Pediatric Intake Form

1. Patient First Name:

Patient Middle Name:

Patient Last Name:

Preferred Name:

Age: (Yr and months)

Date of Birth:

Gender:

- ◯ Male
- ◯ Female

Name of Person Completing this form:

Relationship to child:

- ◯ Self
- ◯ Mother
- ◯ Father
- ◯ Legal Guardian
- ◯ Grandparent
- ◯ Relative
- ◯ Others

Date of Birth:

Street Address:

Apt./Unit #:

City:

State:

- ◯ Alabama
- ◯ Alaska
- ◯ Arizona
- ◯ Arkansas
- ◯ California
- ◯ Colorado
- ◯ Connecticut
- ◯ Delaware
- ◯ Florida
- ◯ Georgia
- ◯ Hawaii
- ◯ Idaho
- ◯ Illinois
- ◯ Indiana
- ◯ Iowa
- ◯ Kansas
- ◯ Kentucky
- ◯ Louisiana
- ◯ Maine
- ◯ Maryland
- ◯ Massachusetts
- ◯ Michigan
- ◯ Minnesota
- ◯ Mississippi
- ◯ Missouri
- ◯ Montana
- ◯ Nebraska
- ◯ Nevada
- ◯ New Hampshire
- ◯ New Jersey
- ◯ New Mexico
- ◯ New York
- ◯ North Carolina
- ◯ North Dakota
- ◯ Ohio
- ◯ Oklahoma
- ◯ Oregon
- ◯ Pennsylvania
- ◯ Rhode Island
- ◯ South Carolina
- ◯ South Dakota
- ◯ Tennessee
- ◯ Texas
- ◯ Utah
- ◯ Vermont
- ◯ Virginia
- ◯ Washington
- ◯ West Virginia
- ◯ Wisconsin
- ◯ Wyoming
- ◯ Puerto Rico
- ◯ District of Columbia
- ◯ US Virgin Islands

ZIP Code:

Home Phone:

Mobile Phone:

Work Phone:

Employer:

Email:

Preferred mode of communication:

May we leave a message?

- ◯ Yes
- ◯ No

2. Parent/Legal Guardian #2:

Relationship to child:

- ◯ Self
- ◯ Mother
- ◯ Father
- ◯ Legal Guardian
- ◯ Grandparent
- ◯ Relative
- ◯ Others

Date of Birth:

Street Address:

Apt./Unit #:

City:

State:

Zip Code:

Home Phone:

Mobile Phone:

Work Phone:

Employer:

Email:

Preferred mode of communication:

May we leave a message?

- ◯ Yes
- ◯ No

3. Parent's Marital Status:

- ◯ Married
- ◯ Single
- ◯ Domestic Partner
- ◯ Divorced
- ◯ Widowed
- ◯ Re-married
- ◯ Other

4. Preferred Language:

- ◯ English
- ◯ Spanish
- ◯ Other

If other, please specify

5. Race (Please check all that apply):

- ☐ White
- ☐ American Indian/Native Alaskan
- ☐ Black
- ☐ Native Hawaiian/Pacific Islander
- ☐ Asian
- ☐ Other

If other, please specify:

6. Ethnicity:

- ◯ Hispanic/Latino(a)
- ◯ Non-Hispanic/Latino(a)

7. How did you learn about this office?

Who referred you?

8. Emergency Contact:

Relationship:

Phone:

Other adult who may bring child in for evaluation and treatment:

Relationship:

- ◯ Sibling
- ◯ Aunt/Uncle
- ◯ Grandparent
- ◯ Babysitter

Other adult who may bring child in for evaluation and treatment:

Relationship:

