Canadian Valley Pediatrics

PATIENT INFORMATION

Patient Name : ☐MALE ☐FEMALE

Date of Birth: _____ **E-MAIL:** _____

Address: _____

PRIMARY NUMBER : _____

_____

SECONDARY NUMBER: _____

_____

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

_____ **Cell:** _____

NAME RELATIONSHIP

FINACIALLY RESPONSIBLE PARTY

Name: _____ **Occupation:** _____

Address: _____

ADDRESS LINE 1 **CELL:** _____

_____

ADDRESS LINE 2 **DOB:** _____

_____

CITY ST ZIP CODE _____

E-Mail: _____

INSURANCE INFORMATION

Primary Insurance: ..... **Effective:** .....

Carrier's Name: ..... **Date of birth:** .....

ID Number: ..... **Group Number:** .....

Secondary Insurance: ..... **Effective:** .....

Carrier's Name: ..... **Date of birth:** .....

ID Number: ..... **Group Number:** .....

Please sign and date below.

Sign: _____ **Date:** _____

DR. DINA BOWEN, MD CANADIAN VALLEY PEDIATRICS* * 1804 COMMONS CIRCLE STE B. YUKON, OK 73099* *(405)577-6700* *FAX (405)265-4135*

Canadian Valley Pediatrics

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Updated 2020

Child's Name: ..... **Date of Birth:** .....

I understand and agree that all co-pays and outstanding balances are due at the time of my appointment. I may be charged $25 for any calls after regular business hours that are considered ***non- emergent*** in nature, this does include medication refills. If your child has a true medical emergency and needs immediate treatment, call 911 or go to the OU Children's hospital or Integris Baptist hospital on NW Expressway. Dr. Bowen and staff reserve the right to terminate patient care at any point.

The Practice is authorized to disclose my child's medical information and remind me of appointments on my home answering machine, voicemail, text or email. ***Please note: any appointment reminder given to the patient by our practice is a courtesy.*** It is the patients responsibly to be aware and keep all appointments. There may be a $25 charge for ALL missed appointments, if a 24 hour notice is **NOT** given.

I understand and agree I will be held responsible for all charges incurred for services rendered. Regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. If I am unable to pay for services rendered in a timely manner, all claims will be turned over to collections. I authorize direct payment to be made to the office of Dr. Dina Bowen, M.D. (the Practice) for any and all medical services rendered. **Please note:** Your insurance plan is a contract between you and your insurance company. Our office provides the medical service and file claims on your behalf. We do our best to provide any information available to us from your insurance company. However, it remains the policy holder's responsibility to know their policies and specific coverage. You will be responsible for any services that your insurance does not cover. You should familiarize yourself and anyone listed below, that has permission to bring your child to the doctor, with the insurance policy

I hereby authorize the office of Dr. Dina Bowen to release any information concerning my health care, advice, treatment or services provided. This information is to be used in administering medical claims and/or discussing treatment options with insurers and/or other medical providers outside of the Practice, when necessary, so that these providers may treat my child; seek payment for treatment and for the purpose of their health care operations. I authorize the Practice to disclose my child's medical information so that the Practice may treat my child, seek payment from third parties for such treatment, and generally carry on the Practice's health care operations (e.g. quality assurance).

The following family members/ friends have my permission to accompany my child to his/her medical appointment: (please print only people over the age of 18 and their relationship to the patient. For example: Tom Jones, grandfather)

_____

_____

_____

I have reviewed the Notice of Privacy Practice. I understand I may receive a printed copy of this information upon verbal or written request now or in the future. To the best of my knowledge, all of the preceding answers are correct. ***If I have any changes in my health status, medication changes, address changes, phone numbers or insurance changes, I shall inform the doctor and staff at the next appointment without fail.***

By signing below, I acknowledge that I have read and understand the statements mentioned above.

Sign: _____ **Date:** _____

HEALTH HISTORY QUESTIONAIRE

NAME _____ BIRTHDATE _____ CITY OF BIRTH _____

HOSPITAL OF BIRTH _____ OBSTETRICIAN _____

PREGNANCY: (MOM)

ANY ILLNESSES? _____ ANY MEDICINES? _____

DID YOU SMOKE? _____ USE ALCOHOL? _____ USE RECREATIONAL DRUGS? _____

WAS BABY EARLY OR LATE? _____ C-SECTION? _____ ANESTHESIA? _____

ANY OTHER PROBLEMS: _____

PERINATAL:

BIRTHWEIGHT _____ DID BABY CRY RIGHT AWAY? _____ APGARS _____

REQUIRE OXYGEN? _____ IV? _____ WAS BABY JAUNDICED (YELLOW)? _____

DAYS IN HOSPITAL _____ IF BREAST FED, HOW LONG? _____ IF BOTTLE FED, WHAT FORMULA? _____

SINCE BIRTH, LIST ANY OF THE FOLLOWING THAT APPLY, INCLUDING DATES:

ILLNESSES _____

_____

HOSPITALIZATIONS _____

SURGERIES _____

ALLERGIES OR REACTIONS TO MEDICATIONS _____

MEDICINES NOW TAKING _____

IMMUNIZATIONS:

PLEASE GIVE THE RECEPTIONIST A COPY OF THE PATIENT'S IMMUNIZATION RECORD SO WE MAY HAVE A COPY FOR THE RECORD.

SCHOOL:

CURRENT GRADE _____ SPECIAL EDUCATION? _____ NAME OF SCHOOL _____

USUAL GRADES: A-B B-C C-D D-F ANY PROBLEMS? _____

LIST THOSE WHO CURRENTLY LIVE IN THE HOME, THEIR DATE OF BIRTH, AND HEALTH STATUS:

1. _____ DOB: _____ Health: _____
2. _____ DOB: _____ Health: _____
3. _____ DOB: _____ Health: _____
4. _____ DOB: _____ Health: _____
5. _____ DOB: _____ Health: _____
6. _____ DOB: _____ Health: _____

OTHER:

DOES YOUR CHILD GO TO A SITTER? _____ DAYCARE? _____ PRESCHOOL? _____

IF YES, WHERE? _____

HEALTH HISTORY QUESTIONAIRE

NAME_____ **AGE**_____ **BIRTHDAY** _____

MEDICAL CONDITIONS	HAS CHILD HAD?		*CHILD'S FAMILY?		WHO?
NERVE OR MUSCLE DISORDERS	YES	NO	YES	NO	
BROKEN BONES/ BONE DISEASE	YES	NO	YES	NO	
BIRTH DEFECTS	YES	NO	YES	NO	
FREQUENT EAR INFECTIONS	YES	NO	YES	NO	
CYSTIC FIBROSIS	YES	NO	YES	NO	
MUMPS, MEASLES, CHICKEN POX	YES	NO	YES	NO	
WHEEZING/ ASTHMA	YES	NO	YES	NO	
PNEUMONIA/ CROUP	YES	NO	YES	NO	
EYE PROBLEMS/ POOR VISION	YES	NO	YES	NO	
DENTAL PROBLEMS	YES	NO	YES	NO	
HEARING PROBLEMS	YES	NO	YES	NO	
HAY FEVER/ ALLERGIES	YES	NO	YES	NO	
ECZEMA/ SKIN PROBLEMS	YES	NO	YES	NO	
ANEMIA/ BLOOD PROBLEMS/ EASY BLEEDING	YES	NO	YES	NO	
ARTHRITIS	YES	NO	YES	NO	
ULCERS/ STOMACH PROBLEMS	YES	NO	YES	NO	
BLOOD TRANSFUSIONS	YES	NO	YES	NO	
DIARRHEA/ CONSTIPATION	YES	NO	YES	NO	
HEART ATTACK BEFORE AGED 55 YEARS	YES	NO	YES	NO	
LEARNING DISORDERS/ SCHOOL PROBLEM	YES	NO	YES	NO	
MENTAL RETARDATION	YES	NO	YES	NO	
KIDNEY/ BLADDER PROBLEMS/ BEDWETTING	YES	NO	YES	NO	
DIABETES	YES	NO	YES	NO	
SEIZURES/ CONVULSIONS	YES	NO	YES	NO	
HEART DISEASE/ ABNORMAL HEART RHYTHMS AS A CHILD OR TEENAGER	YES	NO	YES	NO	
HIGH BLOOD PRESSURE	YES	NO	YES	NO	
HIGH CHOLESTEROL	YES	NO	YES	NO	
LUNG DISEASE/ TUBERCULOSIS	YES	NO	YES	NO	
SEXUALLY TRANSMITTED DISEASES/ HIV	YES	NO	YES	NO	
MENTAL/ EMOTIONAL DISORDERS	YES	NO	YES	NO	
THYROID DISEASE	YES	NO	YES	NO	
CHILDHOOD CANCER	YES	NO	YES	NO	
MIGRAINES/ HEADACHES	YES	NO	YES	NO	
MONO/ HEPATITIS/ LIVER PROBLEMS	YES	NO	YES	NO	
SMOKE OR USE TOBACCO	YES	NO	YES	NO	
CONSUME ALCOHOLIC BEVERAGES	YES	NO	YES	NO	
USE RECREATIONAL DRUGS	YES	NO	YES	NO	
DEATH OF ANY SIBLING	YES	NO	YES	NO	
SIDS/ APNEA/ SNORING/ SLEEPING ISSUES	YES	NO	YES	NO	
FREQUENT TONSILLITIS/ SINUSITIS	YES	NO	YES	NO	
ADENOID PROBLEMS	YES	NO	YES	NO	
LUPUS/ AUTOIMMUNE DISORDERS	YES	NO	YES	NO	

**** FAMILY INCLUDES ONLY PARENTS, SIBLINGS AND GRANDPARENTS OF CHILD***