
## CHILD PATIENT INFORMATION

**Last Name:** _____ **First Name**: _____ **M.I.** _____
**Birth Date:** ___/____/_____ **Gender:** _____ **SSN:** _____
**Home address:** _____ **Apt:** _____
**City:** _____ **State:** _____ **Zip Code:** _____
**Home Number:** _____ **Cell:** _____
**Work Number:** _____
**Preferred Daytime Phone (please circle):** Home Cell Work Other: _____
**Email Address:** _____
**Student (please circle):** Yes No Full Time Part Time
**Employer:** _____ **Occupation:** _____
**May we contact you through text?** Yes No

## WE ARE REQUIRED TO ASK FOR THE FOLLOWING INFORMATION PER THE NEW INSURANCE/FEDERAL REPORTING REQUIREMENTS.

**Race (please circle):** Indian American Asian African American Caucasian Hispanic Other
**Ethnicity (please circle):** Hispanic/Latino Non-Hispanic/Latino
**Preferred Language (please circle):** English Spanish Other: _____

I prefer not to answer

## EMERGENCY CONTACT

**Name:**_____ **Phone Number**: _____
**Relationship to patient:** _____

## PREFERRED PHARMACY

**Name:**_____ **Phone Number**: _____
**Location**: _____

## PRIMARY INSURANCE INFORMATION

**Insurance Company:**_____
**Policy Holder's Name:**_____
**Policy Holder's Date of Birth:** ____/____/_____ **Sex**:_____
**SSN:**_____
**Member ID Number:**_____**Group Number:**_____
**Policy Holder's Relationship to Patient (please circle):** Self Parent Spouse
Other: _____
**Policy Holder's Employer:**_____

## SECONDARY INSURANCE INFORMATION

**Insurance Company:**_____
**Policy Holder's Name:**_____
**Policy Holder's Date of Birth:** ____/____/_____ **Sex**:_____
**SSN:**_____
**Member ID Number:**_____**Group Number:**_____
**Policy Holder's Relationship to Patient (please circle):** Self Parent Spouse
Other: _____
**Policy Holder's Employer:**_____

## RESPONSIBLE PARTY

**Responsible Party Name:**_____
**Address:**_____**Apt:**_____
**City:**_____ **State:**_____**Zip Code:**_____
**Home Number:**_____ **Cell:** _____**Work:** _____
**Birth Date:**____/____/____**Sex:**_____ **SSN:**_____
**Relationship to Patient:** _____

## BENEFIT ASSIGNMENT/ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, private insurance, and any other health plan payment to Healthy Life Family Medicine. This assignment is to be considered as valid as an original. I understand that I am financially responsable for all charges, including but not limited to co-payments and annual deductibles. I hereby authorize said assignee to release any information required to secure the payment.

X_____ X_____
**Signature (parent or guardian if minor)** **Date**

## PAST MEDICAL HISTORY

**Medical History** (Please list any medical condition you have been diagnosed with and the date of onset): Examples: hypertension 2009, depression 2010, diabetes 1999

**Surgical History** (Please list all surgeries and include the date of surgery):

**Current Medications** (Please list ALL medications, prescribed, over the counter, herbs, or supplements):

| Drug | Strength | How Often | Length of time taken |
|---|---|---|---|
| **Example: Lisinopril** | **10mg** | **1 tab a day** | **3 years** |
| | | | |
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**Allergies to medications** (Please list ALL allergies to medications only and the type of reaction to each):

## PAST MEDICAL HISTORY CONTINUED

**Tobacco Use:**

Do you currently use any type of tobacco products? (Please circle) Yes No

If yes, please list type and quantity per day: _____

Any prior use of tobacco? (please circle) Yes No

**Alcohol/Caffeine Use:**

How many drinks of alcohol do you consume per day? _____ Week?_____

How many cups of coffee/tea do you consume per day?_____ Week?_____

How many glasses of soda do you consume per day?_____ Week?_____

**Drug Abuse:**

Any history of drug abuse? (Please circle) **Yes** **No**

If yes, please specify substance and length of use_____

**OB/GYN History (female patients):**

Number of pregnancies?_____ Date of last menstrual cycle?_____

Number of miscarriages?_____ Date of last pap?_____

Number of abortions?_____ Date of last mammogram?_____

Number of living children?_____

Have you ever had an abnormal pap?(please circle) yes no

If yes, what was the diagnosis?_____

## FAMILY HISTORY

**Please circle:**

Father: Alive age_____ Major medical problems:_____
Deceased age of death_____Cause of death:_____

Mother: Alive age_____ Major medical problems:_____
Deceased age of death_____Cause of death:_____

Siblings: Alive age(s)_____Major medical problems:_____
Deceased age(s) of death_____ Caused of death:_____
Siblings: Alive age(s)_____Major medical problems:_____
Deceased age(s) of death_____ Caused of death:_____
Siblings: Alive age(s)_____Major medical problems:_____
Deceased age(s) of death_____ Caused of death:_____
Siblings: Alive age(s)_____Major medical problems:_____
Deceased age(s) of death_____ Caused of death:_____

Children: Alive age(s)_____Major medical problems:_____
Deceased age(s) of death_____ Caused of death:_____

## DEVELOPMENT HISTORY

Does the patient receive any therapies? (Please circle) Yes No
Please circle the ones that apply: speech physical occupational
developmental other_____

Is the patient in school? (Please circle) yes no
If yes, name of school_____ grade level_____

Is the patient taking (please circle)
Regular classes special education classes resource classes

If patient is not in school, what was the highest level of education obtained?_____


# Child Assessment

**Patient:**_____ **Birth Date:**_____

**Does your child have a history of (please circle):**

**Frequent ear infections fractures frequent sore throats chicken pox ear tubes**

**Seizures frequent colds major accidents urinary tract infections**

**Other**_____

**Are the patient's immunizations up to date? Yes No I don't know**

## NEONATAL HISTORY

**Birth weight**_____ **Birth length**_____

**Length of pregnancy (in weeks)**_____ **Method of delivery**_____

**Hospital/place of birth**_____ **Age at discharge**_____

**Please circle:** formula fed breast fed both

**Problems at birth?** Yes No

**If yes, please describe**_____

## SOCIAL HISTORY

**Number of adults in home:**_____

**Number of children in home:**_____

**Does the child live with both parents?** Yes No

**Does the child spend time in day care or with baby sitter?** Yes No

**Are there pets in the home?** Yes No

**If yes, what kind**_____

**Are there smokers in the home?** Yes No

## DEVELOPMENT HISTORY

**At what age did the patient develop these skills:**

**Rolling over**_____ **Single words**_____

**Sitting alone**_____ **Two words together**_____

**Crawling**_____ **Walking**_____

**Toilet trained**_____ **Forming sentences**_____

**Does the patient's hearing seem normal?** Yes No

**Does the patient's vision seem normal?** Yes No

**Has the patient had a dental exam in the past year?** Yes No

**Does the patient drink tap water or take fluid supplement?** Yes No

Healthy Life Family Medicine

# MEDICAL RECORDS RELEASE AUTHORIZATION

Patient Name: _____ DOB: _____

Patient's Current Address: _____

Patient's Current Phone Number: _____ Email: _____

Previous/Other Provider: _____

Address: _____

Office Phone: _____ Office Fax: _____

**Release the Medical Records (PHI) to:**

Healthy Life Family Medicine
750 N. Estrella Parkway Suite 40
Goodyear, AZ 85338

**P**: (623)889-3477
**F**: (623)889-3478

Description of Information to Be Disclosed: ( ) Physician Notes ( ) Complete Records ( ) Other: _____

***Reason for requested information is continuity of medical care for the patient listed above.***

## Please Read and Sign Below

**I understand the following:**

1. I authorize the release of medical records to Healthy Life Family Medicine
2. I may revoke the authorization at any time by writing a written notice to the practice.
3. I may not be able to revoke this authorization if the practice has already acted utilizing this authorization, or if the authorization was obtained as a condition of obtaining insurance coverage.
4. The practice will not condition treatment or payment based on my signing this authorization.
5. I am signing this authorization freely; no one has pressured or coerced me to sign this authorization.
6. The information disclosed in this authorization may be subject to re-disclosure by the practice and no longer protected by federal law or state law.
7. I am aware that I had an opportunity to review this authorization and understand its content.
8. I understand that I am entitled to a copy of this authorization at the time of its execution. If I declare a copy, I will make my request known.
9. I understand that the information may include information relating to sexually transmitted diseases, AIDS, HIV, Behavioral or Mental Services, treatment for alcohol and/or drug abuse.

_____ _____ _____

**Patient/Guardian Signature** **Relationship to Patient** **Date**

Healthy Life Family Medicine

# *Family Medical Release*

I give consent to the family member and/or friend listed below for the following:

1. I give consent for anyone listed to be able to receive any messages regarding test results, consults, and/or prescription refills if I am unable to be reached.
2. I give consent for anyone listed to be able to discuss any billing issues and/or statements.
3. I give consent for anyone listed to be able to pick up any medical records and/or prescriptions that have been requested or ready for me.
4. I give consent for anyone listed (over the age of 18) to be able to bring in patient (if a minor) for their appointment and make medical decisions if necessary.
5. I have the right to deny anyone who is listed to obtain any information for me after signing off on this consent. I understand that I must contact Healthy Life Family Medicine, so this right will be in effect immediately.

| **Name:** | **Relationship:** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

_____ _____

Patient/Guardian Signature Date


**LEAD SCREENING**

**Patient's Name:**_____ **Birth Date:**_____

**Name of person completing questionnaire:**_____**Relationship to Patient:**_____

**PLEASE ANSWER ALL THE QUESTIONS. THIS WILL HELP THE DOCTOR DECIDE IF YOUR CHILD NEEDS A SPECIAL BLOOD TEST.**

| Lead Screening Questionnaire | yes | no |
|---|---|---|
| 1. Does your child live in, often visit, or play near a house or building built before 1978 with recent remodeling? This could include a day care center, preschool, and the home of a babysitter or relative. | | |
| 2. Does your child live in or visit often a house with peeling or chipping paint built before 1960? | | |
| 3. Has your family or child ever lived outside the U.S., or has just arrived from a foreign country? | | |
| 4. Does your child often put things in his/her mouth such as toys, jewelry or keys? Does your child eat anything that is not food? | | |
| 5. Does your child often come in contact with an adult whose job or hobby involves exposure to lead? Jobs include house painting, plumbing, remodeling, construction, auto repair, welding, electronics repair, jewelry or pottery making. Hobby examples are making stained glass or pottery, fishing, making of shooting firearms and collecting lead or pewter figurines. | | |
| 6. Does your child have a brother, sister, housemate or playmate being treated for lead poisoning? | | |
| 7. Does your child live near an active company that melts lead, battery recycling plant, or another industry likely to release lead? | | |
| 8. Does your family use cosmetics from other countries like kohl, surma or sindoor? | | |
| 9. Do you give your child any home remedies or traditional medicines that may contain lead? | | |
| 10. Does your child eat food, drink juice or punch that has been stored in pottery from Mexico or that has been stored in open cars? | | |
| 11. Does your child live near a busy roadway where soil and dust may be contaminated with lead? | | |
| 12. Does your home's plumbing have lead pipes or copper with lead joints? | | |

***For more information about lead exposure and screening, you can visit the Arizona Department of Health (ADHS) webpage about lead at http://www.azdhs.gov/phs/oeh/invsurv/lead/index.htm**
**Or call 602-364-3118**

HEALTHY LIFE FAMILY MEDICINE
Patient Eligibility Screening Record
Vaccine For Children Program

This record must be kept in the healthcare provider's office to reflect the current status of all children 18 years of age or younger declared eligible to receive immunizations through the Vaccine For Children Program. This record may be completed by the parent, guardian, individual of record, or by the healthcare provider. This same record may be used for subsequent visits as long as the child's VFC eligibility status has not changed. Provider verification of response is not required, but it is necessary to retain this record on file for a minimum of three years.

