Community Pediatrics

109 WARREN STREET, SUITE 4
BEAVER DAM, WI 53916
(920) 885-3305
FAX: (920) 885-5506
608 WEST BROWN ST, SUITE 2
WAUPUN, WI 53963
(920) 239-2200
FAX: (920) 324-2024

Thank you for your interest in Community Pediatrics, SC!

Enclosed please find a Patient Information Sheet(s), a Medical Authorization for release of information, a family medical history form, our policy on vaccines, a brochure, and a magnet with our contact information.

Please complete each form for each patient and return to our office at your earliest convenience.

If you have any questions regarding these forms or need additional forms, please do not hesitate to contact our office at (920)885-3305 in Beaver Dam and (920)239-2200 in Waupun.

We look forward to working with you and your family.

Thank you!

The staff of Community Pediatrics

***New patients who no-show their first appointment without 24-hour notification will not be allowed to reschedule. ***

NEW PATIENTS!!

We love new patients!

And we understand situations arise in which you must cancel your appointment. We do require **4 business hours notice** so we can offer your appointment slot to someone else. Unfortunately beginning 6/1/16 if you No-Show your first appointment we will **not** be able to reschedule your appointment. Thank you.

CURRENT PATIENT 'NO SHOW' POLICY

Again, we at Community Pediatrics do understand that unforeseen circumstances do arise making it impossible to keep a scheduled appointment, however due to an increase in appointments being repeatedly missed we will be implementing a No-Show Policy as of **February 1, 2017**.

If you are unable to keep your appointment please call our office a minimum of **4 business hours prior** to your scheduled appointment. Each appointment that is missed (no-show/cancel) without 4 business hours notification will be considered a "no-show". After 3 no-shows in a 12 month period, your account will be reviewed and you may be dismissed from the clinic.

We appreciate that you have entrusted your child's healthcare to us and we want you to know that their welfare is our greatest concern.

VACCINE POLICY STATEMENT

Community Pediatrics, SC

We believe in vaccines

We believe in the effectiveness of vaccines to prevent serious illness, to promote health and wellness, and to save lives.

We believe...

- In the safety of vaccines
- That children and young adults should receive all of the recommended vaccines according to the schedule published by the Centers for Disease Control and Prevention and the American Academy of Pediatrics.
- That, based on all available data, scientific literature, current studies, and evidence-based medicine, that vaccines do not cause autism or other developmental disabilities.
- That thimerosal, a preservative that has been in vaccines for decades, and that remains in only a few vaccines today, does not cause autism or other developmental disabilities.
- We believe that vaccinating children and young adults may be the single most important health-promoting intervention we perform as health care providers, and that you perform as parents/caregivers.

We know, and want you to know

That the recommended vaccines and their schedule are the results of years and years of scientific study and research, with data gathered on millions of children, by thousands of our brightest physicians and scientists.

If you refuse to vaccinate your child despite all our efforts and recommendations, we will ask you to find another health care provider who shares your views.

We're always happy to answer any questions or to discuss any concerns you may have about vaccines.

We understand there has always been controversy surrounding vaccination, and likely always will be, but that controversy does not change the facts, science, or evidence about vaccines. The vaccine campaign is a victim of its own success. It's precisely because vaccines are so effective at preventing illness that we can even discuss whether or not to give them. Because of the safety and effectiveness of vaccines, few have ever seen a child with polio, tetanus, whooping cough, bacterial meningitis, or even chicken pox. And that's wonderful.

We do not write this to scare or coerce you, but to make you aware of the facts and emphasize the importance of vaccinating your child. We recognize the choice may be emotional for some parents, so we will do all we can to support you and help you understand that vaccinating according to the schedule is the right thing to do.

Please understand, however, that delaying or "breaking up" the vaccines to give one or two at a time over two or more visits goes against expert recommendations and can put your child at risk for serious illness or death. Doing this goes against our medical advice and our core principles at Community Pediatrics. Should you choose these options, you must sign a "Refusal to Vaccinate" acknowledgement in the event of lengthy delays.

Date: _____

PATIENT INFORMATION (Please Print)

Patient Name: _____ Date of Birth: _____ Sex: _____

Address: _____ City: _____ State:_____ County:_____ Zip:_____

Phone: ( )_____ Language:_____ Ok to leave message/send mail: Y____ N____

Race:
American Indian or Alaskan Native
Asian
Black
Hawaiian Native or Pacific Islander
White
Declined to Answer

AND

Ethnicity: (circle one)
Unknown
Hispanic or Latino
Not Hispanic or Latino
Declined to Answer

PARENT INFORMATION

Mother: _____ SSN#_____ DOB:_____
Address:_____ City:_____ State:_____ Zip: _____
Phone: ( )_____ Work: ( )_____ Cell: ( )_____
Employer: _____ Occupation: _____ Email: _____

Father: _____ SSN#_____ DOB:_____
Address:_____ City:_____ State:_____ Zip: _____
Phone: ( )_____ Work: ( )_____ Cell: ( )_____
Employer: _____ Occupation: _____ Email: _____

Step Parent: _____ SSN#_____ DOB:_____
Address:_____ City:_____ State:_____ Zip: _____
Phone: ( )_____ Work: ( )_____ Cell: ( )_____
Employer: _____ Occupation: _____ Email: _____

Emergency Contact: If unable to reach you directly (Other than parents)
Name: _____ Relationship to Patient: _____
Address:_____ City:_____ State:_____ Zip: _____
Phone: ( )_____ Work: ( )_____ Cell: ( )_____

Preferred phone contact number for: Medical information: _____
Reminders: _____Text_____Call_____

INSURANCE INFORMATION

Insurance Carrier:_____ Policy Holder: _____ DOB:_____

Subscriber ID: _____ Group # _____

Employer: _____ Relationship to patient: _____

I consent to treatment of myself/my child for routine medical care, including physical exam, well child care, and vaccinations. (I understand that I have the right to refuse treatment.) I hereby authorize Community Pediatrics, SC to release to my insurance carrier any information including the diagnosis and record of any treatment or examination. I also authorize and request that Community Pediatrics, SC be paid directly for services rendered. I understand and agree that I am financially responsible for all charges whether paid by insurance or not.

Signature of Patient/Guardian: _____ Date:_____

PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

(Complete in full. See reverse side for important information.)

I. PATIENT INFORMATION

_____ _____
(Name of Patient) (Date of Birth)

_____ _____
(Street Address) (City, State, Zip)

II. AUTHORIZE:

_____ _____
(Name of Physician/Health Care Facility/Other) (Phone/Fax Number)

_____ _____
(Street Address) (City, State, Zip)

III. TO RELEASE PROTECTED HEALTH INFORMATION TO:

Community Pediatrics, SC **(920)885-3305/ (920)885-5506**
(Name of Physician/Health Care Facility/Other) (Phone/Fax Number)

109 Warren St, Suite 4 **Beaver Dam, WI 53916**
(Street Address) (City, State, Zip)

IV. HEALTH INFORMATION TO BE RELEASED:

_____ All Medical Records from _____
_____ Immunization Records/Growth Chart
_____ Lab Reports
_____ X-Ray Reports
_____ X-Ray Films – Specify
_____ Billing Records – Specify
_____ Other

A. In Compliance with Wisconsin Statutes which require special permission to release otherwise privileged information, please release records pertaining to:

_____ Mental Health
_____ Alcoholism
_____ HIV (AIDS)
_____ Developmental Disabilities
_____ Drug Abuse
_____ Other _____

V. PURPOSE OR NEED FOR DISCLOSURE: (Check applicable categories)

___ Further Medical Care
___ Insurance Eligibility/benefits
___ Disability determination
___ At request of Patient
___ Legal Investigation
___ Other _____
_____ Vocational rehabilitation evaluation

VI. EXPIRATION

This authorization will expire on _____/_____/_____(DD/MM/YYYY). If I do not indicate a date, this will expire one (1) year from the date of my signature below.

VII. SIGNATURE

I have had full opportunity to read and consider the contents of this Authorization that the health care provider my use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

Signature: _____ Date: _____

If this Authorization is signed by a representative on behalf of this patient, complete the following:
Representative's Name: _____
Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

SEE REVERSE SIDE FOR IMPORTANT INFORMATION.

Additional Information Regarding Release of Health Information

Community Pediatrics, SC recognizes the patient's right of confidentiality of their health information under federal privacy regulations and Wisconsin Law. The patient should be aware of the following information when requesting or releasing health information.

- **Right to refuse to sign this authorization**: A patient may refuse to sign this Authorization and this refusal will not affect the patient's ability to obtain treatment or payment of claims.
- **Right to inspect or copy the health information to be used of disclosed**: A patient has the right to inspect or copy the health information they have authorized to be used or disclosed by signing this Authorization form. A patient may arrange to inspect their health information by contacting this office directly.
- **Right to receive copy of this authorization**: A patient has the right to receive a copy of the signed Authorization form.
- **Right to revoke this authorization**: A patient has the right to revoke this Authorization at any time by giving written notice of revocation to the Office Manager listed below. Revocation of this Authorization will not affect any action taken in reliance of this authorization before receipt of the written notice of revocation.
- **Multiple releases of Information**: A patient may request multiple releases of the information stated on the Authorization form. However, all releases based on this form are limited to the records dated up to and including the date of patient's signature. A new Authorization is necessary for release of information for care provided after the date of the patient's signature, unless the Authorization specifically states that specific records that will be generated in the future maybe be released, for example "future records of a specific test" or "future records of specific clinic appointment."
- **Who may sign this Authorization**:
  1. Generally, all patients 18 years and older must sign for release of their own health information unless the following conditions apply:
     a. The patient is incompetent.
     b. The patient is disabled and cannot sign the form.
     c. The patient is deceased. (A surviving spouse or personal representative of the estate may sign. If there is no surviving spouse or personal representative, then an adult member of the immediate family may sign.)
  2. All persons signing for release of health information on behalf of the patient must state their relationship to the patient and provide legal authority of their capacity to act for the patient.
  3. Minors: Patients less than 18 years of age must sign for release of their health information in the following cases:
     a. Alcohol or other drug abuse treatment: age 12 or older.
     b. Mental health treatment: age 14 or older may consent to release of records without parental consent (Parents also retain the right to access this information.)
     c. HIV test results: 14 or older.
     d. Emancipated minors who are married or in the military.
- **Fees for records:** Community Pediatrics, SC, may charge a reasonable fee for viewing, copying, postage and preparation of records to fulfill this request. All fees are based on the applicable laws governing the release of health information.
- **Contact Office:** Community Pediatrics, SC, Office Manager, 109 Warren Street, Suite 4, Beaver Dam, WI 53916 Telephone: 920-885-3305

Initial History Questionnaire

Name

ID NUMBER

FORM COMPLETED BY | DATE COMPLETED

BIRTH DATE | AGE ☐M ☐F

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names, ages, and where they live. _____

What is the child's living situation if not with both biological parents?
☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody
☐ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

Birth History ■ Don't know birth history

Birth weight _____ Was the baby born at term? _____ OR _____ weeks

Were there any prenatal or neonatal complications?
☐ Yes ☐ No Explain _____

Was a NICU stay required? ☐ Yes ☐ No Explain _____

During pregnancy, did mother
Use tobacco ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No
Use drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins
What _____ When _____

Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, why?

Was initial feeding ☐ Formula ☐ Breast milk How long breastfed? _____

Did your baby go home with mother from the hospital?
☐ Yes ☐ No Explain _____

General DK = don't know

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ DK Explain _____

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ DK Explain _____

Has your child had any surgery? ☐ Yes ☐ No ☐ DK Explain _____

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ DK Explain _____

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ DK Explain _____

Do you feel your family has enough to eat? ☐ Yes ☐ No ☐ DK Explain _____

Biological Family History DK = don't know

Have any family members had the following?

Childhood hearing loss	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Asthma	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tuberculosis	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Heart disease (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
High cholesterol/takes cholesterol medication	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Anemia	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bleeding disorder	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Dental decay	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Cancer (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

(Biological Family History continued on back side.)

Biological Family History *(Continued from front side.)* DK = don't know

Liver disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Kidney disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Diabetes (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bed-wetting (after 10 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Obesity	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Epilepsy or convulsions	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Alcohol abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Drug abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Mental illness/depression	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Developmental disability	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tobacco use	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

Additional family history _____

Past History DK = don't know

Does your child have, or has your child ever had,

Chickenpox	☐ Yes	☐ No	☐ DK	When _____
Frequent ear infections	☐ Yes	☐ No	☐ DK	Explain _____
Problems with ears or hearing	☐ Yes	☐ No	☐ DK	Explain _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Explain _____
Problems with eyes or vision	☐ Yes	☐ No	☐ DK	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	☐ DK	Explain _____
Any heart problem or heart murmur	☐ Yes	☐ No	☐ DK	Explain _____
Anemia or bleeding problem	☐ Yes	☐ No	☐ DK	Explain _____
Blood transfusion	☐ Yes	☐ No	☐ DK	Explain _____
HIV	☐ Yes	☐ No	☐ DK	Explain _____
Organ transplant	☐ Yes	☐ No	☐ DK	Explain _____
Malignancy/bone marrow transplant	☐ Yes	☐ No	☐ DK	Explain _____
Chemotherapy	☐ Yes	☐ No	☐ DK	Explain _____
Frequent abdominal pain	☐ Yes	☐ No	☐ DK	Explain _____
Constipation requiring doctor visits	☐ Yes	☐ No	☐ DK	Explain _____
Recurrent urinary tract infections and problems	☐ Yes	☐ No	☐ DK	Explain _____
Congenital cataracts/retinoblastoma	☐ Yes	☐ No	☐ DK	Explain _____
Metabolic/Genetic disorders	☐ Yes	☐ No	☐ DK	Explain _____
Cancer	☐ Yes	☐ No	☐ DK	Explain _____
Kidney disease or urologic malformations	☐ Yes	☐ No	☐ DK	Explain _____
Bed-wetting (after 5 years old)	☐ Yes	☐ No	☐ DK	Explain _____
Sleep problems; snoring	☐ Yes	☐ No	☐ DK	Explain _____
Chronic or recurrent skin problems (eg, acne, eczema)	☐ Yes	☐ No	☐ DK	Explain _____
Frequent headaches	☐ Yes	☐ No	☐ DK	Explain _____
Convulsions or other neurologic problems	☐ Yes	☐ No	☐ DK	Explain _____
Obesity	☐ Yes	☐ No	☐ DK	Explain _____
Diabetes	☐ Yes	☐ No	☐ DK	Explain _____
Thyroid or other endocrine problems	☐ Yes	☐ No	☐ DK	Explain _____
High blood pressure	☐ Yes	☐ No	☐ DK	Explain _____
History of serious injuries/fractures/concussions	☐ Yes	☐ No	☐ DK	Explain _____
Use of alcohol or drugs	☐ Yes	☐ No	☐ DK	Explain _____
Tobacco use	☐ Yes	☐ No	☐ DK	Explain _____
ADHD/anxiety/mood problems/depression	☐ Yes	☐ No	☐ DK	Explain _____
Developmental delay	☐ Yes	☐ No	☐ DK	Explain _____
Dental decay	☐ Yes	☐ No	☐ DK	Explain _____
History of family violence	☐ Yes	☐ No	☐ DK	Explain _____
Sexually transmitted infections	☐ Yes	☐ No	☐ DK	Explain _____
Pregnancy	☐ Yes	☐ No	☐ DK	Explain _____
(For girls) Problems with her periods	☐ Yes	☐ No	☐ DK	Explain _____

Has had first period ☐ Yes ☐ No Age of first period _____

Any other significant problem _____

This American Academy of Pediatrics Initial History Questionnaire is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 3rd Edition.

HE0328

9-223/0109