Hollister Pediatrics
Hue Nguyen-Ngo, D.O.
Nicole A. Shelton MSHS, PA-C

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Patient Demographics

First Name:_____ Middle Name:_____ Last Name:_____
Sex:_____ DOB:_____
Address:_____ City:_____
State:_____ Zip: _____ Date Of Initial Visit:_____
Home Telephone No.( )_____ Cell No.( )_____
Email: _____ Preferred Pharmacy: _____
Race:_____ Ethnicity:_____
Preferred Language:_____ Bill To:_____
(Financially Responsible)

Father Name_____ Mother Name_____
Cell No. ( )_____ Cell No. ( )_____
Telephone No.( )_____ Telephone No.( )_____
Social Security No._____-_____-_____ Social Security No..._____-_____-_____
DOB:_____ Occupation::_____ DOB:_____Occupation:_____
Home Address (If different from Patient's):_____ Home Address (If different from Patient's):_____
_____ _____

IN CASE OF EMERGENCY:
Name of Friend or Relative (not living with patient)_____
Relationship to patient_____Phone No._____

I AUTHORIZE TREATMENT AND ASSIGN PAYMENT OF MEDICAL BENEFITS TO HOLLISTER PEDIATRICS FOR SERVICES RENDERED. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY MY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT OF BENEFITS.

SIGNATURE OF PARENT/GUARDIAN:_____DATE_____

LIST ADDITIONAL SIBLINGS

Name_____ DOB_____ Name_____ DOB_____

Name_____ DOB_____ Name_____ DOB_____

INSURANCE INFORMATION

Insurance Company Name:_____

Member Subscriber Name:_____

Policy or Id Number:_____Group Number:_____

Health and Social History

A. PREGNANCY AND BIRTH

1) Maternal History:

1. Mother's age at patient's birth:_____
2. Any illness/complication during pregnancy? **YES NO**
   If Yes, please specify: _____
3. Did You smoke during Pregnancy? **YES NO**
   If Yes, please specify: _____
4. Did you drink alcoholic beverages during Pregnancy? **YES NO**
   If Yes, please specify:_____
5. Did you used any drugs during pregnancy? **YES NO**
   If Yes, please specify:_____
6. Number of pregnancies you have had:_____
7. Number of living children:_____
8. Number of Miscarriage/Abortion:_____

2) Patient History:

1. What was the Gestational Age? _____
2. What hospital was the baby born at?_____
3. Method of Delivery:
   a. [ ] C-Section Reason for C-Section_____
   b. [ ] Induced
   c. [ ] Spontaneous Vaginal
   d. [ ] Other:_____

3) Other Details:

1. Did Baby have any trouble while in hospital? **YES NO**
   If Yes, Please Specify**?** _____
2. What was the birth weight? **lbs:**_____ **oz:**_____
3. What was the birth height? **Inches:** _____

B. PAST MEDICAL HISTORY:

1. Where has your child gone for check-ups until now?_____
2. Date of last check up:_____
3. Has your child had any Allergic Reaction to Medications, Foods, Insect Bites? **YES NO**
   If Yes, provide details:_____
4. Has your child had reactions to any Immunizations? **YES NO**
   If Yes, provide details:_____
5. Any Hospitalization other than for birth? **YES NO**
   If Yes, provide details:_____
6. Has your child had any of the following illnesses?
   [ ] PNEUMONIA [ ] EAR INFECTION [ ] STREP THROAT
   [ ] SINUS INFECTION [ ] URINE INFECTION [ ] SKIN INFECTION
   [ ] ASTHMA [ ] OTHER ILLNESS:_____
7. Any Serious Injuries? **YES NO**
   If Yes, provide details:_____
8. Any Surgeries? **YES NO** If Yes, provide details:_____

C.CURRENT MEDICATION (Or Medication taken on regular basis):

1. _____
2. _____
3. _____
4. _____

D.SOCIAL & FAMILY HISTORY:

1. MOTHER
   a. Age:_____
   b. Height:_____
   c. Health Status:
2. FATHER
   a. Age:_____
   b. Height:_____
   c. Health Status:
3. List Sex, Age and General Health of Brothers and Sisters:_____
   _____
   _____
4. Mark diseases/problem that this child's parents, brother, sisters, grandparents or aunts and uncles have had:

