Infant/Toddler Paperwork

Child's name:

Date of birth:

Gender

○ Male ○ Female

Parent's/guardian name(s):

Address:

City: **State:** **Zip:**

Phone:

Reason for Visit

What is the reason for today's visit?

When did the problem start?

Is it getting better or worse with time?

Are there any factors that makes it better or worse?

Is there a history of any of the following conditions?

☐ Acid reflux ☐ ADD ☐ ADHD ☐ Asperger's ☐ Autism ☐ Cerebral Palsy
☐ Colic ☐ Congenital anomalies ☐ Difficulty eating ☐ Difficulty walking
☐ Down's syndrome ☐ Ear infection (chronic) ☐ Bed wetting ☐ Epilepsy
☐ Febrile convulsions ☐ Fever ☐ Pain ☐ Foot flare ☐ Headache
☐ Inability to thrive ☐ Jaundice ☐ Seizures ☐ Sleeping problems
☐ Speech difficulties ☐ Torticollis ☐ Other

Delivery

How was the baby delivred?

☐ C-section ☐ Vaginal delivery with epidural ☐ Vaginal delivery without epidural
☐ Vaginal delivery at home

Where forceps used?

☐ Yes ☐ No ☐ Unknown

Was vacuum extraction used?

☐ Yes ☐ No ☐ Unknown

How many hours was the labor?

How long was the pushing?

Was this a single childbirth or multiple?

☐ Single ☐ Identical Twins ☐ Identical Triplets ☐ Fraternal twins
☐ Fraternal triplets ☐ Other

What was the birth weight?

How many inches long?

What was the final APGAR score?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ unknown

At how many weeks was the child born?

.....

History

Has the child received vaccinations?

○ Yes ○ No ○ Unknown

Were nutritional supplements taken during pregnancy?

○ Yes ○ No ○ Unknown

If yes, please explain:

.....

Were any invasive procedures performed during pregnancy?

○ Yes ○ No ○ Unknown

If yes, please explain:

.....

Did the mother have any illnesses during pregnancy?

○ Yes ○ No ○ Unknown

If yes, please explain:

.....

Were there any significant trauma or falls during pregnancy?

○ Yes ○ No ○ Unknown

If yes, please explain:

.....

Any evidence of birth trauma?

☐ Bruising ☐ Cord around neck ☐ Fast/slow birth ☐ Odd shaped head

☐ Respiratory depression ☐ Stuck in birth canal ☐ Unsure ☐ Other ☐ None

Development

Was the child breastfed?

○ Yes, still actively ○ Yes ○ No ○ Unknown

Was formula introduced?

○ Yes, still actively ○ Yes ○ No

○ Unknown

If yes, at how many months old?

.....

Has cow's milk been introduced?

○ Yes ○ No ○ Unknown

If yes, at how many months?

.....

Have solids been introduced?

○ Yes ○ No ○ Unknown

If yes, at how many months?

.....

Does the child have any food intolerances or allergies?

○ Yes ○ No ○ Unknown

If yes, please explain:

.....

Milestones

What milestones have been acheived?

1 month:

☐ Feeds slowly ☐ Sucks effectively ☐ Focuses eyes ☐ Watches moving objects

☐ Reacts to bright lights ☐ Has good muscle tone ☐ Responds to loud sounds

1-4 months:

☐ Can support head well ☐ Can grasp objects ☐ Can focus moving objects

☐ Smiles ☐ Reacts to loud sounds ☐ Acknowledges new faces

☐ Is not upset by new people/surroundings

4-8 months:

☐ Has good muscle tone ☐ Can hold head steady ☐ Can sit on own

☐ Responds to noises or smiles ☐ Is affectionate ☐ Reaches for objects

8-12 months:

☐ Crawls ☐ Doesn't drag one side when crawling ☐ stands without support

☐ Finds obvious hidden objects ☐ Says words ☐ Uses gestures

☐ Points or shakes head "no"

Consent to treat.

I certify that I am the patient or the legan guardian listed above. I have read and understand the included information and understand it to be true and accurate to the best of my knowledge. I consent to the collection and use of the information above to this office. I authorize this office and it's staff to examine and treat my conditionas the doctors see fit. I hearby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement or charges incurred by me. I grant the use of my signed statement of

authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me and I am responsible for timely payment of such service. I understand and agree that health/accident insurance policies are an arrangement between insurance carrier and myself. I understand that the fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Please type your name to sign the consent to treat.

HIPAA CONSENT

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Our Obligations We are required by law to:

• Maintain the privacy of protected health information

• Give you the notice of your legal duties and privacy practices regarding health information about you • Follow the terms of our notice that is currently in effect

How We May Use and Disclose Health Information

Described as follows are the ways we may use and disclose health information that identifies you (“Health

Information”). Except for the following purposes,

we will use and disclose health information only with your written permission. You may revoke such permissions at any time by writing to our practice’s privacy officer.

Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for treatment and services you receive. For example, we may give your health plan information so that they will pay for your treatment.

Health Care Operations. We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care to operate and manage our office. For example, we may use and disclose information to make sure the obstetric or gynecologic care you receive is of the highest quality. We also may share information with our entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services. We may use and disclose Health Information to contact you and remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who receive one treatment to those who receive another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes.

Special Situations

As required by law. We will disclose Health Information when required to do so by international, federal, state, or

If you have any questions about the above notice, please contact our Office at

local law.

To Avert a Serious Threat to Health of Safety. We will disclose Health Information when necessary to prevent a serious threat to your health and safety or the public, or another person. Disclosure, however, will be made only to someone who may be able to help provide treatment.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or to provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than that as specific in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation, and transplantation.

Military and Veterans. If you are a member of the army forces, we may use or release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Worker’s Compensation. We may release Health Information for worker’s compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosure to prevent or control disease, injury, or disability; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate

government authority if we believe a patient has been a victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit of a dispute, we may disclose Health Information in response to a court or a court administrator order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of crime even if, under certain circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises and; 6)in an emergency to report a crime to the location of the crime if victims, or the identity, description, or location of the person who committed the crime.

Coroners, Medical Examiners, Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Protective Services and Intelligence Activities. We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or other custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others, or; 3) for the safety and security of the correctional institution.

Your Rights

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have the right to inspect and copy Health Information that we may used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this information, you must make your request in writing, to our Privacy Officer.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the

information is kept by or for our office. To request an amendment, you must make your request, in writing, to our Privacy Officer.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our Privacy Officer.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operation. You also have a right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you can ask that we not share information about your particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our Privacy Officer. We are not required to agree with your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communications, you must make your request, in writing, to our Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You must ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice by contacting our office.

Changes to This Notice

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a current copy of our notice at our office. The notice will contain the effective date on the first page, in the top right hand corner.

Complaints

If you believe your privacy has been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer. All complaints must be made in writing. You will not be penalized for filing a complaint.

By Subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

Please type your name to acknowledge the HIPAA consent form: