a) ____

Child's Date of Birth (Fecha de Nacimiento del Nino/a) ________________________

FAMILY HISTORY (HISTORIA MEDICA DE FAMILIA)

Mother's age/Mama edad __________ Brother's ages/Hermanos edad ____________________________

Father's age/Papa edad _________ Sister's ages/Hermanas edad ____________________________

Check if any blood relatives have or had any of the following (brothers, sisters, mom, dad, grandparents):
Marque los problemas que tienen los parientes del nino/a (hermanos, padres, tios, abuelos):

___ Allergies/Alergias
___ Anemia
___ Arthritis/Artritis
___ Asthma/Asma
___ Birth defects/Defectos al nacimiento
___ Blood disorder/Enfermedad de sangre
___ Cancer
___ Diabetes
___ High blood pressure/Alta presión
___ Heart murmur/Sopio del corazón
___ Heart attack/Ataques cardíacos
___ High cholesterol/Alto colesterol
___ Stroke/Derrame/embolio cerebral
___ Kidney disease/Enfermedad de riñones
___ Learning problems/Problemas de aprendizaje
___ Liver disease/Enfermedad de hígad
___ Sickle cell/Sicle cell
___ Lung disease/Enfermedad de pulmones
___ Mental illness/Enfermedad mental
___ Mental retardation/Retardo mental
___ Seizures/Ataques re
___ Thyroid disease/Enfermedad de la tiroides
___ Tuberculosis

BIRTH HISTORY (HISTORIA DE NACIMIENTO)

Gestational Age (gestacion edad) ___________ weeks (semanas)
Birth Weight (Pesó en libras cuando nació) ___________
Problems with pregnancy (Problemas con el embarazo)? ________________________________
Problems with labor/delivery (Problemas con el parto)? ________________________________
C-section delivery (Parto por cesarea) _________________
Vaginal delivery (Parto vaginal) ____________________
Problems with baby after birth (El nino/a tuvo problemas despues que nacio)? ____________________

CHILDHOOD ILLNESS (ENFERMEDADES DEL NINO/A)

___ Allergies/Alergias
___ Asthma/Asma
___ Bladder infection/Infección de vejiga
___ Chicken pox disease/Enfermedad de Varicella
___ Ear infections/Infecciónes de oidos
___ Heart problem/Enfermedad de corazón
___ Seizures/Ataques
___ Skin problems/Problemas de piel
___ Other/Otros problemas ____________________

HOSPITALIZATIONS OR SURGICAL PROCEDURES (HOSPITALIZACION O CIRUGIA)

Age (Edad) Reason for hospitalization (Razón por hospitalizacion/cirugia)

_________ ____

_________ ____

Medication allergies/Alergias a medicinas: ____

Medications taken daily/Medicinas que toma regularmente: ________________________________

DE28-105 REV. 11/07

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SOCIAL HISTORY/HISTORIA SOCIAL

Marital status of parents/Estadocivil de los padres:

_____ Married/Casados
_____ Divorced/Divorciados
_____ Single Parent/Solteró/a

Does the child go to day care or preschool/Atiende su hijo/a al prekinder o guarderia? _____ Yes/Si _____ No

Does your child use a car seat or seat belt/Usa el nino cinturon de seguridad o silla del carro? _____ Yes/Si _____ No

Any smokers in the home/Fuma alguien en la casa? _____ Yes/Si _____ No

DEVELOPMENT/DESAROLLO)

Do you have any concerns about the following? (Por favor marque las preocupaciones que tiene Usted):

Behavior/Comportamiento ____

Eating habits/Alimentacion ____

Sleeping habits/Como duerme el nino/a ____

Discipline/Disciplina ____

Signature/Firma _______________________________ Date/Fecha _______________

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Patient Privacy Consent Form

We are concerned with protecting your privacy. Our Notice of Privacy Practices provides information about how we may use and disclosure protected health information about your child. You have the right to review our Notice before signing this consent. The terms of our Notice may change, and you may obtain a revised copy by contacting our office.

By signing this form, you consent to our use and disclosure of protected health information about your child for treatment, payment, and healthcare operations as described in our Notice. The Practice may condition receipt of treatment on this consent.