**Please print or type**

**Initial Screening Date: _____**

**Child Last Name:_____ First Name: _____**

**Child's Date of Birth:_____**

**Parent/Guardian/**
**Individual of Record Last Name: _____First Name:_____**

**Provider: _____ Insurance Co. _____**

This child qualifies for vaccination through the VFC program because he or she (check only one):

- o Is enrolled in KidsCare
- o Is enrolled in AHCCCS
- o Does not have health insurance
- o Is American Indian or Alaskan Native (no matter what the insurance situation is)
- o Has health insurance that does not pay for vaccines.
- o This child does not qualify for VFC
- o Check here if this child has health insurance that pays for vaccines.

| **Date of Eligibility Changes and Updates** | | | | |
|---|---|---|---|---|
| **Kids Care** | **AHCCCS** | **Un-Insured** | **Native American/Alaska Native** | **Under-Insured** |
| | | | | |
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Please be advised:
If your insurance company does not cover immunizations and you do not let us know at the time of the visit, it is your responsibility to pay the cost involved. We cannot make the Vaccines For Children Program retroactive and you are only eligible for the Vaccines for Children Program at the time of the visit. If you are unsure if immunizations and well checkups are covered, please contact your insurance company. Thank you.

Please sign below indicating that you understand and agree with the above statement.

**Signature: _____ Date: _____**

# Healthy Life Family Medicine Payment Policy

Thank you for choosing Healthy Life Family Medicine as your primary care provider. We are committed to providing you with quality and affordable health care. Our practice financial policy is as follows:

1. **Insurance.** We participate in most insurance plans. If you are not insured by a plan we do business with, payment in full is required at each visit. Knowing your insurance benefits is your responsibility. Contact your insurance company directly for any questions regarding your coverage. By signing this form you authorize Healthy Life Family Medicine to release the necessary information in order to complete and process your insurance claims.

2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of our contract with your insurance company.

3. **Non-covered services.** I understand that some, and perhaps all, of the services I received may not be covered by my insurance or not considered reasonable or necessary by Medicare or other insurers. I agree to pay for any services which have been determined by my insurance plan to be "non-covered". Payment in full for these services is generally due at each visit.

4. **Updates.** Our staff will ask you to verify you're billing information at each and every visit. Current information is essential in order for us to contact you regarding your treatment and for obtaining timely payment from your insurance company.

5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. It is your responsibility to comply in a timely manner with their request. Please be aware that the balance of your claim is your responsibility, whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

6. **Coverage changes.** If your insurance changes, please notify us as soon as possible so we can make the appropriate changes to help you receive your maximum benefits.

7. **Missed appointments.** You will be charged a $25.00 fee for any missed appointments if you do not notify us at least 12 hours prior to your scheduled appointment time. Help us to serve you better by keeping your regularly scheduled appointment.

8. **Returned checks (NSF).** You will be charged a $15.00 processing fee for any personal check returned for nonpayment.

9. **Form Completion**- Please note that any completion of forms for insurance purposes, short term disability, and FMLA leave require an appointment with one of our providers in order to be completed. There will be a $25.00 fee for any Short term disability or FMLA paperwork.

**I have read and understand Healthy Life Family Medicine's payment policy and agree to abide by its guidelines:**

_____ _____

**Signature** **Date**

I give consent to be contacted by Healthy Life Family Medicine through

☐ Email ☐ Text ☐ Phone

to remind me of any upcoming appointments, laboratory or imaging test results.

## Healthy Life Family Medicine Health Portal

Healow app can be accessed through your desktop computer as well as your mobile device. Provide our staff with an email address to sign you up for our health portal.

- View your medical history, labs, referrals and imaging reports.
- Request Refills
- Send direct messages to your provider

**Email: _____**

**Please sign below acknowledging the email above is correct and that we may use it to activate your health portal account.**

_____ _____

**Patient signature** **Date**