Pediatric Health History Questionnaire:

Child's name________________________________ Date of birth________________________________
Mother's name: ______________________________ Father's name: ______________________________
Telephone: _________________________________ Telephone: _________________________________
Address____

Pregnancy and Birth History	
Mother's age at birth:	Father's age at birth:
Did mother have any of the following during pregnancy?	
☐ Fever or rash	☐ Tobacco use (how much)
☐ Group B strep	☐ Alcohol use (how much)
☐ Sugar in urine / diabetes	☐ Street drug use (what type)
☐ High blood pressure	☐ Medication use (prescription or over-the-counter - list below)
☐ Anemia	
☐ Infections (if yes what type and how were they treated)	

Newborn History		
Birth Weight:	Birth length:	Head Circumference:
Born on time? ☐ Early ☐ Late How much:		
Type of delivery ☐ Vaginal ☐ C-section (why):		
How old was baby when she/he left the hospital?		
During the first week of life did your child have any of the following		
☐ Feeding trouble	☐ Seizures	☐ Fever
☐ Excess vomiting	☐ Breathing trouble	☐ Receive antibiotics
☐ Jaundice (yellow skin)	☐ Need of oxygen	☐ Diarrhea
☐ Cyanosis (blueness)	☐ Blood transfusion	☐ In intensive care unit

Family History

Relationship	Name	Living Y/N	Age	Major Medical Problems and/or Cause of Death
Father				
Mother				
Siblings				
If more than 3 siblings continue on back				

Have any of the child's relatives had the following conditions

Condition	Relative	Condition	Relative
☐ Diabetes		☐ Kidney problems	
☐ Cancer		☐ Heart disease	
☐ Seizures		☐ Stroke	
☐ Allergies/asthma		☐ Anemia	
☐ Bleeding problems		☐ HIV	
☐ High blood pressure		☐ Skin problems	
☐ Lung disease		☐ Chemical dependency	

☐ Mental illness		☐ Other:	
Are there any religious or cultural factors that you would like us to take into account when planning your child's healthcare?			

Past Medical History		
Where has child gone for check-ups previously:		
Date of last medical checkup:		
Date of last dental check-up:		
Is your child up-to-date on immunizations? Please supply immunization records.		
Does any of the following apply to your child:		
☐ Chicken pox	☐ Wears glasses	☐ Asthma
☐ Measles	☐ Heart murmur	☐ Allergies
☐ Mumps	☐ Kidney or bladder infection	☐ Broken bones
☐ Frequent ear infections (>4 year)	☐ Bed wetting (>5 years old)	☐ Head injury
☐ Frequent throat infections (>4 year)	☐ Diabetes	☐ Seizures
Has your child ever been hospitalized or had surgery? If yes, list age and reason:		
Has your child ever been on medication regularly that is not on their current medication list? If yes, list medication(s) and reason:		
Do you have any concerns about your child's development? If yes, please describe:		

Childs Social Characteristics	
School Grade/Preschool:	City Water: Yes / No
Hours of TV/Electronics Each Day:	Pets:
Special Diet:	Sports:
Weekly Hours of Outdoor Activity:	Hobbies:
Membership in External Organizations:	
Other:	

At Risk Behaviors	
Tobacco use (how much) Yes / No	Sexually Active Yes / No
Alcohol use (how much) Yes / No	Do you use protection during sex Yes / No
Street drug use (what type) Yes / No	Do you make yourself sick by eating too much Yes / No
Exposure to Second Hand Smoke: Yes / No	Do you worry about your weight Yes / No
Guns in Home: Yes / No	Is food one of your biggest conerns Yes / No
Wears Sunscreen: Yes / No	Other:
Wears Seatbelt/Car Seat/Booster: Yes / No	

Allergies		
Please list any allergies to medications or foods and environmental allergies		

Medications	
Please list any medications that your child takes including over the counter medications, herbs, vitamins and supplements. Include dose and frequency (if more room is needed continue on back)	

It is very important that your child take the medication(s) your health care professional has given you. Please check any of the below

Are you unable to fill your child's prescription(s) because of the cost ☐ Yes ☐ No

Are you unable to fill your child's prescriptions because of lack of transportation ☐ Yes ☐ No

Have you ever applied for any pharmacy assistance ☐ Yes ☐ No

Specialty Providers	
In order that we can best coordinate your child's care, please list any medical providers the child sees outside of this practice and list the year that they last saw them (if more room is needed continue on back)	

Health Literacy Questionnaire	
Many times in healthcare staff and providers use words that are unfamiliar to the general population. Please rate the following questions on a scale of 1 to 10; 1 being strongly disagree and 10 being strongly agree	
I feel that I have a thorough understanding of the instructions that my doctors and nurses give me about my health	1 2 3 4 5 6 7 8 9 10
I feel that I remember the instructions given to me at my doctor's office when I get home	1 2 3 4 5 6 7 8 9 10
I feel that I have a strong understanding of medical language	1 2 3 4 5 6 7 8 9 10

Parent Signature:______________________________ Date:____________________

7 Yorkshire Street
Suite 201
Asheville NC 28803
828.761.1710
Fax-828.505.8345

Designated Individuals' Authorization- HIPAA Compliance

To protect your patient confidentiality, we need to know if there is a phone number (with voicemail) for you where we can leave the results of your laboratory test or other sensitive information. Please indicate the information below, and we will keep this in your file until you instruct Us in writing to remove it.

