DVPeds
Desert Valley Pediatrics

No-Show Policy

A missed appointment leaves an open appointment that could have been used by a patient in need of medical care. A no-show appointment occurs when a parent or legal guardian fails to give adequate notice that the appointment cannot be kept. The parent or legal guardian's failure to cancel or reschedule an appointment by 8:00 AM the day of the scheduled appointment will result in a no-show. If three (3) no-shows are accrued during a calendar year (Jan - Dec) the family will be dismissed from the practice and unable to receive future treatment at Desert Valley Pediatrics.

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. You are required to supply DVP with all medical insurance policy information that your child is covered by at the time of service.

As a courtesy, for medical coverage with health plans, 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 assigned co-payment, deposit towards deductible or deposit towards self-pay visit at time of service.

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.

Privacy Consent

We are concerned with protecting your privacy. Our Notice of Privacy Practices provides information about how we may use and disclose 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 the form provided, 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.

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By signing this form, I acknowledge that I've read and understand the following policies:

No Show Policy

Financial Policy

Privacy Consent

Patient Name:_____ DOB: ____/____/____

Patient Name:_____ DOB: ____/____/____

Patient Name:_____ DOB: ____/____/____

Printed Name of guardian:_____ Date: ____/____/____

Signature of guardian:_____ Relation to Patient:_____

Because there may be times that you are not able to bring your child to an appointment you grant permission to the following person(s) to seek treatment on behalf of your child and allow DVP to disclose relevant healthcare information regarding that treatment. This authorization does not allow the person(s) listed below to obtain medical records regarding the patient(s).

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Practice Witness: _____

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

Desert Valley Pediatrics

Phone: 623-877-7337 Fax: 623-772-0686

☐ West Valley Office	☐ At The Ball Park	☐ Goodyear Office	☐ Surprise Office
4137 N 108th Ave Phoenix, AZ 85037	3802 N 53rd Ave Ste. 160 Phoenix, AZ 85031	700 N Estrella Parkway Ste. 110 Goodyear, AZ 85338	15264 W Brookside Ln Ste. 155 Surprise, AZ 85374

Patient Account #_____

Child's Last Name _____ First _____ MI _____

Birth Date _____ Age _____ Sex: F M Primary Language _____

Race _____ Ethnicity _____

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 _____

E-mail _____

SS# _____ Date of Birth _____

Guardian's/
Mother's Name _____

Address _____

City _____ State _____ Zip _____

Home/Message Phone _____

Business Phone _____

Cell Phone _____

E-mail _____

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 (Fecha)_____ Child's Name (Nombre del Niño/a)_____

Child's Date of Birth (Fecha de Nacimiento del Niño/a)_____

PATIENT'S BIRTH HISTORY (HISTORIAL DE NACIMIENTO DEL PACIENTE)

Born Premature/Su bebé nació prematuro Y____ N____ If so, how many weeks gestation/Si es así, edad de gestación?
Birth Weight (Peso en libras cuando nació) _____
Problems with pregnancy (Problemas con el embarazo)? _____
Problems with labor/delivery (Problemas con el parto)? _____
C-section delivery (Parto por cesárea) _____
Vaginal delivery (Parto vaginal) _____
Problems with baby after birth (El niño/a tuvo problemas después de nacer)? _____

PATIENT'S CHILDHOOD ILLNESS (ENFERMEDADES INFANTILES DEL PACIENTE)

____ Allergies/Alergias
____ Asthma/Asma
____ Bladder infection/Infección de vejiga
____ Chicken pox disease/Varicela
____ Ear infections/Infecciónes de oídos
____ Heart problem/Enfermedad de corazón
____ Seizures/Convulsiones
____ Skin problems/Problemas de piel
____ Other/Otros problemas_____

HOSPITALIZATIONS OR SURGICAL PROCEDURES (HOSPITALIZACIONES O CIRUGIAS)

Age (Edad) Reason for hospitalization (Razón de la hospitalización/cirugía)

_____ _____

_____ _____

Medication allergies/Alergias a medicinas: _____

Medications taken daily/Medicinas que toma regularmente: _____

FAMILY HISTORY (HISTORIAL MEDICO DE FAMILIA)

Patient's Mother's age/Edad de la mamá _____ Sister's ages/Edad de las hermanas_____

Patient's Father's age/Edad del papá _____ Brother's ages/Edad de las hermanos_____

Check if any blood relatives have or had any of the following, notate their relationship(brother, sister, mom, dad, grandparent):
Verifique si algún familiar cercano tiene o ha tenido cualquiera de los siguientes. Por favor anote el parentesco (hermanos, padres, abuelos):

_____ Allergies/Alergias
_____ Anemia
_____ Arthritis/Artritis
_____ Asthma/Asma
_____ Birth defects/Defectos de nacimiento
_____ Blood disorder/Enfermedad de sangre
_____ Cancer
_____ Diabetes
_____ High blood pressure/Alta presión
_____ Heart murmur/Soplo del corazón
_____ Heart attack/Ataques cardiacos
_____ High cholesterol/Alto colesterol
_____ Stroke/Derrame/embolio cerebral
_____ Kidney disease/Enfermedad de riñones
_____ Learning problems/Problemas de aprendizaje
_____ Liver disease/Enfermedad de hígado
_____ Sickle cell/Sicle cell
_____ Lung disease/Enfermedad pulmonar
_____ Mental illness/Enfermedad mental
_____ Mental retardation/Retraso mental
_____ Seizures/Convulsiones
_____ Thyroid disease/Enfermedad de la tiroides
_____ Tuberculosis

Turn over/Voltee la pagina

SOCIAL HISTORY/HISTORIAL SOCIAL

Marital status of parents/Estado civil de los padres:

_____ Married/Casados
_____ Divorced/Divorciados
_____ Single Parent/Soltero/a
_____ Together but not married/Juntos pero no casados

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

If newborn, will the child go to daycare after maternity leave/Para los recién nacidos, su hijo va a asistir a la guardería después de maternidad? _____ Yes/Si _____ No

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

Any smokers in the family/Fuma alguien en la familia? _____ Yes/Si _____ No

Any pets in the home/Alguna mascota en su hogar? _____ Yes/Si _____ No Type/Tipo?_____

If newborn, what hospital treated/Si es recién nacido, en que hospital nacio? _____

If seen by another practice, what offices have treated/Si fué tratado en otra clínica anteriormente, que oficina/doctor?

_____