- ◯ Sibling
- ◯ Aunt/Uncle
- ◯ Grandparent
- ◯ Babysitter

9. Please provide your child's insurance information below:

Primary Insurance Company

Member ID / Policy #

Group Number

Client Relationship to Insured

- ◯ Self
- ◯ Spouse
- ◯ Child
- ◯ Other

Insured Name

Insured Phone #

Insured Date of Birth

Insured Gender

- ◯ Female
- ◯ Male

Insured Street Address

Insured City

Insured State

- ◯ Alabama
- ◯ Alaska
- ◯ Arizona
- ◯ Arkansas
- ◯ California
- ◯ Colorado
- ◯ Connecticut
- ◯ Delaware
- ◯ Florida
- ◯ Georgia
- ◯ Hawaii
- ◯ Idaho
- ◯ Illinois
- ◯ Indiana
- ◯ Iowa
- ◯ Kansas
- ◯ Kentucky
- ◯ Louisiana
- ◯ Maine
- ◯ Maryland
- ◯ Massachusetts
- ◯ Michigan
- ◯ Minnesota
- ◯ Mississippi
- ◯ Missouri
- ◯ Montana
- ◯ Nebraska
- ◯ Nevada
- ◯ New Hampshire
- ◯ New Jersey
- ◯ New Mexico
- ◯ New York
- ◯ North Carolina
- ◯ North Dakota
- ◯ Ohio
- ◯ Oklahoma
- ◯ Oregon
- ◯ Pennsylvania
- ◯ Rhode Island
- ◯ South Carolina
- ◯ South Dakota
- ◯ Tennessee
- ◯ Texas
- ◯ Utah
- ◯ Vermont
- ◯ Virginia
- ◯ Washington
- ◯ West Virginia
- ◯ Wisconsin
- ◯ Wyoming
- ◯ Puerto Rico

◯ District of Columbia ◯ US Virgin Islands

Zip Code

If child does not have insurance at this time, please specify if this is a self-pay visit or which insurance child will have:

Please upload an image of the FRONT and BACK of your insurance card

Attach images with this form

Please upload an image of your photo ID

Attach images with this form

Medical History

10. Does your child have or had any of the following:

Anxiety

◯ Yes ◯ No

Additional details:

Asthma

◯ Yes ◯ No

Additional details:

Anemia

◯ Yes ◯ No

Additional details:

ADHD

◯ Yes ◯ No

Additional details:

Bleeding Disorder

◯ Yes ◯ No

Additional details:

Bowel disease

◯ Yes ◯ No

Additional details:

Chicken Pox

◯ Yes ◯ No

Additional details:

Chronic Pain

◯ Yes ◯ No

Additional details:

Depression

◯ Yes ◯ No

Additional details:

Diabetes Type I

◯ Yes ◯ No

Additional details:

Diabetes Type II

◯ Yes ◯ No

Additional details:

Eye Disease

◯ Yes ◯ No

Additional details:

Ear Infections

◯ Yes ◯ No

Additional details:

Heart Disease

◯ Yes ◯ No

Additional details:

Kidney Disease

◯ Yes ◯ No

Additional details:

Liver Disease

◯ Yes ◯ No

Additional details:

Physical Abuse

◯ Yes ◯ No

Additional details:

Seizures/Epilepsy

◯ Yes ◯ No

Additional details:

Sexual Abuse

◯ Yes ◯ No

Additional details:

Thyroid Problems

◯ Yes ◯ No

Additional details:

Urine Infections

◯ Yes ◯ No

Additional details:

11. Cancer

◯ Yes ◯ No

If yes/currently, please specify type:

Birth History

12. Adopted?

◯ Yes ◯ No

13. If yes, access to child's family history?

◯ Yes ◯ No

14. Full Term (>37 weeks)?

◯ Yes ◯ No

15. Age (weeks) at delivery:

16. Delivery:

◯ Vaginal ◯ C-Section ◯ Complication

If with complication, specify:

17. Problems during mother's pregnancy?

◯ Yes ◯ No

18. If yes, which problem?

☐ Infertility ☐ Drug Use ☐ No Prenatal Care

☐ Gestational DM ☐ Pre-eclampsia/Eclampsia ☐ Abnormal Ultrasound

☐ Prenatal Infection ☐ Other

If other, specify:

19. Prolonged Hospitalization?

◯ Yes ◯ No

20. If yes, please explain:

21. Birth Weight:

Passed newborn hearing screen?