[ ] Anemia	[ ] Allergies	[ ] Diabetes
[ ] High Blood Pressure	[ ] Heart Trouble	[ ] Tuberculosis
[ ] Mental Illness	[ ] Drug Problems	[ ] Alcohol Problems
[ ] Inherited Illnesses	[ ] Venereal Disease	[ ] Cancer
[ ] Aids	[ ] Vision Problem	[ ] Hearing Problems
[ ] Kidney Disease	[ ] Intestinal Problems	[ ] Sickle Cell Disease
[ ] Bone or Joint Disease	[ ] SEIZURES [ ] OTHERS:_____	

5. Any Family History of Childhood Death? **YES** **NO** If Yes, provide details:_____

E. Feeding and Nutrition:

1.Is your child's appetite usually good? **yes** **no**
2.Is it good now? **yes** **no**
3.If still on formula which one do you use?_____
4. Please list what your child eats on a typical day:
   Breakfast_____
   Lunch_____
   Dinner_____
   Snacks_____
5.Any food allergies? **yes** **no**
If yes, please
Specify:_____
_____
_____

SUMMARY OF THE NOTICE OF PRIVACY PRACTICE

Here is a summary of the *Notice of Privacy Practices* issued by: Dr. Hue Nguyen-Ngo
The document describes in detail, how your information as a patient may be used and disclosed. It also advises you of your rights to obtain this information.

By using this notice Dr. Nguyen-Ngo advises you that your health information may be shared for purposes of treatment, payment or healthcare operations. This "sharing" of health information is used solely to address your healthcare needs and to assist us in maintaining or improving the quality of the services, which we provide to you.

You are advised that the following entities will comply with restrictions of this notice:

- Anyone authorized to enter information into your patient chart
- All employees, staff and other practice personnel.

We are required by law to:

- Ensure that medical information that identifies patient is kept private;
- Give every patient a copy of this notice about your legal duties and privacy practices with respect to your medical information;
- Follow the terms of the Notice

Dr. Nguyen may use and disclose your medical information:

- For Treatment
- For Payment
- For Healthcare Operations
- Appointment Reminders
- Treatment Alternatives
- Health Related Benefits and Services
- To Identify patients in our care related to Disaster Relief Circumstances
- Research
- As Required by Law
- To Avert Serious Threats to Health or Safety

Additionally, there are some special situations for releasing information:

- Organ and Tissue Donation
- Military and Veterans
- Workers' Compensation
- Public Health Risk
- Health Oversight Activities
- Lawsuits and Disputes
- Law Enforcement
- Coroners, Medical Examination
- National Security and Intelligence Activities
- Protective Services
- Inmates

HIPAA Consent Form

I understand that, under the Health Insurance Portability & Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physicians' certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description and uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke in writing at any time, except to the extent that you have taken action relying to my consent.

Name:_____

Signature:_____

Relationship to Patient: _____

Date: _____

PARENTAL CONSENT

I, _____, hereby authorize the following person(s) to bring my children to their scheduled appointments at Dr. Nguyen's Office. The person(s) named below may act on my behalf to decide on any treatments pertaining to my children's illness, or vaccines at their well child check-ups. This includes any necessary tests that my child may be due for, or that are recommended by the doctor.

Name of Child

1)_____2)_____

3)_____4)_____

5)_____6)_____

Authorized Person(s)' Printed Name, Relationship, and Phone Number, In Case of Emergency (Apart from Parents/Legal Guardians)

1)_____Relationship_____Phone#:_____

2)_____Relationship_____Phone#:_____

3)_____Relationship_____Phone#:_____

4)_____Relationship_____Phone#:_____

_____

Print Parent Name/Legal Guardian

_____ _____

Signature of Parent/Legal Guardian Date

Appointment Contract

Starting June 25th 2018, we will begin charging **$50** for each missed visit after the first occurrence. Your account will be automatically charged after these instances;

- Missed Scheduled Appointments
- No Show on Confirmed Appointments
- Same-Day Missed/Canceled Appointments
- Late Cancellations (Within 24 hours of Scheduled Time)
- Missed Well Child Appointments

Confirmation calls are done as a courtesy and cannot always be made.

Please bring all forms of paperwork (school, sports, daycare, immunization's, etc.) needing completion at the time of your child's scheduled physical.

Starting February 1st 2019 there will be a **$10** charge for completing paperwork outside of scheduled physicals.

We make an effort to provide you with quality service by preparing your child's chart a day in advance; therefore, we ask you to ***kindly give a 24hr notice, or call first thing in the morning if you can't keep your scheduled appointment.***

This way we don't refuse a sick patient that may need to be seen.

Thank you for your cooperation on keeping scheduled appointments

I, _____, hereby understand the rules and conditions of the clinic and will honor said terms and conditions.

_____ _____

Signature Date