

Pediatrics

of Oberlin

Patient's Name: _____ Date of Birth: _____ Age Today: _____

Questionnaire completed by: _____ Relationship to Patient: _____

TO YOUR KNOWLEDGE ARE YOUR CHILD'S IMMUNIZATIONS UP TO DATE? Yes / No

List any medication or foods to which your child may be allergic to and the reaction _____

Please indicate answers by filling in the blanks, or by circling Yes or No:

SOCIAL HISTORY

Family Members

NAME	RELATION TO PATIENT	LIVE IN HOUSEHOLD	DATE OF BIRTH
_____	_____	Yes/ No _____	_____
_____	_____	Yes/ No _____	_____
_____	_____	Yes/ No _____	_____
_____	_____	Yes/ No _____	_____
_____	_____	Yes/ No _____	_____
_____	_____	Yes/ No _____	_____

Is the child yours by: Birth / Adoption / Stepchild / Other _____

If adults in the household work outside the home what childcare arrangements are made for this child?

Are there any cultural concerns we need to be aware of?

PREGNANCY AND BIRTH

Mother's age at birth of child _____

Did mother have any illness during pregnancy? Yes/ No

Did the mother smoke, drink or take illicit drugs while pregnant? Yes / No

Did she take any medications other than vitamins and iron. Yes/ No

What hospital/birth center? _____

Was the baby on time? Yes / No

Was the birth by C-section or vaginal? _____

Obstetrician/Midwife name _____

Pediatrician who saw the baby in the hospital _____

What was the birth weight _____ length _____

Did the baby have any trouble starting to breath? Yes/ No

Did the baby have any problems while in the hospital? Yes/ No

(Jaundice, infections, other?)

What kind? _____

Did the baby receive Hepatitis B vaccine in the nursery? Yes / No

Please note any other important facts:

FAMILY HISTORY

Are the child's parents both in good health? Yes / No

Circle any diseases that the child's siblings, parents, grandparents, aunts, uncles, or 1st cousins have: AIDS, alcohol problems, allergies, asthma, blood disorders, cancer, diabetes, drug problems, epilepsy, heart trouble, high blood pressure, high cholesterol, inherited illness, kidney disease, liver disease, lung disease, lupus, mental illness, multiple sclerosis, muscular dystrophy, SIDS, tuberculosis, venereal disease, ADHD, depression, OCD, anxiety, tics, learning problems, others.

Use this space to note which relative has which disease:

SAFETY AND ENVIRONMENT

Do you live in a private house, apartment, mobile home , other? (Circle)

Do you know the hottest temperature of the water in your pipes Yes/No

Is there a working smoke alarm on each floor in the house? Yes/No

Does this child always use a car seat/ seat belt when a car? Yes/No

Are there any smokers in the house? Yes/No

Are there any problems with the condition of your home? (Peeling paint, insects, rats or mice) Yes/No

Does your child always wear a helmet when riding a bicycle / skateboard or other like activities? Yes/No

Are there pets in the house? Yes/No

If yes, how many and what type? Yes/No

Are there guns in the house? Yes/No

Is there a swimming pool located at the home? Yes/No

PAST MEDICAL HISTORY

Where has your child gone for medical care before coming here?

Date of last check up: _____
Date of last dental check up: _____
Has your child had any allergic reactions to any medications, foods, or insect bites? Yes/ No
Has your child had a bad reaction to any immunizations? Yes/No
If Yes, which ones: _____
Any hospitalizations/ surgeries other than for birth? Yes/No
For what? _____

Any chronic illnesses? Yes/No
If so, please list: _____

Any serious injuries/ broken bones/ stitches? Yes/No
What kind? _____
Are any medications taken regularly? Yes/No
Which ones? _____

Please note any other important facts:

REVIEW OF SYSTEMS

Has your child had frequent ear infections? Yes/ No
Any hearing problems? Yes/ No
Any vision problems? Yes/ No
Has s/he had any problems with teeth? Yes/ No
Does this child have frequent colds or sore throat? Yes/ No
Does s/he have a history of allergies, asthma, pneumonia, bronchitis or recurrent cough? (Circle any which are yes) Yes/ No
Does s/he have a heart murmur or any heart problem? Yes/ No
Any problems with kidneys, bladder or urination? Yes/ No
Any problems with diarrhea or constipation? Yes/ No
Have there been any convulsions or other problems with the nervous system? Yes/ No
Any eczema, hives or other skin conditions? Yes/ No
Has your child ever been anemic? Yes/ No
Has your child ever seen a specialist? Yes/ No
If so, for what? _____

Please note any other important facts:

DEVELOPMENT/BEHAVIOR

(answer if the child is less than 5 years – ONLY)

At what age did this child sit alone? _____
At what age did s/he walk alone? _____
Did s/he say any words by the 15 months of age? Yes/ No
How does this child compare to others his or her age? Same, Advanced, Behind (Circle One)
Are there any problems with sleeping? Yes/ No
(answer if child is older than 5 years – ONLY)
What grade is this child in? _____
Has s/he had any trouble with school? Yes/ No
Does s/he get along well with other children? Yes/ No
If your child has had any of the following, please circle: Nail biting, thumb sucking, bed wetting, bad temper, problems with toilet training, hyperactivity, nightmares, speech problems, problems with discipline, others: _____

FEEDING AND NUTRITION

Current nutrition: breast fed, formula fed, table food. (Circle)
For the first 6 months was this child breast fed or formula fed? (Circle)
If formula fed, which one? _____ Amount _____ oz
If on regular milk, which? Whole, 2%, 1% Amount/day _____
Is your child's appetite usually good? Yes/ No
Is it good now? Yes/ No
Was there severe colic or any other unusual feeding problems during the first three months? Yes/ No
Do any foods disagree with him/her? Yes/ No
Does s/he take vitamins/fluoride? Yes/ No
Which ones? _____

IS THERE ANYTHING ELSE THAT SHOULD BE IN THIS PATIENT'S MEDICAL RECORDS?

Notice of Privacy Practices
Kidz First Pediatrics of Oberlin, LLC

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions about this Notice please contact: John R. Sanderson, DO at 440-775-1555.

This Notice of Privacy Practices describes how we may use and disclose your **Protected Health Information (PHI)** to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. "PHI" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all PHI that we maintain at that time. You may request a revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or by asking for one at the time of your next appointment.

Uses and Disclosures of Protected Health Information

Uses and Disclosures of PHI Based upon Your Written Consent: You will be asked by your physician to sign a consent form. Once you have consented to use and disclosure of your PHI for treatment, payment and health care operations by signing the consent form, your physician will use or disclose your PHI as described in this Section 1. Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your PHI may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice.

Following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make once you have signed our consent form. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided consent.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your PHI. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. We will also disclose PHI to other physicians who may be treating you when we have the necessary permission from you to disclose your PHI. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to quality assessment activities, employee review activities, training of medical students and residents, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We will share your PHI with third party "business associates" that perform various activities (e.g., billing, and transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI.

We may use or disclose your PHI, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your PHI for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Contact and request that these fundraising materials not be sent to you.

Uses and Disclosures of PHI Based upon Your Written Authorization

Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your PHI in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your PHI. If you are not present or able to agree or object to the use or disclosure of the PHI, then your physician may, using professional judgement, determine whether the disclosure is in your best interest. In this case, only the PHI that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your PHI in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your PHI to treat you.

Communication Barriers: We may use and disclose your PHI if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgement, that you intend to consent to use or disclosure under the circumstances.

I have received a copy of the Notice of Privacy Practices as published by Kidz First Pediatrics of Oberlin, LLC, and further understand that I can address questions, comments, and complaints to Dr. Sanderson.

Signature

Print Name

Date

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your PHI in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your PHI to the extent that law requires the use or disclosure. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury, or disability. We may also disclose your PHI, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and civil rights laws.

Abuse or Neglect: We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI if we believe that you have been a victim of abuse, neglect, or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your PHI to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. PHI may be used and disclosed for cadaveric organ, eye, or tissue donation purposes.

Research: We may disclose your PHI to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your PHI, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: we may disclose your PHI as authorized to comply with workers' compensation laws and other similar legally established programs.

Inmates: We may use or disclose your PHI if you are an inmate of a correctional facility and your physician created or received your PHI in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

Your Rights

Following is a statement of your rights with respect to your PHI and a brief description of how you may exercise these rights.

You have the right to inspect and copy your PHI. This means you may inspect and obtain a copy of PHI about you that is contained in a designated record set for as long as we maintain the PHI. There will be a reasonable fee imposed for duplicating your personal copy of your PHI. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI. Depending on the circumstances, a decision to deny access may be revisable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if you have questions about access to your medical record.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by **contacting the practice administrator in writing.** We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You may have the right to have your physician amend your PHI. This means you may request an amendment of PHI about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. This right applies to disclosures for purposes other than treatment, payment, or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions, and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Kidz First Pediatrics of Oberlin

RECORDS REQUEST

I AUTHORIZE THE USE/DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW.

Patient Name: _____

Patient's Date of Birth: _____

Patient's SSN: _____

A. Person(s) or Organization(s) authorized to provide the information: (records are coming from)

B. Person(s) or Organization(s) authorized to receive the information: **Kidz First Pediatrics
John Sanderson, D.O.
12289 Leavitt Rd. Unit D
Oberlin, OH 44074
Ph: 440-775-1555 Fax: 440-775-1556**

C. Specific description of the information that may be used or disclosed (including date(s)):
All records including immunizations, all notes, labs, consult reports, and other outside reports.

D. Specific description of how the information will be used: **Continued Medical Treatment**

- 1) I understand that this authorization will **expire** on / / .
- 2) I understand that I may **revoke** this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying the person or organization mentioned in A (above) in writing.
- 3) I understand that I can **refuse to sign** this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits if applicable.
- 4) I may **inspect or copy** any information used or disclosed under this agreement.
- 5) I understand that if person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would **no longer be protected** by these regulations.

Patient's Signature or Patient's Representative

Date

Printed Name of Patient's Representative

Relationship to Patient

You have the right to know specifically what information you are authorizing for release (e.g., "results of a lab test performed on 1/4/03" or, if your entire medical record is included, "all health information.").

You have the right to know the name(s) or other identification of the person(s) or organizations(s) authorized to release the information (e.g., the names of your health care provider(s)).

You have the right to know who is going to use it and what it is going to be used for (e.g., John Smith, PhD / Research).

You have the right to alter this request. We have preprinted options for your convenience. You may alter these Items if needed.

You have the right to receive a copy of this form.