- ◯ Yes
- ◯ No

22. Has your child ever been hospitalized?

- ◯ Yes
- ◯ No

23. If yes, please list reason and approximate month & year:

1 (Reason for hospitalization, Month/Year)

2 (Reason for hospitalization, Month/Year)

3 (Reason for hospitalization, Month/Year)

24. Surgical History?

- ☐ No
- ☐ Circumcision
- ☐ Tonsillectomy
- ☐ Appendectomy
- ☐ Hernia
- ☐ Ear Tubes
- ☐ Other

If other, specify:

25. Medications?

- ◯ Yes
- ◯ No

26. List all medications, including any over-the-counter medications, herbs or vitamins:

1 (Medication Name, Dosage, Frequency, Reason for taking)

2 (Medication Name, Dosage, Frequency, Reason for taking)

3 (Medication Name, Dosage, Frequency, Reason for taking)

27. Allergies?

- ◯ Yes
- ◯ No Known Allergy

28. If yes, please list (Including reaction):

1 (Allergy, Reaction)

2 (Allergy, Reaction)

3 (Allergy, Reaction)

Please upload your child's immunization records

Attach images with this form

Environmental History

29.

Lives with both parents

◯ Yes ◯ No

Siblings

◯ Yes ◯ No

2nd Hand Smoke

◯ Yes ◯ No

Pets in the House

◯ Yes ◯ No

Guns in the home

◯ Yes ◯ No

Family History

30. Is there a family (parent, grandparent, sibling) history of:

Anxiety/Depression

◯ Yes ◯ No

If yes, who?

Alcohol/Drug Abuse

◯ Yes ◯ No

If yes, who?

Asthma

◯ Yes ◯ No

If yes, who?

Autoimmune Disorder

◯ Yes ◯ No

If yes, who?

Diabetes

◯ Yes ◯ No

If yes, who?

Epilepsy/Seizures

◯ Yes ◯ No

If yes, who?

Heart Disease

◯ Yes ◯ No

If yes, who?

High Blood Pressure

◯ Yes ◯ No

If yes, who?

HIV/AIDS

◯ Yes ◯ No

If yes, who?

Kidney Disease

◯ Yes ◯ No

If yes, who?

Liver Disease

◯ Yes ◯ No

If yes, who?

Stroke

◯ Yes ◯ No

If yes, who?

Tuberculosis

◯ Yes ◯ No

If yes, who?

Cancer

◯ Yes ◯ No

If yes, who?

If with cancer, what type:

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31. Did any family member(s) die younger than age 50, excluding accidental death

◯ Yes ◯ No

32. If yes, please explain:

ENTIRELY KIDS PEDIATRICS OFFICE POLICIES

Patient First Name:
-

Patient Middle Name:
-

Patient Last Name:
-

Patient Date of Birth:
-

Thank you for choosing Entirely Kids Pediatrics for your child's medical care. Our goal is to provide quality care to parents and patients, so we strive to make your visit as pleasant and stress-free as possible. We ask that you please review the information below regarding our office policies and initial each item in order to avoid any misunderstandings in the future.

☐ Office Hours: Our office is open Monday through Friday, 8:30am - 12:00pm and 1:00pm - 5:00pm; we are closed for lunch from 12:00pm to 1:00pm. Should we miss your call during normal business hours, please leave us a message, and we will return your call promptly. *

☐ After Hours: For any emergencies, please visit your nearby emergency room. General health and medical concerns should be directed to the nurse advice line provided on your child's insurance card. If you have an urgent matter that you need to discuss with the physician after-hours, please call our office main line and select the option to leave a message for the on-call physician. The doctor will return your call as soon as possible. Please note medication refills are not done after-hours, and after-hours services are subject to a charge. *

Appointments:

☐ 1. Scheduling - When calling to schedule an appointment, our front desk will typically ask you the reason for the visit (i.e. for well exam or illness). Please note that a well exam cannot be performed on the same day as an appointment scheduled for a sick visit/illness. *

☐ 2. Late policy - Please understand that late arriving patients can have an impact on the schedule of the physician and other patients. We kindly ask that, if you are running late or won't be able to make your appointment, to notify us as soon as possible. If you are more than 15 minutes late to an appointment, we will try to work you in depending on the schedule for the day, but you may be asked to reschedule to a later date. *

☐ 3. Cancellation/No Show - We value your time and we ask that you do the same for us. For any cancellations, please give at least 24 hours notice. We make attempts to send appointment reminders 1- 2 days before the appointment, but it is still your responsibility to maintain the appointment that you scheduled. Late cancellations/no-shows are subject to a fee, and excessive no-shows or short-notice cancellations may result in dismissal from the practice. *

☐ 4. As previously stated, we know your time is valuable, so we strive to stay on time and attempt to be as efficient as possible while still providing quality care. However, please understand that emergencies do occur, and we ask that you be understanding if we happen to run a little behind schedule. *

