Dignity Health Medical Group Nevada

Please complete the form below. Your Pediatrician will review it with you at the time of your appointment.

Patient Information

Last Name:_____ First Name:_____ Middle Initial:_____

Date of Birth: _____/_____/_____ Age:_____ SSN:_____-_____-_____

Gender: Male / Female Marital Status: M S D W

Address:_____ Apt #: _____

City:_____ State:_____ ZIP: _____

Phone Number: ( ) _____ - _____

Cell Number: ( ) _____ - _____

Work Number: ( ) _____ - _____

Race:

□ Caucasian □ Asian

□ African American □ Pacific Islander

□ Hispanic/Latino □ Native American

□ Do not wish to answer

□ Other: _____

Guarantor/Guardian Information (person responsible for payment)

Responsible Party:

Name: _____ Relationship: _____ Male / Female

Date of Birth: _____/_____/_____ SSN:_____-_____-_____

Address:_____ Apt #: _____

City:_____ State:_____ ZIP: _____

Phone Number: ( ) _____ - _____ Cell Number: ( ) _____ - _____

Employer: _____ Work Number: ( ) _____ - _____

Email Address: _____

Additional Responsible Party:

Name: _____ Relationship: _____ Male / Female

Date of Birth: _____/_____/_____ SSN:_____-_____-_____

Address:_____ Apt #: _____

City:_____ State:_____ ZIP: _____

Phone Number: ( ) _____ - _____ Cell Number: ( ) _____ - _____

Employer: _____ Work Number: ( ) _____ - _____

Email Address: _____

Dignity Health Medical Group Nevada

Emergency Contact

Primary:

Emergency Contact Name: _____ Relationship: _____

Home Phone: ( ) _____ - _____ Cell Phone: ( ) _____ - _____

Work Phone: ( ) _____ - _____

Secondary:

Emergency Contact Name: _____ Relationship: _____

Home Phone: ( ) _____ - _____ Cell Phone: ( ) _____ - _____

Work Phone: ( ) _____ - _____

Primary Care / Referring Physicians

Primary Care Physician: _____Phone Number: ( ) _____ - _____

Referring Physician: _____Phone Number: ( ) _____ - _____

Insurance Information

Primary Insurance:

Insurance Name:_____ Plan Type: HMO PPO POS EPO Other

I.D. Number: _____ Group Number: _____

Subscriber's Name: _____ Date of Birth: _____/_____/_____

Employer: _____ Work Phone: ( ) _____ - _____

Secondary Insurance:

Insurance Name:_____ Plan Type: HMO PPO POS EPO Other

I.D. Number: _____ Group Number: _____

Subscriber's Name: _____ Date of Birth: _____/_____/_____

Employer: _____ Work Phone: ( ) _____ - _____

Dignity Health Medical Group Nevada

JOINT NOTICE OF PRIVACY PRACTICES FOR MEDICAL INFORMATION

Effective April 14, 2003, the law requires that Dignity Health Medical Group give patients a copy of its Notice of Privacy Practices for Health Information. We will give you a copy at the time of first treatment and, if we change our notice, thereafter at the next treatment visit.

Patient Initials _____

CONSENT AND ASSIGNMENT OF BENEFITS

Dignity Health Medical Group is contracted to various health insurance programs, including Medicare, and accepts assignments only for those health insurances. If a contract exists between my insurance company and Dignity Health Medical Group, Dignity Health will file my health insurance. I request that payment be made by my insurance on my behalf to Dignity Health Medical Group, LLC. I agree to pay any portion of my charges rendered by Dignity Health Medical Group that my contracted health insurance determines is my responsibility. In the event a charge is determined to be cosmetic, I agree to pay for the cosmetic services in full at the time service is rendered.

If I do not have a health insurance plan that Dignity Health Medical Group is contracted with, I agree to pay all fees in full at the time services are rendered.

I understand that I am ultimately responsible for payment of my medical bill. If it becomes necessary for Dignity Health Medical Group to collect payment, I understand that I will be responsible for legal costs, including attorney's fees.

I understand that as a result of refusal to sign this form, or if I have altered this form in any way, Dignity Health Medical Group may refuse to diagnose and treat me. I have the right to revoke this consent and assignment of benefits in writing except for services that have already occurred.

Patient Initials _____

By initialing above each section and signing below, you acknowledge receipt of the Joint Notice of Privacy Practices for Medical Information and understand the Assignment of Benefits as the patient, the patient's personal representative, the patient's authorized agent or an individual involved in the patient's medical care.

Patient Name: _____ Witness Signature: _____

Acknowledgement Signature: _____ Date: _____

Print Name: _____ Relationship to Patient: _____
(If signed by someone other than patient)

REFUSAL TO CONSENT

Patient has refused to sign this form.

Staff Member Name : _____ Signature: _____

Dignity Health Medical Group Nevada

Medical History

Review of Symptoms

Within the last week has your child had any of the following symptoms

	Yes	No		Yes	No		Yes	No
General			**Respiratory**			**Neurologic**		
Fever			Cough			Headaches		
Night sweats/chills			Wheezing			Seizures		
Decreased appetite			Difficulty breathing			Weakness		
Increased crying			**Cardiovascular**			**Psychiatric**		
Skin			Shortness of breath			Change in sleep pattern		
Itching			Chest pain			Fussiness		
Rash			Difficulty breathing on exertion			**Endocrine**		
New lesion			Sweating while feeding (infants)			Changes in hair		
Excessive sweating			**Gastrointestinal**			**Hematology**		
Eyes/Ears/Nose/Throat			Abdominal pain			Easy Bruising		
Red eye(s)			Vomiting			Enlarged lymph nodes		
Excessive tearing			Diarrhea			**Urologic**		
Eye discharge			Constipation			Pain with urination		
Earache			Difficulty swallowing			Blood in urine		
Ear discharge			**Musculoskeletal**					
Runny nose			Decreased range of motion					
Nasal congestion			Muscle weakness					
Sore throat			Join pain/swelling					

Neck			**Immunizations**		
Neck stiffness			Are your child's immunizations up to date?		
Swollen glands			If possible, please show us your child's vaccine record		
Has your child had:	☐ Chicken Pox ☐ Measles ☐ Scarlet Fever ☐ Mumps ☐ Other:				

Family History

Is there a family history of the following:

	Yes	No	Relationship to Child		Yes	No	Relationship to Child
Diabetes				Cancer			
Allergies				Heart Disease			
Convulsions				Tuberculosis			
Asthma				Other_____			

Family Profile

	Name	Age	Health
Parent			
Parent			
Sibling			
Sibling			
Sibling			
Sibling			

Child's Parents are: ☐ Married ☐ Separated ☐ Divorced ☐ Other

Highest level of Education? Occupation

Highest level of Education? Occupation

Number of people living in your house? _____

Any smokers in your house? ☐ Yes ☐No Outside? ☐ Yes ☐ No

Pets? ☐ Yes ☐ No What kind? _____

Number of people living with your child: _____

Does your child have frequent contact with anyone who is receiving chemotherapy, on medications regularly such as steroids or has had an organ transplant? ☐ Yes ☐ No

Dignity Health Medical Group Nevada

Medications					
Name	dose (mg)	times/day	Name	dose (mg)	times/day

Pharmacy information	
Name:	Phone:
	Fax:
Address:	

Past Medical History			
Serious Injuries or Illness:	**Allergies:**		
	Drugs: ☐ Yes ☐ No	Food: ☐ Yes ☐ No	Latex: ☐ Yes ☐ No
	Environmental: ☐ Yes ☐ No		
	Allergy Testing: ☐ Yes ☐ No		
Hospitalizations (including NICU at birth):	Please explain all Yes answers:		
Surgeries:			

Development	
School History:	
My child is in: ☐ Daycare ☐ Preschool ☐ Public School ☐ Private School ☐ Home School	
School Name:	Year in School:
School Problems: ☐ Yes ☐ No	Discipline or Behavior Problems ☐ Yes ☐ No
Has your child been seen by a Psychologist, Speech Therapist or Special Teachers? ☐ Yes ☐ No	
Is your child in any special classes? ☐ Yes ☐ No	
Please explain any yes answers:	

Dignity Health Medical Group Nevada

Development (continued)				
*** Children Under Five Only**				
Age when your child first:				Any known development delays? ☐ Yes ☐ No
Rolled		Walked		If yes, please explain:
Sat		First Teeth		
Crawled		Toilet trained		
First Word		Talked		

*** Children Under Two Only**			
Birth History:			
Mother's 1st, 2nd, 3rd pregnancy:		Method of Delivery: ☐ Vaginal ☐ Caesarian section	
Weeks pregnant at delivery:		Birth Weight:	
Mothers age at patient's birth:		Birth Hospital:	
Fathers age at patient's birth:		Days in Hospital	
Problems with: ☐ Sleep ☐ Urination ☐ Stooling ☐ Weight ☐ Height ☐ Behavior			
Problems during delivery?			
Passed newborn hearing screen? ☐ Yes ☐ No		Problems in the first month?	
Feeding history:	☐ Breastmilk ☐ Formula ☐ Both		
Age started solid food:	Feeding issues or intolerance:		
Special Diet?			

Please Explain any yes answers:

Comments/ Concerns/ Extra Space

Dignity Health Medical Group Nevada

Authorization to Release Medical Records

I authorize the following entity where I have received care (typically your previous primary care doctor):

Practice or facility name**:**_____

Physician name**:**_____

Practice or facility fax number:_____

Practice or facility phone number:_____

To disclose all information concerning my treatment to:

Dignity Health Medical Group Nevada

10001 S. Eastern Ave. Ste. 101

Henderson, NV 89052

Phone: 702-616-5870

Fax: 702-616-5895

Patient Name (Print): _____

Date of Birth: _____ **Social Security #:** _____

Patient/Guardian Signature: _____

Witness: _____