Smita Tandon, MD
DR 2 KIDS
Where kids come first

Smita Tandon, MD

Patient's First Name Primer Nombre de Paciente		**M.I.**	**Patient's Last Name** Apellido		
Sex M F Sexo	**Date of Birth** Fecha de Nacimiento	**SSN** Numero Social		**Preferred Language** Idioma Preferido	
Address Dirección		**Apt #**	**City** Ciudad		**Zip Code** Código Postal
Home Phone Telefono de Casa	**Cell Phone(18+)** Numero Celular(18+)	**Ethnicity** □Caucasian □Latino □Asian □Other: Etnica □Caucásico □Latino □Otro:			
E-Mail Address					

Mother madre	**Name** Nombre	**Age** La Edad	**SSN** Numero Social	
	Occupation La Ocupación	**Education** La Educación	**Work Phone/Cell Phone** El Numero del Trabajo /Cell	
	Employer Trabajo	**Employer's address** La dirección del trabajo		
Father Padre	**Name** Nombre	**Age** La Edad	**SSN** Numero Social	
	Occupation La Ocupación	**Education** La Educación	**Work Phone/Cell Phone** El Numero del Trabajo /Cell	
	Employer Trabajo	**Employer's address** La dirección del trabajo		
Guardian de guardián	**Name**[Stepparent/grandparent] Nombre	**Age** La Edad	**SSN** Numero Social	
	Occupation La Ocupación	**Education** La Educación	**Work Phone/Cell phone** El Numero del Trabajo /Cell	
	Employer Trabajo	**Employer's address** La dirección del trabajo		

Emergency Contact 1 En caso de Emergencia	**Phone #** El teléfono #	**Relationship to Child** La relación al Niño
Emergency Contact 2 En caso de Emergencia	**Phone #** El teléfono #	**Relationship to Child** La relación al Niño
Child's Primary Insurance El Seguro primario del paciente		**ID #**
Secondary Insurance Seguro secundario		**ID #**

Reason for today's visit Rasone para la visita de hoy

Where did you hear about us? ¿Dónde usted oyó hablar de nosotros?

Referring Doctor El Doctor refiriéndose

I give my consent and authorize any medical treatment deemed necessary and/or requested for the above named patient by Smita Tandon, MD. This includes all diagnostic tests, X-rays, treatments etc. I agree to assume all financial responsibility and obligations incurred for such services and authorize the payment of medical benefits directly to Smita Tandon, MD. I will also assume any costs, if incurred, for collection. I authorize the doctor to photograph my child for the purposes of medical consultation and teaching. I agree to arbitration in a neutral setting to settle any disputes. I hereby authorize said assignee to release medical information to secure payments and care for my child.

PARENT SIGNATURE: _____ **DATE:**_____

Yo doy mi consentimiento y autorizo que cualquier tratamiento médico juzgó el requisito Y/o pidió para el paciente nombrado anterior por Smita Tandon, MD. Esto incluye todo el diagnóstico prueba, Rayos X, etc de los tratamientos. yo estoy de acuerdo en asumir la responsabilidad todo financiera y obligaciones incurridas en para cosas así repara y autoriza el pago de beneficios médicos directamente a Smita Tandon, MD. Yo también asumiré cualquier costo, si incurrió en, para la colección. Yo autorizo que el doctor fotografíe a mi niño para los propósitos de consulta médica y de enseñar. Yo acepto el arbitraje en una escena neutra establecer cualquier disputa. Yo autorizo dicho el cesionario para soltar la información médica para afianzar los pagos y querer a mi niño por la presente.

FIRMA DEL PADRE: _____ DATE:_____

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Patient History

Please complete to the best of your ability. Circle all that apply. Ask the doctor if you have questions or you need help to fill in answers.

Patient's Name		Nickname, if any		Date of Birth
Name of School	City	Grade	Daycare? Y ____ N ____	
Mom's Name	Contact Number		Dad's Name	Contact Number

Birth History	Name of Hospital, Address				Birth weight ____ lbs ____ oz
Prenatal History	Age of Mother	No. of times pregnant	No. of children	Abortions or miscarriages	
Problems that mom had during Pregnancy	High Blood Pressure Meds	High Sugar	Infections	Medications	Smoke yes no Alcohol yes no Drugs yes no
	VDRL	HBsAg	Group B Strep	Rubella	Other Problems

Past Medical Problems of child	Emergency room visits	
	Hospitalizations	
	Chronic Problems	
	Recurrent Problems	

