

Bridge City Family Medical Clinic

Pediatric New Patient (0-12 years of age)

Please Complete ALL Questions ~ We Require ALL Information to be Filled In

PATIENT INFORMATION					
Last Name	First Name	M.I.	Date of Birth	Check Which Applies	
			/ /	Male	Female
				FtoM	MtoF
				Other	
Address			City	State	Zip
Home Phone #	Cell Phone #	Work Phone #		Marital Status - check which applies	
()	()	()		Married	Single
				Divorced	Widowed
				Dom. Partner	
Employer	Employer Address	City	State	Zip	Driver's License #
Emergency Contact Name			Emergency Contact Phone #		

RESPONSIBLE PARTY = PARENT / GUARDIAN INFORMATION					
Last Name	First Name	M.I.	Date of Birth	Social Security #	
			/ /		
Address			City	State	Zip
Home Phone #		Cell Phone #			
()		()			

INSURANCE INFORMATION					
<u>Primary Insurance Company</u>		Insurance Address		State	Zip
Member ID #		Group #		Plan #	
Insurance Phone #		Insurance Coverage Type - check which applies			
		EPO	PPO	POS	HMO
Subscriber / Patient Relationship					
Self		Spouse		Child	
				Other	

<u>Secondary Insurance Company</u>		Insurance Address		State	Zip
Member ID #		Group #		Plan #	
Insurance Phone #		Insurance Coverage Type - check which applies			
		EPO	PPO	POS	HMO
Subscriber / Patient Relationship - check which applies					
Self		Spouse		Child	
				Other	

I hereby authorize *Bridge City Medical Clinic* to furnish information to insurance carriers concerning my illness and treatment and to imitate a complaint to the Oregon Insurance Commissioner on my behalf, if and when necessary. Assign any and all insurance benefits for treatment to *Bridge City Family Medical Clinic*. Acknowledge that I am ultimately responsible for any prior authorization or referral required by my insurance company. Assume complete financial responsibility for costs denied or rejected and for services not covered by my insurance company. Understand that any account sent to outside collections will be charged a \$40.00 Collection Fee which I am responsible to pay.

Patient/ Guardian Signature

Date

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Pediatric Health & Social History (0-12 years of age)

Child's Name: _____

Date of Birth: _____

Parents Name: _____

Sex: Male Female

Are there any medication taken regularly

If yes, (check which apply)

Fluoride Vitamins Aspirin Tylenol Cold Medicine Other _____

Any known drug/ medicine allergies?

If Yes, please list: _____

Received vaccinations for: DTP

Polio

Hib

MMR

TB Skin Test

Child's Birth History

(Please complete age 2 & under)

Birth Weight: _____ lb. _____ oz.

Length: _____ in.

Vaginal or C-Section? _____

Born at: Hospital _____

Other _____

Place of Birth: City _____

State _____

County _____

Was child full term? If no, please explain:

Problems with Pregnancy/Labor/Delivery?

Child's Known Health Issues

(Check all that apply)

Eye/Vision Problem

Ear/Hearing Problem

Toothache/Decay

Asthma/Breathing Problem

Heart Disease/Murmur

High Blood Pressure

High Cholesterol

Anemia

Stomach ache

Sickle Cell Anemia

Diabetes

Headaches

Low Blood Sugar

Kidney/Bladder Problem

Seizures/Epilepsy

Blood Transfusion

Bone/Joint/Muscle Problem

Accidents/Injury

Vagina Problem

Penis/Scrotum/Testicles Problem

History of Physical/Sexual Abuse

Unusual Bruising/Bleeding Disorder

Exposure to Dangerous Chemicals/Materials

Other

Has your child had any of the following?

Chicken Pox Age: _____

Hepatitis Age: _____

Mononucleosis Age: _____

Pneumonia Age: _____

Rheumatic Fever Age: _____

Other:

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First & Second heel-stick / Newborn Screen checks completed?
 Hearing Screen passed?

Please describe any concerns that you have today:

Child Development

(At what age did your child...)

Sit Alone: _____	<input type="checkbox"/> Not Yet	<input type="checkbox"/> Do Not Know	Stand Alone: _____	<input type="checkbox"/> Not Yet	<input type="checkbox"/> Do Not Know
Start to Speak: _____	<input type="checkbox"/> Not Yet	<input type="checkbox"/> Do Not Know	Use Sentences _____	<input type="checkbox"/> Not Yet	<input type="checkbox"/> Do Not Know
Use Toilet: _____	<input type="checkbox"/> Not Yet	<input type="checkbox"/> Do Not Know	Walk Alone _____	<input type="checkbox"/> Not Yet	<input type="checkbox"/> Do Not Know
Skip: _____	<input type="checkbox"/> Not Yet	<input type="checkbox"/> Do Not Know	Read _____	<input type="checkbox"/> Not Yet	<input type="checkbox"/> Do Not Know

Attend Daycare/ School? Yes No

If yes, name of institution and grade currently in:

Family History

(Check which apply)

	<u>Child's Mother</u>	<u>Child's Father</u>	<u>Child's Siblings</u>	<u>Child's Grandparents Mother's Side</u>	<u>Child's Grandparents Father's Side</u>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug Abuse/ Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis (A,B,C)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Other Family Medical Concerns:

Child's Parents
(check which apply)

Mother:
Living _____ Deceased _____
If Deceased, age and reason: _____

Father:
Living _____ Deceased _____
If Deceased, age and reason: _____

Mother's Pregnancy History

(Complete for children less than 2 years of age)

Number of Pregnancies: _____ Miscarriages: _____ Abortions: _____ Living Children: _____

Did Mother receive Prenatal Care? _____ At what month did prenatal care begin? _____

Did Mother have any problems with Pregnancy/Labor/Delivery?

If Yes, please explain:

Delivery was:

Did Mother use Drugs/Medicine during pregnancy? Yes No

Alcohol Tobacco Caffeine
 Street Drugs if yes, which? _____ Needles if yes, describe _____
 Prescription from Physician _____ Over the Counter _____

Has Mother been in a treatment program for Drug/Alcohol Abuse? Yes No If Yes, please explain: _____

Child History

GENERAL

How many hours of television (video games) does your child watch each day?

In one week, on how many days does your child usually play actively/ exercise for at least 30 minutes?

How many cups/bottles of milk does your child usually drink in 1 day? _____

How many cups of soda, fruit drinks, sports and juice does your child usually drink in one day? _____

Are you ever concerned about you or your child's safety in your home? _____

Are you concerned your child may have been physically, emotionally, or sexually abused in his/her life? _____

Has your child had a change in appetite, eating habits, or energy level? _____

RESPIRATORY

Has your child ever had wheezing, asthma, or coughed up blood? _____

Does your child snore loudly or have breathing problems while sleeping? _____

Does your child frequently cough while running or playing? _____

NEUROLOGICAL

Had your child ever had seizures, memory loss, or unexplained trembling or dizziness? _____

Any concerns with the way your child learns, walks or talks? _____

CARDIAC

Have you ever been told your child has a heart murmur? _____

Has your child ever had chest pain, "racing heart", or shortness of breath during regular daily activities?

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GASTROINTESTINAL

Does your child have problems with frequent diarrhea or constipation? _____

Does your child frequently complain of stomachaches? _____

URINARY

Has your child ever had trouble urinating? Frequent or painful urination? _____

Any problems with toilet training or bed wetting? _____

HEENT

Has your child had a change in vision or hearing? _____

Has your child had an eye exam in the last year? _____

Does your child get frequent headaches or sinus congestion? _____

SKIN

Has your child had problems with rashes, acne, warts or moles? _____

BONES

Has your child broken any bones in the past? If yes, which bone and date occurred? _____

Has your child ever had bone or joint swelling? _____

NECK

Has your child had swollen glands, pain or stiffness? _____

MOOD

To your knowledge, does your child have any school or family problems troubling him/her? _____

Does your child ever seem depressed, anxious, or talk about death or suicide? _____

Has your child ever been in counseling or been treated by a mental health professional? _____

DENTAL

When was the last time your child saw a dentist? _____

Have you noticed brown or white spots on your child's teeth? Has the child ever complained of tooth aches/ pains?

Patient / Parent / Guardian Consent

I authorize release of any information necessary to process my medical insurance claim. I authorize benefits payable directly to Bridge City Family Medical Clinic, PC.

Print Child Name **Date**

Signature of Parent/Guardian **Date**

Relationship to Child **Date**

Provider Signature **Date**

Bridge City Family Medical Clinic

Patient Responsibilities

Patient Responsibility: Patients are responsible for all charges resulting from treatment by *Bridge City Family Medical Clinic (BCFMC)*. As a service to you we will bill most insurance companies directly; however you are responsible for your account. Payment is due within thirty (30) days of receiving your bill, unless other payment arrangements are made. If your account goes to collection, you will be responsible for all fees incurred. *Patients are responsible for knowing what their insurance will and will not cover.*

Initial visit: At your first visit you will need to pay cast at the time of service. This will establish a credit history with the clinic. You must have your current insurance Card(s) and photo ID. Patients who do not need to pay cast at time of service are those with *HMO/ PPO* insurance, *Medicaid* and *Medicare* insurance, OHP members with the correct doctor (PCP), *Worker's Compensation* and established families with good credit history. You will be asked to pay for your visit if you do not have your current insurance information.

Insurance: You are responsible for deductibles, co pays, noncovered services, coinsurance and items considered "not medically necessary" by your insurance company. Copayments are due at the time of service. The remaining balance should be paid off within one (1) month of notice from the insurance company. If you or your insurance company makes a payment that exceeds your balance, reimbursement will be made. We will bill your primary insurance for you. *Providing correct insurance information is the responsibility of the patient/ guarantor.* Patients must bring their current insurance cards to each appointment. If payment cannot be made at each visit, notify the business office to make other arrangements.

HMO/PPO Plans: *Co-Payments are due at each visit.* You will not receive a monthly unless there is a balance owing from the patient.

Oregon Welfare and Oregon Health Plan: It is your responsibility to bring your current insurance card with you to each visit. If you do not bring your current card to your visit, you will be asked to reschedule your appointment.

Medicare: We are Medicare Providers.

Worker's Compensation: In order to file a Worker's Compensation claim, you will need the name of your insurance carrier, the date of your injury and your claim number. You must notify the scheduler that your appointment is for a worker's compensation injury.

Motor Vehicle or other Liability Claims: We will bill your auto insurance or other liability insurance on (1) time as a courtesy. Settlement of these claims can take several months, full payment for the visit or financial arrangements must be made at the time of service.

Divorced Parents: *BCFMC* will not be responsible for disputes between parents due to a divorce. The parent who brings the child in will be responsible for the bill unless a court order is brought to the appointment showing parent responsibility for bills.

Collection Charges: The Guarantor will be responsible for the cost of collection and/or court costs and reasonable legal fees. Accounts assigned to collections will be charged a fee of \$40.00.

Return Checks: Patients will be charged \$25.00 return check fee for checks that are returned by the bank; further payments must be made in case or money order.

Abusive Behavior: Verbal or physically abusive behavior towards staff will not be tolerated. This type of behavior will result in immediate discharge from the clinic.

Missed/ Late Appointments: You are expected to arrive 10 minutes prior to your scheduled appointment. If you arrive more than 10 minutes passed your scheduled appointment time we will need to reschedule your appointment. If we do need to reschedule your appointment due to being late or not showing up entirely, a \$25.00 charge may be billed to your account. Chronic tardiness and missed scheduled appointments may result in dismissal from the clinic.

Advanced Notice for Appointment Cancellations/ Reschedules: If a cancellation or reschedule is needed for a schedule appointment, BCFMC requires at least a one (1) day prior notice. Failure to cancel an appointment in the given time may result in a fee of \$25.00 billed to your account. Chronic failure to notify staff of cancellations or reschedules in the appropriate time may result in dismissal from the clinic.

Pharmacy: We require seventy-two (72) hours prior notifications on all prescription refills. Refill requests made on Friday will not be available until the following Monday. No refills will be done after hours or on weekends.

I have read and received a copy of the Patient Responsibilities for *Bridge City Family Medical Clinic*. I accept this policy for treatment with *Bridge City Family Medical Clinic*.

Print Patient / Guarantor Name

Signature Patient / Guarantor

Date _____

Bridge City Family Medical Clinic

Phone 503-460-0405

1410 NE 106th Ave, Portland, OR 97220 \

Fax 503-460-0434

Privacy Notice Acknowledgement

To our Patients:

Federal Law requires that we provide you with a copy of our Privacy Notice.

The Privacy Notice explains how we may use and disclose health information about you. We ask that you sign this form for our records so that we may document your receipt of the Notice.

If you have any questions about the Privacy Notice, please feel free to direct these to Privacy Officer at any time. The name and contact number of the Privacy Officer is listed on your copy of the Privacy Notice.

I HAVE RECEIVED A COPY OF THE PRIVACY NOTICE

Print Patient Name

Signature of Patient/ Guardian

Date

Bridge City Family Medical Clinic

Phone 503-460-0405

1410 NE 106th Ave, Portland, OR 97220 \

Fax 503-460-0434

Consent for Release of Protected Health Information

Patient Information

Name: _____ Date of Birth: _____
Street Address: _____ City _____ State _____ Zip _____
Also Known As: _____

I hereby authorize and give my permission to the providers/ individuals listed below to release and/or receive a copy of my record

To Bridge City Family Medical Clinic
FROM THE PARTY NAMED BELOW

From Bridge City Family Medical Clinic
TO THE PARTY NAMED BELOW

To Verbally exchange with
THE PARTY NAMED BELOW

Medical Facility/ Individual Records may be shared with

Name Individual records will be coming from or sent to (Provider, Doctor, Attorney) _____

Facility Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Telephone Number: _____ Fax Number: _____

Record Delivery Method

Fax Mail

Purpose for this Disclosure

Medical Care Legal Eligibility Determination Client Request Other

By **INITIALING BELOW**,

I GIVE MY PERMISSION TO RELEASE: All records from all dates seen by Provider/Clinic.

Physician Reports _____ Radiology Reports _____ Exam Forms _____
Medical Log _____ Immunization Records _____ Laboratory Reports _____
Other _____

Release of the following records & information requires specific authorization: By initialing the spaces below, I specifically authorize the voluntary release of the following medical records, if such records exist. I understand they are protected by Federal & State Law (ORS433.045(3); OAR33312270(8)(a); ORS659.7100). I also understand that I may revoke this authorization at any time to the extent that information has already been released based upon this authorization.

HIV/ AIDS _____ Sexually Transmitted Disease Info. _____ Mental Health Records _____
Genetic Information _____ Drug/ Alcohol Records _____

Patient Consent

My consent may be revoked at any time. The only exception is when the action has already occurred as instructed in the consent. In Oregon, unless revoked earlier, this consent will expire in 120 days from the date of signing or shall remain in effect for the period reasonable needed to complete the request. I understand that by not signing this, I will still be able to receive medical care from Bridge City Family Medical Clinic.

Patient/ Guardian Signature: _____ Date: _____

The information disclosed to you by this authorization is protected by state law (ORS179.505.192.525) & Federal regulations (42 CFR Part 2, 45 CFR Parts 160-164). You are instructed that you may not further disclose this information without the written consent of the person to whom the information pertains. A general authorization for the release of medical information or other information is not sufficient for the purpose of alcohol/ drug treatment records. Federal rules restrict the use of alcohol/drug treatment records to criminally investigate or prosecute any alcohol/drug abuse patient.

These records are being requested for continuity of care. We are requesting this as a medical courtesy and do not offer reimbursement.