Caldwell IMMEDIATE CARE

2523 S 10th Ave.
Suite 103
Caldwell, ID 83605

Phone: (208) 459-7788
Fax: (208) 455-3277
www.cicimmediatecare.com

PEDIATRIC INTAKE FORM

Please fill out this form completely as possible. This information will help us to better assess your child.

Today's date:	Preferred language:
Person completing form:	Relationship to patient:

PATIENT INFORMATION

First name:		Last name:		
Date of birth:	Age:	Sex:	❑ Male	❑ Female
Permanent address:				
City:	State:	Zip		
SSN:	Home phone:	Cell phone:		
Email:				
Have you been seen here before?			❑ Yes	❑ No

PARENT(S) INFORMATION

Mother's first name:		Mother's last name:	
Father's first name:		Father's last name:	
Other guardian first name:		Other guardian last name:	
Who is the patient's primary caretaker?	❑ Mother	❑ Father	❑ Other (please specify):

INSURANCE INFORMATION

(please provide copies)

❑ *Check here if patient is uninsured*

Name of Insurance Company:	Subscriber's Name
Subscriber's DOB:	Subscriber's phone number:
Policy Number (ID):	Group Number:

PREGNANCY HISTORY

Were there any problems in the pregnancy? *Please check all that apply.*	❑ Yes	❑ No	❑ Unknown
Bleeding	❑ Hospitalization	❑ Surgery	
❑ Diabetes	❑ Premature Labor	❑ Toxemia	
❑ High blood pressure	❑ Pre-eclampsia	❑ Other:	
❑ Infection(s), please specify:			

Were any medications or drugs used in the pregnancy? *Please check all that apply.*	❑ Yes	❑ No	❑ Unknown
❑ Alcohol *(amount):*	❑ Smoking *(amount):*		
❑ Prescription medication *(please specify):*	❑ Other drugs *(please specify):*		
❑ Prenatal Vitamins	❑ Folic Acid		
❑ Other:			

Were any medications or drugs used in the pregnancy? *Please check all that apply.*	❑ Yes	❑ No	❑ Unknown
❑ Alcohol *(amount):*	❑ Smoking *(amount):*		
❑ Prescription medication *(please specify):*	❑ Other drugs *(please specify):*		
❑ Prenatal Vitamins	❑ Folic Acid		
❑ Other:			

Delivery:			
Mother's age at delivery:		Length of pregnancy (weeks):	
Labor: ❑ Spontaneous ❑ Induced, *reason:*		Delivery: ❑ Vaginal ❑ C-section	
Were there any problems during the delivery?	❑ Yes	❑ No	❑ Unknown
Please describe:			

SUMMARY OF PRESENTT ILLNESS/PRIMARY CONCERN

What is your child's primary medical concern?

BIRTH HISTORY

(For patients under age of 1 year)

Weight:	Length:	Head circumference:
Apgars scores if known:	Days spent in the hospital:	
Did your child spend time in the NICU (Neonatal intensive care unit)?	❑ Yes	❑ No
Please explain:		

Were there any medical concerns when the child was a newborn? *Please check all that apply.*		❑ Yes	❑ No
❑ Breathing problems	❑ Jaundice		
❑ Birth defect *(Please specify):*	❑ Low muscle tone		
❑ Feeding problems	❑ Other:		

DEVELOPMENTAL HISTORY

Were you concerned about your child's development? *If yes, at what age?*				❑ Yes	❑ No
How old (in months) was your child when he/she began to:					
Smile:	Roll over:		Sit:	Crawl:	
Pull to stand:	Walk:		Use single words:	Make sentences	
Is your child speech delayed now?				❑ Yes	❑ No
Has your child lost any of the above skills?				❑ Yes	❑ No
Is your child in a special education program right now?				❑ Yes	❑ No
❑ Early Intervention			❑ Inclusion Program		
❑ Special Education classroom			❑ Other:		
Does your child currently receive any special therapy?				❑ Yes	❑ No
❑ Speech *(times per week):*			❑ Occupational therapy *(times per week):*		
❑ Physical therapy *(times per week):*			❑ Other:		
Has your child ever had IQ testing? *If yes, please specify numerical results below.*				❑ Yes	❑ No
❑ Full scale IQ:	❑ Verbal IQ:		❑ Non-verbal IQ:		
Do you have any concerns about your child's behavior? *Please check all that apply:*				❑ Yes	❑ No
❑ ADHD (Attention Deficit Hyperactivity Disorder)	❑ ADD (Attention Deficit Disorder)		❑ OCD (Obsessive Compulsive Disorder)		
❑ Bipolar Disorder	❑ PTSD		❑ Anxiety		
❑ Depression	❑ Self-stimulation		❑ Aggressive		
❑ Frequent tantrums	❑ Self-injury		❑ Atypical sleeping pattern		
❑ Hyperactive	❑ Schizophrenia		❑ Atypical eating habits		
❑ Autism Spectrum Disorder	❑ Other:				

SPECIALIST VISITS

Please list all doctors your child has seen, except primary care doctor and emergency room visits.

Type of Specialist	**Date(s)**	**Doctor/Hospital**	**Reason for visit**	**Notes attached?**	
Genetics				❑ *Yes*	❑ *No*
Cardiology (Heart Doctor)				❑ *Yes*	❑ *No*
Neurology/Neurosurgery				❑ *Yes*	❑ *No*
Ophthalmology (Eye doctor)				❑ *Yes*	❑ *No*
Gastroenterology				❑ *Yes*	❑ *No*
ENT (Ear nose & throat doctor)				❑ *Yes*	❑ *No*
Pulmonologist (Lung doctor)				❑ *Yes*	❑ *No*
Nephrologist (Kidney doctor)				❑ *Yes*	❑ *No*
Orthopedist (Bone doctor)				❑ *Yes*	❑ *No*
Psychiatrist/Psychologist				❑ *Yes*	❑ *No*
Other *(please specify):*				❑ *Yes*	❑ *No*

MEDICAL HISTORY

Does your child have any of the symptoms listed below? *Please check all that apply.*

Skin: ❑ Yes ❑ No

❑ Inability to sweat	❑ Poor wound healing	❑ Unusual birthmarks	❑ Unusual hair
❑ Lumps or growths	❑ Rash	❑ Unusual nails	❑ Other:

Head: ❑ Yes ❑ No

❑ Brain Malformation	❑ Hydrocephalus	❑ Seizures
❑ Dizziness	❑ Large head size	❑ Small head size
❑ Spina bifida	❑ Headaches	❑ Other

Eyes: ❑ Yes ❑ No

❑ Aniridia	❑ Dislocated lenses	❑ Macular degeneration	❑ Retinal disease
❑ Blind	❑ Glaucoma	❑ Nystagmus	❑ Severe myopia
❑ Cataracts	❑ Lazy eye	❑ Poor night vision	❑ Other:

Ears: ❑ Yes ❑ No

❑ Chronic infections	❑ Pits/Tags	❑ Ringing in ears	❑ Unusual shape
❑ Missing ear (s)	❑ Conductive or Sensorineural hearing loss		❑ Other:

Mouth: ❑ Yes ❑ No

❑ Cavities	❑ Crowded teeth	❑ Large tongue	❑ Unusually shaped teeth
❑ Cleft lip or palate	❑ Extra teeth	❑ Missing teeth	❑ Other:

Lungs: ❑ Yes ❑ No

❑ Asthma	❑ Bronchitis	❑ Pneumonia	❑ Emphysema
❑ Shortness of breath	❑ Breathing problems		❑ Other:

Blood: ❑ Yes ❑ No

❑ Anemia	❑ Hemophilia	❑ Low platelets	❑ Unexplained bruising
❑ Blood clots	❑ Leukemia	❑ Low white count	❑ Unexplained bleeding
❑ Cancer *(please specify):*		❑ Other:	

Stomach/Intestines: ❑ Yes ❑ No

❑ Abdominal pain	❑ Inflammatory bowel disease	❑ Tracheoesophageal atresia
❑ Cellac disease	❑ Malrotation	❑ Trouble swallowing
❑ Frequent constipation	❑ Polyps	❑ Ulcers
❑ Frequent diarrhea	❑ Reflux	❑ Vomiting
❑ Hirschsprung disease	❑ Other:	

Bladder/Kidney: ❑ Yes ❑ No

❑ Frequent urination	❑ Reflux	❑ Urinary tract infections
❑ Kidney stones	❑ Renal failure	❑ Other:

Genitalia: ❑ Yes ❑ No

❑ Abnormal external appearance	❑ Absent ovaries	❑ Undescended testicles
❑ Absent uterus	❑ Hypospadias	❑ Other:

Muscle/Joints: ❑ Yes ❑ No

❑ Abnormal electro myelogram	❑ Hypotonia	❑ Muscle pain
❑ Arthritis	❑ Increased joint flexibility	❑ Muscle wasting
❑ Contractures	❑ Joint dislocation	❑ Poor coordination
❑ Hypertonia *(increased muscle tone/spasticity)*	❑ Joint pain	❑ Other:

Skeletal: ❑ Yes ❑ No

❑ Abnormal bone age	❑ Low bone density	❑ Pectus carinatum (pigeon chest)
❑ Fractures without trauma	❑ Scoliosis	❑ Other:
❑ Pectus excavatum (sunken chest)		

Hands and Feet: ❑ Yes ❑ No

❑ Extra fingers or toes	❑ Unusually shaped fingers or toes	❑ Missing fingers or toes