You have the right to request, in writing, that we restrict the disclosure of health information about your child. We are not required to agree to this restriction but if we do, we will honor our agreement.

You understand that this consent will remain in force from this time forward and that it may be revoked by providing written notice.

By signing, you understand and agree to the terms of this consent.

Patient Name: ___________________________________ **DOB:** _____/_____/_____
Parent/Guardian's Signature: ______________________________________ **Date:** _____/_____/_____
Parent/Guardian's Printed Name: _____________________________ **Relationship to Patient:** _____________

Because there may be times that you are not able to bring your child to an appointment or gather information from your child's health record, you grant permission to disclose healthcare information and to seek treatment on behalf of your child to:

Name: ___________________________________ **Relationship to Patient:** ______________

Name: ___________________________________ **Relationship to Patient:** ______________

Name: ___________________________________ **Relationship to Patient:** ______________

(This form will expire 1 year from date of signature)

Witness (Practice Representative): ____

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Patient Office Policy Acknowledgment

Lab Work Policy

In the event that lab work is necessary, Desert Valley Pediatrics will do our best to send specimens to the correct laboratory contracted with your insurance company. If for any reason your insurance company denies a laboratory claim due to laboratory incorrect billing, services not covered under your plan, insurance change, or specimen being sent to the wrong laboratory, **Desert Valley Pediatrics will not be liable for your laboratory charges/fees.**

Financial Policy

The parent or legal guardian accompanying a minor to the office is responsible for full payment at the time of service. We cannot bill a third party (other than a contracted insurance company) or other parent if they are not present at the time of service.

For medical coverage with health plans we are contracted with, we will submit a claim for office visits, procedures, and hospital services provided by our physicians. You, the responsible party, will be required to make payment of your assigned co-payment or co-insurance at the time of service.

For medical coverage with health plans with which we are not contracted, please understand that we will collect for the visit in full at the time of service and then you may be reimbursed by your insurance company based on your policy benefits. As a courtesy, we will submit your claims to the insurance company unless you choose to do so yourself.

Desert Valley Pediatrics will not become involved in disputes between you and your insurance company, other than to supply factual information as necessary. You are responsible for any balance that your insurance company has not or will not pay. If your insurance company has not paid or denies benefits, please contact their claims department if there are any questions or complaints.

By signing this form, I acknowledge that I understand the Lab Work and Financial Policy.

Patient Name: ______________________________ **DOB:** _____/_____/_____

Parent/Guardian's
Signature: ______________________________ **Date:** _____/_____/_____

Parent/Guardian's
Printed Name: ________________________ **Relationship to Patient:** ________

(This form will expire 1 year from date of signature)

Witness (Practice Representative): ______________________________

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Authorization for Release of Health Information

Patient Name: ______________________________ **DOB:** _____/_____/_____

1. I authorize Desert Valley Pediatrics to use, disclose and/or obtain protected health information described below.

2. I authorize release of information for the period of health care:

   ☐ all past, present and future period OR ☐ From ____________ to ____________

3. ☐ (a) I authorize release of my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse)
   OR
   ☐ (b) I authorize release of my complete health record with the exception of the following information:
   - ☐ mental health records
   - ☐ communicable diseases (including HIV and AIDS)
   - ☐ alcohol/drug abuse treatment
   - ☐ other: ______________________________

4. ☐ I authorize this information to be **released** to:
   Name/Facility: ______________________________
   Address: ______________________________
   City: ______________________________
   Phone: ____________________ Fax: ____________________

   ☐ I authorize this information to be **obtained** from:
   Name/Facility: ______________________________
   Address: ______________________________
   City: ______________________________
   Phone: ____________________ Fax: ____________________

5. This authorization shall be in effect for **90 days** unless otherwise specified.

6. I understand I have the right to revoke this authorization in writing at any time.
   I understand a revocation is not effective to the extent that any person has acted in reliance of my authorization.

By signing this form, I acknowledge that I have read it in full, understand it, and agree to its terms.

Signature of Patient's Parent/Guardian: ____________________ **Date** _____/_____/_____

Printed Name: ____________________ **Relationship to patient:** ____________________