I give Dogwood Family Medicine employees permission to leave confidential Healthcare information for me at the following phone number(s):

If none please note:

____

____

____

I understand these numbers will be used until I notify Dogwood Family Medicine in writing if they are no longer to be used.

I authorize the following people to receive information regarding my medical status including access to my medical records and financial records ongoing.

Name	Relationship	Phone

Patient Name: ______________________________ **Date of Birth:** ____________

Signature: ________________________________ **Date:** __________________

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Office and Financial Policies

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance about our office policies allows for a good flow of communication and enables us to achieve our goal. *Please read each section carefully and initial.* If you have any questions, please ask a staff member.

Appointments

1- We value the time we set aside for each patient. We do not double book appointments. If you are not able to keep your appointment, we would appreciate 24-hour notice. **There is a charge of $50 for missed appointments. ($100 for missed ultrasound appointments)** this charge is not filed to insurance and will be *patient* responsibility.
2- If you're late for your appointment (>15 minutes), we will do our best to accommodate you. However, in certain situations, it may be necessary to reschedule your appointment.
3- We strive to minimize any wait time; however, emergencies do occur and will take priority of rescheduled visits. We appreciate your understanding.
4- Before making an annual physical appointment, check with your insurance company as to whether the visit will be covered as a wellness visit.

Initial: ________

Insurance Plans

Please understand that our office files insurance as a courtesy to our patients.

1- It is your responsibility to keep us updated with your correct insurance information. **If the insurance company, you designated is incorrect you will be responsible for payment of the visit.** We MUST have a copy of your insurance card on file to file a claim. Please be prepared to present your insurance card at each visit if necessary. **If you do not have a card or your policy is not current/active you will be responsible for payment of the visit.**
2- Some insurance companies require you to specify primary care physician. If we are your primary care physician, make sure Raleigh Durham Medical Group Associates appears on

your card. If your insurance company has not yet been informed that we are your primary care physician, you may be financially responsible for your current visit.

1- You are responsible for understanding your benefit plan regarding covered services and participating Laboratories. For Example:
    a. Not all plans cover annual healthy (well) physicals, sports physicals, vision screenings and other services. If these are not covered, you will be responsible for the payment.
2- It is your responsibility to know if a written referral or authorization is required to see specialists, whether preauthorization is required prior to a procedure, and what services are covered.

Initial:________

Financial Responsibility

1- According to your insurance plan, you are responsible for all co-payments, deductibles and co-insurances.
2- **Co-payments, coinsurance percentages and deductible estimates** are due at the time of service. For patients with deductibles to meet, we collect $50 up front because it is almost impossible to know the allowable amounts for each insurance policy- charges are then filed and an additional bill may be sent based on the insurance assessment of the claim.
3- Self-pay patients are expected to pay for services in FULL at the time of visit. A 25% discount is applied for self-pay patients.
4- If we do not participate in your insurance plan, full payment is expected from you at the time of your visit.
5- Patient balances are not to exceed $100 before additional attempts at collection may be made. We cannot extend credit or allow large balances to build. If a balance exceeds $100, payment will need to be made towards that balance prior to future appointments.
6- We accept cash, checks, Visa and MasterCard, American Express, Discover credit and debit cards.
7- A $35 fee will be charged for any tax return for insufficient funds.

Initial: ______

Forms

1- There is a $15 per page fee for any forms that are filled out by our providers/staff outside of an office visit. Forms exceeding five pages will be charged based on the time taken to complete the forms.

Initial: ______

Medical Records

1- For your protection all medical records require a signed consent before they can be released to or received from another party.

Initial: _____

Prescription Refills

1- For medication refills, we require 48 hours' notice, during regular business hours. Please plan accordingly. Due to the high volume of medication refills/request, we ask that you contact your Pharmacy to verify the prescription has been completed.

Initial: _____

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name: ____

Patient Signature ______________________________ **Date** ______________

If patient is a minor:
Parent/Guardian Name: _________________________ **Relationship:** ____________

Parent/Guardian Signature ______________________ **Date** ______________