FAMILY HISTORY

Is the child adopted? *If yes, please answer the family history information to the best of your knowledge.*				❑ *Yes*	❑ *No*
Is the child's mother alive?				❑ *Yes*	❑ *No*
If No,	Age of death:	Cause of death:			
Please list any health problems in the mother:					
What is the mother's ancestry? *Please check all that apply.*					
❑ Caucasian	❑ African American	❑ Asian	❑ Native American		❑ Hispanic
❑ Jewish	❑ Unknown	❑ Other:			
Has the child's mother had any pregnancy losses (miscarriage)?				❑ *Yes*	❑ *No*
If yes, please list number and reason(s):					
Is the child's father alive?				❑ *Yes*	❑ *No*
If No,	Age of death:	Cause of death:			
Please list any health problems in the father:					
What is the father's ancestry? *Please check all that apply.*					
❑ Caucasian	❑ African American	❑ Asian	❑ Native American		❑ Hispanic
❑ Jewish	❑ Unknown	❑ Other:			
Are the child's parents related to each other?				❑ *Yes*	❑ *No*
If yes, please indicate relationship (first cousins, second cousins, etc.):					
Does the child have any FULL brothers and sisters? (I.E. same mother and father) *If sibling is deceased, please write age of death as "d. 14y" and records cause of death in health problems section.*				❑ *Yes*	❑ *No*

Name			**Age**	**Healthy?**		**Health problems**
	❑ M	❑ F		❑ Yes	❑ No	
	❑ M	❑ F		❑ Yes	❑ No	
	❑ M	❑ F		❑ Yes	❑ No	
	❑ M	❑ F		❑ Yes	❑ No	

Does the child have any HALF brothers and sisters from his/her mother or father? *If sibling is deceased, please write age of death as "d. 14y" and records cause of death in health problems section.*	❑ *Yes*	❑ *No*

Name			**Age**	**Healthy?**		**Health problems**
	❑ M	❑ F		❑ Yes	❑ No	
	❑ M	❑ F		❑ Yes	❑ No	
	❑ M	❑ F		❑ Yes	❑ No	
	❑ M	❑ F		❑ Yes	❑ No	

Please add any additional information that you think would be helpful:

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SUMMARY OF ACKNOWLEGMENT OF RECEIPT FOR NOTICE OF PRIVACY PRACTICE

The Organization Health Care Arrangement (OHCA) of Caldwell Immediate Care Center will provide with a copy of their "Notice of Privacy Practices". The OHCA will use and disclose health information about you for the purpose of treatment and/or alternatives, payment and individuals involved in your care and for health care operations.

Caldwell Immediate Care employees and healthcare providers will show you the respect, maintain your dignity and make you feel as comfortable as possible while you are receiving care from us. Good healthcare is a partnership. You can help by providing accurate and timely information to your heart health care provider asking questions and following your individualized treatment plan.

Information about you and your care will be kept confidential (private) your medical records are private and only you and other authorized people or agencies are allowed to see them. You have the right to see and obtain copies of your medical records. **(Fees may apply.)** To obtain your records you will need to give us a request in writing it may take a few days for us to make your medical records available.

We reserve the right to change the "Notice of Privacy Practices". We also reserved the right to make the revised or changed notice affective for health information we already have about you as well as any information received in the future. We will post a copy of the most current notice of privacy practices please read the full notice of privacy practices that has been given to you it explains our privacy practices in further detail.

I hereby acknowledge that I have received a copy of the full "Notice of Privacy Practices"

Patient Name:	Date:
Signature of Patient or Legal Representative:	Relationship to Patient:

Please list name of family members of friends you authorized to receive/discuss your health care

Name:	Relationship:

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General Information for Insured/Uninsured Patients

- We ask for payment at the time of service unless other plans are pre-arranged.
- We are required to collect your insurance plan's co-payment at the time of service.

Please remember that insurance is considered a method of reimbursing the patient for fee paid to the doctor and is not substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

I authorize the release of any medical information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance and other agency reimbursements to Caldwell Immediate Care. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said Insurance, I hereby authorize said assignee to release all information necessary to secure the payment.

Signature:	Date:

General Information on Payment and Procedure

1. If after sixty (60) days, insurance has not responded to the claim, the billing is expected to be paid in full by the responsible party. We do require a payment within 30 days of time of service.
2. Patients with health insurance should remember that serviced are rendered and charged to the patient. Any dispute over an insurance claim is a matter between the patient and insurance carrier. Should a dispute arise, we will make every effort to help resolve the claim.

Signature:	Date:

Authorization and Agreement for Treatment

1. CONSENT TO TREATMENT: I understand that medical treatment will be performed by independent physicians, their assistants, and employees of Caldwell Immediate Care Center between the working hours of 8:00am and 7:00pm. Caldwell Immediate Care Center is not responsible for the care between the hours of 7:00pm and 8:00am. I hereby give my authorization and consent to treatment and procedures, and certify that no guarantee or assurance has been made as to the results of such treatment and procedures.

Signature:	Date:

Consent for Electronically Prescribing

- ePrescribing is way for providers to send electronically an accurate, error free, and understandable prescription from Caldwell Immediate Care to the pharmacy of your choice. EPrescribe includes:
    - Formulary and benefit transactions- Gives providers information about which frugs are covered by your drug benefit plan.
    - Refill notification- Allows providers to receive electronic refill requests from the pharmacy.

Understanding all the above, I hereby consent Caldwell Immediate Care to enroll me in the ePrescribe program.

Signature:	Date: