



Date :

**Family Information**

Parents' Marital Status:

Married  Divorced  Single  Separated  Widowed

Mother  Step Mother  Other Describe:

Last Name:

First Name:

D.O.B (mm/dd/yyyy):

SSN:

Street Address:

City:

State:

Zip:

Home Phone:

Cell Phone:

Work Phone:

Employer:

Occupation:

Email:

Father  Step Father  Other Describe:

Last Name:

First Name:

D.O.B (mm/dd/yyyy):

SSN:

Street Address:

City:

State:

Zip:

Home Phone:

Cell Phone:

Work Phone:

Employer:

Occupation:

Email:

**Children's Information**

Last Name:

First Name:

D.O.B (mm/dd/yyyy):

Male  Female

Last Name:

First Name:

D.O.B (mm/dd/yyyy):

Male  Female

Last Name:

First Name:

D.O.B (mm/dd/yyyy):

Male  Female

Last Name:

First Name:

D.O.B (mm/dd/yyyy):

Male  Female

Last Name:

First Name:

D.O.B (mm/dd/yyyy):

Male  Female

Preferred Pharmacy:

How did you hear about our practice?

Do you consider your child to be Alaskan or Native American?  Yes  No



303-688-5226  
Fax: 303-814-0717  
2352 Meadows Blvd. Suite 170  
Castle Rock, CO 80109

### Insurance Information

Guarantor's Name:

Relationship to Patient:

**Primary Insurance Name:**

ID Number:

Group Number:

Copay Amt:

Effective Date:

Subscriber's Full Name:

Subscriber's D.O.B:

(mm/dd/yyyy)

**Secondary Insurance Name:**

ID Number:

Group Number:

Copay Amt:

Effective Date:

Subscriber's Full Name:

Subscriber's D.O.B:

(mm/dd/yyyy)

***I hereby authorize my insurance carrier(s) to pay directly to Pediatrics at the Meadows, P.C. I am responsible to pay for non-covered services and authorize the release of information to my insurance carrier for billing and payment purposes.***

### Patient Contact Information

*We may need to contact you regarding treatment, test results, or when we confirm an appointment. Please complete the following:*

**Primary Phone Number:**

It is okay to leave a message at this number with (name):

It is okay to leave a voicemail at this number

Please leave a call back number only at this number

**Secondary Phone Number:**

It is okay to leave a message at this number with (name):

It is okay to leave a voicemail at this number

Please leave a call back number only at this number



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Thank you for choosing Pediatrics at the Meadows, P.C. to care for your child(ren)! We look forward to partnering with you in managing your child's health and development.

### **Financial Policy**

It is mutually beneficial that you understand our financial policies. If you have any questions, please feel free to call us and we will be happy to provide clarity.

Payment for services is due and payable at the time of service. We accept cash, check, Visa, MasterCard, Discover or American Express. If your check is not honored by your financial institution, an additional \$25.00 fee may be assessed.

We no longer accept new patients with Medicaid. Effective 11/1/17, if you are a new patient to this practice and change your insurance to Medicaid within the first six months, you will need to transfer the care of your child/children to a new physician. This policy does not affect current families who are covered by Medicaid and add children or current families that switch to Medicaid coverage.

Copays are due before services are rendered. The payment of copays is a part of your contract with your insurance company, and we are required to collect these copays from you. If you have insurance, we will file a claim to your insurance company on your behalf. It is your responsibility to know your plan benefits. Please provide complete and current insurance information at each visit.

We only mail statements out if there is a balance due by you, including deductibles, coinsurance or non-covered services. A fee of \$12.00 may be added to your balance each month a statement is generated after the initial statement is sent. Failure to pay any balance in full may result in your account being forwarded to a collection company and dismissal of your children from this practice. If an account is forwarded to collection, you may be responsible for any cost of collection, including court and attorney fees. If you are unable to pay the balance in full, please call us to make a payment arrangement. It is important to note that it is your responsibility to request a payment arrangement. The \$12.00 statement fee will be waived while the payment arrangement remains in good standing.

Kindly give at least 24 hours' notice if you need to cancel an appointment. We allow for one missed appointment. After that, a \$40.00 fee may be assessed for a missed appointment.

### **Authorization and Release**

I understand the policies stated and agree to be responsible for payment of all services rendered to my child/children. I authorize Pediatrics at the Meadows, P.C. to release any information including the diagnosis and records of any treatment or examination rendered to my child/children to my insurance company and/or other health practitioners. I authorize my insurance company to pay benefits directly to Pediatrics at the Meadows, P.C. and its physicians.

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**Signature**

**Date (mm/dd/yyyy)**



303-688-5226  
Fax: 303-814-0717  
2352 Meadows Blvd. Suite 170  
Castle Rock, CO 80109

### Notice of Privacy Practices for Protected Health Information (PHI)

I acknowledge that I have been provided with a copy of the Practice's Notice of Privacy Practices.

Child's Name:

D.O.B (mm/dd/yyyy):

Parent Signature:

Print Parent Name (above)

Today's Date (above) (mm/dd/yyyy)

#### For Practice Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify):

# 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.)

American Academy of Pediatrics

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Initial History Questionnaire

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

Liver disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Kidney disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Diabetes (before 55 years old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Bed-wetting (after 10 years old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Obesity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Epilepsy or convulsions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Alcohol abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Drug abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Mental illness/depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Developmental disability	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Immune problems, HIV, or AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Tobacco use	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Additional family history _____					

## Past History DK = don't know

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

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

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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