UPPER VALLEY NATURAL HEALTH CENTER

Pediatric Patient Registration Form

This registration form is to be completed by a parent, guardian, or other legal representative of the patient.

PATIENT INFORMATION

Last Name: _____ First Name:_____MI: ____

Previous Name: _____ Date of Birth: _____ Gender: ____

Mailing Address: _____ Street Address: _____

City: _____ State: _____ Zip:_____

Employer/School:_____ E-mail Address: _____

Cell Phone: _____ Home Phone: _____ Work Phone:_____

Emergency Contact: _____ Contact's Phone(s):_____

Emergency Contact is my: (specify relationship) _____

Mother's Name: _____ Father's Name: _____

How did you hear about us? ❑ *Friend/Family* ❑ *Medical Referral* ❑ *Newspaper Ad* ❑ *Website* ❑ *Yellow Pages*

RESPONSIBLE PARTY INFORMATION please identify the person(s) financially responsible for the patient's account.

Name:_____Phone: _____

Street Address: _____

City: _____ State: _____ Zip:_____

HEALTH INSURANCE INFORMATION Please provide your insurance card(s) for photocopying.

Primary Insurance Company: _____ Insurance Phone: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Patient's Relationship to Subscriber: (check one) ❑ *Self* ❑ *Spouse* ❑ *Child*

Secondary Insurance Company: _____ Insurance Phone: _____

Do you have a **Health Savings Account (HSA)** or **Health Reimbursement Arrangement (HRA)**? _____

PAYMENT IS EXPECTED AT THE TIME OF SERVICE.

This includes amounts due for insurance co-pays and any natural medicines dispensed.
Telephone / email consultations and labs not covered by insurance are the patient's responsibility.
We accept cash, personal checks and credit cards (MasterCard, Visa, American Express, Discover.)
Returned Checks: There will be a charge of $25 for each returned check.
Cancellations: Please provide at least 24 hours advance notice if an appointment needs to be rescheduled or cancelled.
There is a $50 charge for missed appointments or late cancellations.

UPPER VALLEY NATURAL HEALTH CENTER

Contact Preferences

In general, the HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). Individuals have the right to request receipt of confidential communications from us by alternative means or at alternative locations.

I wish to be contacted in the following manner: (check all that apply)

TELEPHONE COMMUNICATION: appointment reminders, requests to call office on billing or medical matters

Cell Phone: _____

- ❑ OK to leave message with detailed information
- ❑ Leave office name and call-back number ONLY

Home Phone: _____

- ❑ OK to leave message with detailed information
- ❑ Leave office name and call-back number ONLY

Work Phone: _____

- ❑ OK to leave message with detailed information
- ❑ Leave office name and call-back number ONLY

WRITTEN COMMUNICATION: appointment reminders, lab results, billing statements

- ❑ Mail to my home address
- ❑ Do NOT mail to home address. Please mail to:

_____

_____

EMAIL COMMUNICATION: administrative matters (supplement re-orders, etc.), conversations with physician via email regarding my health care

Email address: _____

- ❑ OK for administrative use
- ❑ OK for medical consultations

I understand that information sent via email is not considered secure and may result in the accidental disclosure of personal health information.

_____
Patient's Name (PRINT)

_____
Signature of Parent / Guardian / Representative

_____
Name of Patient's Parent / Guardian / Representative (PRINT)

_____
Relationship to Patient

_____
Date

(OVER)

FOR OFFICE USE ONLY: Record of Disclosures						
Date	Disclosed to Whom	Authorized	Purpose	By Whom Disclosed	Type	Method

Type key: T=Treatment Records, P=Payment Information, O=Healthcare Operations; A=Authorization on file; D=Discretionary

UPPER VALLEY NATURAL HEALTH CENTER

Patient Agreement

Please initial each section of this agreement and sign at the end.

CONSENT TO CARE **PARENT/GUARDIAN INITIALS: ____**

I wish to be treated by the health care provider(s) at Upper Valley Natural Health Center. I understand that this care may include any of the following procedures and therapies as necessary to properly evaluate, diagnose and treat my health concerns: physical exams; diagnostic imaging (X-rays, ultrasound, etc.); venipuncture, Pap smears and other specimen collection for diagnostic labwork; dietary and lifestyle counseling; botanical medicines, homeopathic medicines, nutrient therapy (including oral and intramuscular injection); soft tissue and bony manipulations; hormonal therapies and prescription medications.

I am entitled to receive clear and understandable information about the treatment options for my health concerns. I understand that I may ask questions regarding my individual treatment and that I am free to refuse any specific procedure or treatment or to terminate care at any time. I have the right to seek a second opinion from another health care professional. With this knowledge, I consent to the routine evaluation and treatment deemed necessary or advisable by the health care provider(s) responsible for my care, realizing that no guarantees have been given to me by Upper Valley Natural Health Center.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION **PARENT /GUARDIAN INITIALS: ____**

I agree to authorize Upper Valley Natural Health Center to use and/or disclose my health information as necessary to treat me, to obtain payment for services, and to conduct other internal health care operations as described in the Notice of Privacy Practices.

In addition, I authorize Upper Valley Natural Health Center to disclose my protected health information (PHI) and/or discuss my care with the following specific individuals:

Physicians:_____

Other Healthcare Practitioners: _____

Family Members or other Individuals: _____

AUTHORIZATION TO ASSIGN INSURANCE BENEFITS **PARENT /GUARDIAN INITIALS: ____**

If I have health care insurance, I agree that Upper Valley Natural Health Center (UVNHC) may bill these insurers and they may make their payments directly to UVNHC. I understand that I am liable to UVNHC for all related charges, whether or not covered by insurance, and the amount I am charged by UVNHC will be based on the benefits of my individual policy.

STATEMENT OF FINANCIAL RESPONSIBILITY **PARENT /GUARDIAN INITIALS: ____**

I acknowledge that I am legally responsible for all charges for the services provided to me by Upper Valley Natural Health Center to the extent that those charges are not covered or paid by my insurance carrier/health plan or other payment source such as Medicare or Medicaid. I understand that my insurance carrier/health plan may not approve or pay for the medical services provided by Upper Valley Natural Health Center. I understand that I am personally responsible for payment of all charges not paid in full, co-payments, policy deductibles, and co-insurance, *except where my liability is limited by contract or State or Federal law*. **(OVER)**

NON-COVERED AND/OR NON-MEDICALLY NECESSARY SERVICES **PARENT /GUARDIAN INITIALS: ____**

I acknowledge that I am legally responsible for all charges associated with the provision of non-covered and/or non-medically necessary services. I understand Upper Valley Natural Health Center is not responsible for ensuring that I understand which services are not covered or are not considered medically necessary by my insurance carrier/health plan *except where required by contract or State or Federal law*. I understand it is my responsibility to review my insurance plan benefits and accept responsibility for payment should I choose to proceed with care.

PATIENT POLICIES **PARENT /GUARDIAN INITIALS: ____**

I acknowledge that I have received and understand the policies for patients as written in the Welcome Letter.

_____ _____

Patient's Name (PRINT) **Signature of Parent / Guardian / Representative**

_____

Name of Patient's Parent / Guardian / Representative (PRINT)

_____

Relationship to Patient

_____

Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been offered a copy of Upper Valley Natural Health Center's Notice of Privacy Practices that outlines the types of uses and disclosures that may occur involving my protected health information, describes my rights, and explains how I may exercise those rights. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted or required by law. I understand that if I have questions or complaints, I may contact the Upper Valley Natural Health Center at 802-281-6989. I also understand that I am entitled to receive updates upon request if Upper Valley Natural Health Center amends or changes its Notice of Privacy Practices in a material way.

_____ _____

Patient's Name (PRINT) **Signature of Parent / Guardian / Representative**

_____

Name of Patient's Parent / Guardian / Representative (PRINT)

_____

Relationship to Patient

_____

Date

FOR OFFICE USE ONLY: Unable to Obtain Acknowledgement of Receipt

This section serves as a record of Upper Valley Natural Health Center's good faith effort to obtain written acknowledgement from the patient of receipt of the Notice of Privacy Practices. Patient was given a copy of the notice on: _____.

❑ Patient refused to sign acknowledgement.
❑ Patient is physically unable to sign acknowledgement.
❑ Other: _____

Upper Valley Natural Health Center

Pediatric Health History

Last Name: _____ First Name: _____ MI: _____

Nickname: _____ Date of Birth: _____ Age: _____ Gender: ___

Present Health Concerns: *Please list the top 2 health concerns for your child, including date of onset.*

1. _____

2. _____

What do you believe is causing your child's most important health concerns? _____

_____

What goals do you have for your child's visit today? _____

_____

Healthcare Practitioners: *Please list your child's current medical practitioners with their contact information.*

	Practitioner's Name	Office Name	City	Phone
Pediatrician				
Pharmacy				

Medications: *Please list any prescription drugs or over-the-counter medications your child is currently taking, including supplements (vitamins, minerals, nutrients, herbs, homeopathic remedies, etc.).*

Medication/Supplement	Reason	Date began	Dose

Past Medical History: *Please list the date of or age at each event and describe*

Serious Illnesses and Injuries: _____

Surgeries: _____

Hospitalizations: _____

Date of last physical: _____ Date of last blood tests: _____

Allergies: *Please list any severe or life-threatening allergies to medications, stings, foods, etc.:*

❍ NONE or _____ **(OVER)**

Review of Systems: *Check ☑ symptoms that your child currently experiences.*

Constitutional	Heart & Circulation	Neurological & Cognitive	Skin, Hair, Nails
❍ Appetite change	❍ Heart murmur	❍ Dizziness	❍ Acne
❍ Abnormal weight change	❍ Heart palpitations	❍ Seizures	❍ Dry skin *or* Itchy Skin
❍ Fevers *or* Chills	❍ Fainting	❍ Headaches	❍ Rash *or* Hives
❍ Sweats	❍ Cold hands or feet	❍ Poor coordination	❍ Moles *or* growths
❍ Fatigue	❍ Easy bruising or bleeding	❍ Spaciness	❍ Poor wound healing
Eyes	❍ Blood transfusions	❍ Easily distracted	❍ Hair loss
❍ Eye irritation *or* infection	**Chest & Lungs**	❍ Hyperactivity	❍ Nail Problems
❍ Glasses *or* Contacts	❍ Shortness of breath	❍ Learning disability	**Bladder & Kidney**
❍ Blurred *or* Double vision	At rest Walking Lying down	**Mental & Emotional**	❍ Frequent / Urgent urination
Ears, Nose, Mouth, Throat	❍ Wheezing *or* asthma	❍ Mood swings	❍ Recurrent infections
❍ Ringing in ears	❍ Cough: wet *or* dry	❍ Anger, frustration, irritability	❍ Bed Wetting
❍ Earaches	**Digestion & Intestines**	❍ Sadness *or* depression	❍ Daytime accidents
❍ Itchy ears	❍ Bad breath	❍ Anxiety *or* worry	**GIRLS: Reproductive**
❍ Excessive ear wax	❍ Excessive thirst	❍ Phobias	❍ Vaginal itching or soreness
❍ Hearing loss *or* hearing aid	❍ Difficulty swallowing	❍ Insomnia *or* disrupted sleep	❍ Vaginal discharge
❍ Nosebleeds	❍ Belching	❍ Nightmares	❍ Sores on genitals
❍ Stuffy *or* Runny nose	❍ Heartburn *or* Reflux	❍ Social difficulties	Age period started: _____ yrs
❍ Postnasal drip	❍ Nausea	**Development**	Length of cycle: _____ days
❍ Sinus problems	❍ Vomiting	Sit up: _____ months	Length of flow: _____ days
❍ Change in taste *or* smell	❍ Abdominal pain *or* cramping	Crawl: _____ months	❍ Irregular menstrual cycle
❍ Cavities or Dental problems	❍ Gas or Bloating	Walk: _____ months	❍ Heavy periods
❍ Grinding teeth	# Bowel movements/ day: ____	First tooth: _____ months	❍ Painful periods
❍ Gum problems	❍ Constipation	First word: _____ months	❍ Premenstrual syndrome
❍ Mouth sores	❍ Loose stools *or* Diarrhea	First sentence: _____ months	**BOYS: Reproductive**
❍ Dry mouth	❍ Mucus in stool	Toilet trained: _____ months	❍ Undescended testes
❍ Sore throat	❍ Blood in stool	**Birth Complications**	❍ Testicle lump/swelling/pain
❍ Hoarseness	❍ Anal pain *or* itching	In utero exposures:	❍ Sores on genitals
Immune System	❍ Bowel Incontinence	❍ Tobacco	❍ Urethral Discharge
❍ Frequent infections	**Muscles, Bones & Joints**	❍ Alcohol	**Safety**
❍ Allergies to environment	❍ Joint pain	❍ Recreational Drugs	❍ Car Seat or Seatbelt
❍ Sensitivity to foods	❍ Joint swelling	❍ Medications	❍ Bike/ski/skate Helmet
❍ Sensitivity to chemicals	❍ Muscle pain *or* cramps	❍ Premature birth _____ wks	❍ There are guns or weapons at home
❍ Lymph gland swelling / pain	❍ Poor muscle tone	❍ Birth Trauma *or* Injury	

Immunizations: *Please indicate your child's immunization status.*

❍ All immunizations up to date ❍ Delayed schedule ❍ Refused all immunizations

Childhood Illnesses: *Please check ☑ all that apply:* Your child's health is: ❍ Good ❍ Fair ❍ Poor

❍ Chicken Pox	❍ Mononucleosis (Mono)	❍ Rheumatic Fever
❍ Diphtheria	❍ Mumps	❍ Tonsillitis
❍ Ear Infections (recurrent)	❍ Pertussis (whooping cough)	❍ Scarlet Fever
❍ German Measles (Rubella)	❍ Pneumonia	❍ Strep Throat (recurrent)
❍ Measles	❍ Polio	❍ Positive TB test

❍ Other: _____

Personal and Family Medical History: *Check ☑ each condition that applies to <u>your child</u> or <u>his/her biological family members</u>.* **Key: P**=Paternal; **M**=Maternal; **GF**=Grandfather; **GM**=Grandmother

		Parents		Grandparents				Siblings				
	Child	**Mom**	**Dad**	**MGM**	**MGF**	**PGM**	**PGF**					
Current Age / Age at Death ⇨												
☑ Check if DECEASED ⇨		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anemia												
Bleeding *or* Clotting Disorder												
Seasonal Allergies												
Eczema												
Asthma												
COPD / Emphysema												
Diabetes												
Thyroid disorder												
Osteoporosis												
Arthritis / Joint Disease												
Autoimmune Disease												
Celiac Disease												
Crohn's Dis. / Ulcerative Colitis												
Liver Disease / Hepatitis												
Gall Bladder Disease												
Kidney Stones *or* Disease												
Heart Attack / Heart Disease												
High Blood Pressure												
High Cholesterol												
Stroke												
Migraines												
Epilepsy *or* Seizures												
Alzheimer's *or* Dementia												
Tobacco / Alcohol / Drug Abuse												
Disordered Eating or Exercising												
Abuse or Trauma												
Anxiety / Panic Attacks / PTSD												
Depression / Suicide attempt												
Schizophrenia												
Cancer *(what type?)*												
Other:												

Social History

Parents: ❍ Biological ❍ Adoptive ❍ Foster ❍ Step-parent(s)

Parents' Marital Status: ❍ Single ❍ Significant Other ❍ Married ❍ Civil Union ❍ Divorced ❍ Widowed

Mother's Occupation:_____ Full *or* Part Time Father's Occupation:_____ Full *or* Part Time

Siblings: ❍ *Yes* ❍ *No* Please list their age(s) _____

Household: ❍ Parent(s) ❍ Sibling(s) ❍ Grandparent(s) ❍ Pet(s) _____

❍ Other _____

Pre-School/Daycare/School: _____ Hours per day:____ Days per week: ____ **(OVER)**

Personality and Habits:

How does your child react to stressful events? _____

What are your child's primary sources of stress? _____

How much does stress impact your child's life? _____ Hours of play per day? _____

Favorite activities? _____

Does your child:

Get exercise regularly? ❍ Yes ❍ No What kind? _____

Sleep soundly and wake rested? ❍ Yes ❍ No If no, why? _____

Sleep: _____ hours per night Naps: _____ hours per day

Play well with others? ❍ Yes ❍ No If no, why? _____

Enjoy time alone? ❍ Yes ❍ No If no, why? _____

Have sensory sensitivities? ❍ Yes ❍ No What kind? _____

Have strong fears or phobias? ❍ Yes ❍ No What kind? _____

Have rituals/repetitive behaviors? ❍ Yes ❍ No What kind? _____

Diet:

Infant Feeding: ❍ Breast Fed for_____ months ❍ Formula Fed for ____months Type of formula: _____

Age Solid Foods Begun: _____ months First Foods: _____

Age of Introduction for: Milk /Dairy: _____ months Wheat: _____ months

Does your child have any dietary restrictions? _____

Your child's favorite foods? _____

Foods your child refuses? _____

How is your child's appetite? _____ Thirst? _____

Protein Sources: ❍ Beef ❍ Pork ❍ Poultry ❍ Fish ❍ Shellfish ❍ Eggs ❍ Dairy ❍ Soy ❍ Beans ❍ Nuts

Please describe meals for a typical day below:

Breakfast *Time*:_____	Lunch *Time*:_____	Dinner *Time*:_____	Snacks *Times*:_____

Water: _____ oz. per day Other beverages: _____

What else would you like us to know about your child?

This form has been reviewed by the doctor with the parent or guardian.

_____ _____

Signature of Parent or Guardian Date Signature of Doctor Date