Family History **Any members of the child's family with**	**Disease**	**Mother**	**Maternal Relatives -** grandma etc.	**Father**	**Paternal Relatives -** grandma etc.
	Heart Disease				
	Diabetes				
	Hypertension				
	Cancer				
	Kidney Problems				
	Seizures				
	Asthma				
	Allergies				
	Other				

Under 40 lbs Car Seat in rear Seat Facing Backwards Facing Forwards	**40 – 60 lbs in rear seat Booster Seat?** Yes No	**Over 60 LBS Seat Belt?** Yes No **Which Seat?** Over12y Front Under12y Back

Lives in	Apartment? Which Floor?	Single Family Home Single story / Two Story	
Child Lives with	Mom / step mom / Dad/ step dad / Grandma / Grandpa / Guardian/ sisters/ brothers / cousins	Additional Adults in Home	Additional Children in Home

Sister's Name	**Age**	**Sister's Name**	**Age**	**Brother's Name**	**Age**	**Brother's Name**	**Age**

Sleep Habits	Infant Sleeps on Back Stomach Side	Naps Yes No	Child Sleeps Through Night Yes No
Fire Safety	Smoke Detector In Working Condition Yes No		Fire Evacuation Plan Yes No
Dental Care	Has Teeth Yes No	Brushing Yes No	Last Dental Visit [Date]
Pets	Please list animal, number, indoor or outdoor.		

Comments / Questions?

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Smita B. Tandon, MD, FAAP
Clinical Professor of Pediatrics, UCI

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand your "Notice of Privacy Practices" containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its "Notice of Privacy Practices" from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the "Notice of Privacy Practices."

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions but if you do not agree then you are bound to abide by such restrictions.

Education/Training: On occasion, we participate in the education and training of health care professionals. We may use and disclose your medical information to current and prospective students, residents and/or observers as part of the training and educational process.
Example: Your physician may allow a student or observer to monitor your treatment as a part of a learning experience.

Patient Name:

Patient Representative:

Signature:

Date:

OFFICE USE ONLY

I attempted to obtain the signature of the patient or patient's representative Acknowledging the receipt of the "Notice of Privacy Practices" for DR2KIDS Medical Group, but was unable to do so, as documented below:

Dated: **Initials:** Reason:

11100 Warner Avenue, Suite 368, Fountain Valley, CA 92708-7514
Phone: 714 241 1777 Fax: 714 241 7221
Web Site:www.dr2kids.com email: doctor@dr2kids.com

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Patient Financial Responsibility Letter
Paciente Carta de Responsabilidad Financiera

Date: _____

To/ Para: Dr. Tandon

If it should be determined that I am not eligible for benefits or that this service is not covered through my insurance plan, I , _____, Father/Mother/Guardian of _____ agree to pay Dr. Smita Tandon, DR2KIDS, the usual and customary charges incurred for medical services rendered to myself or my dependents.

Si se determina que no soy elegible para los beneficios o que este servicio no está cubierto a través de mi plan de seguro, _____, padre o madre/tutor de _____ acepto pagar Dr. Smita Tandon, DR2KIDS, los gastos habituales y consuetudinarios generados por los servicios médicos prestados a mí o a mi cargo.

_____ _____
Parent/Guardian's Name / de nombre Signature / firma

_____
Relationship to Patient / Relación con el paciente

Permission to Allow Observers/ Students/ Residents in Rooms
Permiso para permitir observadores / estudiantes y residentes en habitaciones

Our clinic participates with UCI and other Teaching Institutions as a teaching clinic in which Medical Students, Residents, Fellows, Nurse Practitioner Students, Observers and other Personnel Observe, Communicate with and examine the Patients. Your signature here permits your child to be seen with and by these members. If at any time you do NOT wish to participate in teaching sessions, please inform one of our staff members. On behalf of all learners we thank you for your cooperation.

Nuestra clínica participa con la UCI y otras instituciones de enseñanza como una clínica de enseñanza en el que los estudiantes de medicina, residentes, becarios, enfermera practicante estudiantes, observadores y demás personal observar, a comunicarse con y examinar a los pacientes. La firma aquí permite al niño a verse con y por los miembros. Si en cualquier momento no desea participar en las sesiones de enseñanza, por favor a uno de nuestros funcionarios. En nombre de todos los estudiantes le agradecemos su colaboración.

_

_____ _____
Print Name / de nombre Relationship to Patient/ Relación con el paciente

_____ (_____)_____
Signature / firma Telephone Number/ Número de teléfono

_____ _____
Address /Dirección City, State, Zip Code / ciudad, Estado, código postal

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