☐ Immunizations: At Entirely Kids Pediatrics, we firmly believe in the protective benefits of immunizations. While we would love to accommodate all families, we simply cannot put at risk the children who are too young to be immunized and any immunocompromised individuals. Therefore, we are unable to provide services to patients who decide not to be vaccinated. We follow the recommendations made by the American Academy of Pediatrics and the Advisory Committee on Immunization Practices with respect to the childhood and adolescent immunization schedules. Should you have any questions or concerns regarding immunizations, we would be glad to address these at your child's visit. *

Financial: As a courtesy to our patients, Entirely Kids Pediatrics is happy to file insurance claims on your behalf. If you also have a secondary insurance, please let our staff know. We will need a copy of all cards. It is your responsibility to call your insurance company before your first appointment and make sure our office is in-network with your insurance, as well as any PCP (primary care provider) changes are made. It is also your responsibility to inform our office of any changes in insurance coverage. Failure to do so will cause delays or denial of insurance payment.

☐ Co-payments and self-pay amounts are due at the time of service. You will be billed for any deductible or co-insurance amounts, and/or fees for services not covered by your insurance (as stated in your insurance contract). If we are unable to verify insurance coverage prior to scheduled appointments, patients will be responsible for fees associated with office visits at the time of service. *

☐ Treatment of Minors: A parent or legal guardian must accompany a minor to their first appointment at this practice. For future visits, individuals who have been specifically listed on the patient's intake form as having permission to bring the child in may do so as requested by the parent or legal guardian. Please note that a photo ID is required in these circumstances. It is also the responsibility of the trusted individual to relay details of the visit back to the parent/legal guardian. Alternatively, the parent/legal guardian may refer to the patient portal for the visit summary. *

☐ Patient Portal: One of our goals is to make patient care and coordination more efficient for the family and our office staff. We highly encourage families to utilize the patient portal to access medical records and submit non-urgent office requests. For access to the patient portal or for more information, please access: https://patientportal.intelichart.com *

By signing below, I acknowledge that I have received, read and understand the above office policies for Entirely Kids Pediatrics.

Parent/Legal Guardian Signature (ESign)

Date :

CONSENTS

Consent for Medical Treatment of a Minor

Patient First Name:
-

Patient Middle Name:
-

Patient Last Name:
-

Date of Birth:
-

I am the parent or legal guardian of the above stated minor and have the power to consent to medical treatment for him/her. In the event that I cannot be contacted or am not present for consent, I will authorize and appoint another individual to consent on my behalf; this authorization will be submitted in writing. Medical treatment in this office may include, but is not limited to, examination, immunizations, medication administration, imaging studies, procedures, and coordination of care with other specialties and providers.

Relationship to Patient:
-

E-Signature (draw, upload or type) (ESign)

Date :

DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that as part of my healthcare, Entirely Kids Pediatrics originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

Entirely Kids Pediatrics' **Notice of Privacy Practices** provides specific information and complete description of how my personal health information may be used and disclosed. I have been provided a copy of or access to the **Notice of Privacy Practices** and understand that I have the right to review the notice prior to signing this consent. I understand that Entirely Kids Pediatrics reserves the right to change the **Notice of Privacy Practices**, and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment or healthcare operations and Entirely Kids Pediatrics is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that Entirely Kids Pediatrics has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I have been provided and have reviewed Entirely Kids Pediatrics' **Notice of Privacy Practices** dated 01/01/2018.

*Please use the link below to access the Notice of Privacy Practices:
http://www.entirelykidspediatrics.com/wp-content/uploads/2018/03/Notice-of-Privacy-Practices-English.pdf

Parent/Legal Guardian Signature (ESign)

Date :

Authorization for Release of Medical Records to EKP

Patient's First Name | Patient's Middle Name | Patient's Last Name

DOB:

I hereby authorize medical records to be released **from:**

Name:

Address:

Phone: | Fax:

To: Entirely Kids Pediatrics
5575 Warren Parkway, Suite 116
Frisco, TX 75034
Phone: 469-425-3600
Fax: 469-425-3599

Please check information requested to be released:

- [ ] Complete medical record from this office
- [ ] Immunizations only
- [ ] Growth charts only
- [ ] Diagnostic testing & results
- [ ] Other (please specify):

Other (please specify):

Signature of Parent/Guardian:

Date: