Healthy Kidz Pediatrics

PATIENT REGISTRATION (REGISTRO DE PACIENTE)

Nombre				Mr Mr.C.
Date of Birth	Male/ Hombre	Social Security #	Phone	
Fecha de Nacimiento	Female/Mujer			
Address:		City	State/Zip	-
Domicilio	_	Ciudad	Estado/Codigo Posta	al
School		50		
Escuela		E-mail ac		
Father/Guardian		D.O.B.	SS#	
raure/Guardian			# de SS	
Phone		Mobile Phone	Employment	
releptono				
Mother/Guardian		D.O.B.	SS#	
		Fecha de Nacimiento		
mergency Contact			Phone	
Contacto de Emergencia				
Closet Relative			Phone	
	_		Telefono	
Person Responsible			Relationship	
ersona Responsible			Parentesco al	Paciente
Address			Phone	
Jomicilio:			Telefono	
Aseguranza		cha Efectiva		
1 Insurance Aseguranza		fective Date	Address	
City		ate/Zip	Phone	
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	Es		Phone Telefono	
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Health History

Joints

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Sex O Male	Race			Social Security #	-	DOB	
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-	Name)	_	DOB	Occupation		Education
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Have any of the child's brothers or sisters died? If YES, give age and cause. ○ Yes□ ○ No Have any of the child's blood relatives had the following diseases? If YES, please list family member. Heart disease С O Yes□ O No Ĺ. Tuberculosis O Yes□ O No \Box High Blood Pressure O Yes□ O No С Kidney Disease O Yes□ O No Allergies/Asthma O Yes□ O No Cancer O Yes□ O No Diabetes O Yes□ O No Mental/Emotional Problems J O Yes□ O No J Sickle Cell O Yes□ O No J Setzures O Yes□ O No • • • DEVELOPEMENT • • • Do you have any concerns about the following? If YES, please explain. Developement O Yes□ O No 3 Behavlor O Yes∃ O No **Eating Habits** O Yes□ O No Sleeping Habitts O Yes□ O No] School Experience O Yes□ O No IJ Bathroom/Toilet Habits O Yes□ O No \Box Discipline. O Yes□ O No Otner (explain) J O Yes O No IMMUNIZATIONS WILL BE COPIED ON IMMUNIZATION RECORD BY OFFICE STAFF • • • This Section is for Teenagers and is to Completed by the Teenager • • • Notes: Do you: Use Tabacco? O Yes□ O No Drink Beer or other Alcoholic Beverages? Use any kind of drugs? O Yes O No. (For Females) How old were you when you had your first period?_ Are you sexually active? O Yes□ O No If YES, do you use birth control? O Yes□ O No Have you ever been pregnant or fathered a child? O Yes□ O No Do you have any concerns about the following? If YES, please explain. Safety Issues O Yes□ O No _ Substance Use (drugs, alcohol, tabacco) O Yes□ O No _ Sexually transmitted Diseases O Yes□ O No _____ Family Planning O Yes ☐ O No _____ Other (explain) O Yes⊡ O No _____ O Yes: 1 () No

Date

· · · FAMILY HISTORY

Reviewed By

Vaccines for Children (VFC) Program Patient Eligibility Screening Record

A record of all children 18 years of age or younger who receive immunizations must be kept in the health care provider's office for 6 years. The record may be completed by the parent, guardian, individual of record, or by the health care provider. VFC eligibility screening and documentation of eligibility status must take place with each immunization visit to ensure the child's eligibility status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine. Providers using a similar form (paper-based or electronic) must capture all reporting elements included in this form.

3/53			mo) muot oupture	an reporting elem	ents included in [iii	S IOIIII.		
1.	Child's Name	<u> </u>		4 1 1 4 4	_ps	. * .		
		Last Name		First	Name	Marin da	MI	
2.	Child's Date of	of Birth:/	J					
3.	Parent/Guard	ian/Individual of R	ecord.					
		ian in	Last Name		First Name		MI	•
4.	Primary Provi	der's Name:						
		Last N			Name		MI	
5.	immunization	encounter/visit en	h 18 years of age) ter the date and m	ark the appropriat	ive federal vaccine te eligibility categor ible for federal VFC	y. If Column A-	C and state progra D is marked, the ch	ms, at each nild is eligible for
7			Eligible for	VFC Vaccine		Not	eligible for VFC	Vaccine
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		*: A	Saw Bir Ag	SEE/C	60% D		Fig.	G
	Date	Medicaid Enrolled	No Health Insurance	American Indian or Alaskan Native	arne *Underinsured served by FQHC, RHC or deputized provider	Has health insurance that covers vaccines	**Other underinsured	***Enrolled in KidsCare
					orne:			
Clinic progra	(RHC) or under a m in order to vacc	n approved deputized cinate underinsured cl	provider. The deputize pildren.	urea chilaren must be ed provider must havi	nly covers specific vac vaccinated through a l e a written agreement v	Federally Qualified I vith an FQHC/RHC	Health Center (FQHC) (and the state/local/terri	or Rural Health torial immunization
** Oth	er underinsured a. VRHC or a deputiz	re children that are un red provider. Howeve	derinsured but are not r, these children may b	eligible to receive fed se sêrvêd if vaccines	leral vaccine through th are provided by ไก๊ฮ sta	e VFC program bed nas nemn te program to cover	cause the provider or fa these non-VFC eligible	cility is not a children.
***Chii	idren enrolled in s	eparate state Children	's Health Insurance Pr	noram (CHIP) Thes	e children are considen administered through pa	ad incomed and	1 5 77 5	
Please	e be advised:		эт Э					
If you	er insurance con red. We cannot	mpany does not co	ver immunizations	and you do not let	us know at the tim	e of the visit, it i	s your responsibilit	y to pay the cost
	· · · · · · · · · · · · · · · · · · ·	unsure if immuniz	rations and well che	am retroactive and ck-ups are covered	d you are only eligib l, please contact you	le for the Vaccin r insurance com	es for Children Pro Dany.	gram at the time
Thani	k You.		· months ()			į	, — "	
Please			derstand and agree		3 9	·		



MEDICAL RECORD RELEASE AUTHORIZATION

Previous Medical	Provider or Facility Name:	
Address:		
Phone:		
From:	HEALTHY KIDZ PI 215 SOUTH POWEI MESA, AZ 85206	
Kidz Pediatrics it's em NCLUDE ALL CON 86-661) CONFIDENT A.R.S. SECTION 36-6 AS DEFINED IN 4	ployee or agents. FOR THE FIDENTIAL HIV-RELATEI IAL COMMUNICABLE DI 561), CONFIDENTIAL ALC	ential medical records to possession or control of Healthy PURPOSES HEREOF, "MEDICAL RECORDS" SHALL DINFORMATION (AS DEFINED IN A.R.S. SECTION SEASE RELATED INFORMATION (AS DEFINED IN COHOL OR DRUG ABUSE-RELATED INFORMATION SEQ.), AND CONFIDENTIAL MENTAL HEALTH
Patient's Full Nar	me	Date of Birth
Part 2, and other procommunicable dise	ovisions set forth in A.R.S	protected by Code of Federal Regulations, 42 CFR. Sections 36-661, they may include items related to Section 36-661). This request is in compliance with ility act of 1996 (HIPAA).
The inform	ation requested is to be use	ed for the purpose of:
I specifical	ly request the following typ	be of information be released:
been taken in reliar	ization is subject to revoca ace of this consent prior to from the date of signature.	tion at any time, except to the extent that action has revocation. In any event, this authorization expires
Relationship to Pa	rdian: itient: ess:	Date: