GENERAL PEDIATRIC INTAKE FORM

Patient's Name: _____ DOB: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ Sex: M / F

Mother's Name and Occupation: _____

Father's Name and Occupation: _____

Contact Email: _____ Daytime Phone: _____

Evening Phone: _____ Work Phone: _____

Emergency Contact: _____

Parents are (circle): Married Separated Divorce Other: _____

Insurance Company: _____ Insured Name: _____

Relationship to Patient: _____ Employer: _____

Insurance ID #: _____ Group #: _____ CoPay: _____

Insured's Date of Birth: _____

REFERRED BY: _____

☐ I give Sivan Dirks, L.Ac. permission to e-mail me appointment notifications & occasional announ

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Reason for Office Visit: _____

_____

Has your child been seen by any other doctor(s) for this complaint? Yes No Past

Please describe past care for this complaint: _____

_____

_____

Previous Pediatrician's Name and Phone: _____

_____

Last time child had blood work done and what labs: _____

_____

Any known allergies to food, drugs, environment, animals, etc: _____

_____

List all surgeries and hospitalizations, including date occurred:

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

List all medications (from drugstore or prescription) child is on now and dosages if known:

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

List all supplements child is now taking, and dosages if known:

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

PREVIOUS MEDICAL HISTORY

YES (Y) indicates the child gets the problem **regularly**
NO (N) indicates the child **never** had the problem
PAST (P) indicates the child had the problem in the **past, but not recently**
Please circle the correct one for your child

Ear infections: Y N P If has had, how frequent per year: _____

Colds: Y N P If has had, how frequent per year: _____

Strep Throat: Y N P If has had, how frequent per year: _____

How many times has your child taken antibiotics: _____

Has your child had any of the following:

Chicken Pox: Y N
Age: _____

Rubella: Y N
Age: _____

Mumps: Y N
Age: _____

Whooping Cough: Y N
Age: _____

Rubeola: Y N
Age: _____

What medications has the child taken in the past and how often:

1) _____ 3) _____

2) _____ 4) _____

Hearing test normal: Y N Not Tested

Vision test normal: Y N Not Tested

Speech Impediments: Y N Past

Learning Impediments: Y N Past

VACCINATION HISTORY

Yes, has had; **No,** has not; **Some,** did not finish all shots:

MMR: Yes No Some **DPT:** Yes No Some **Hep B:** Yes No Some

Hib: Yes No Some **Chicken Pox:** Yes No Some **Polio:** Yes No Some

Others: _____

Any reactions to vaccinations? If so, please explain: _____

_____

FAMILY HISTORY

Allergies: Y N P **Obesity:** Y N P **Cancer:** Y N P

Tuberculosis: Y N P **Mental Illness:** Y N P **Heart Disease:** Y N P

Other diseases in your family: _____

If answers yes to any of the above, please write relationship of family member to child and severity of the disease: _____

_____

MOTHER'S PREGNANCY HISTORY

Age at conception: _____ **Length of Labor:** _____ **Vaginal Birth:** Y N

Traumatic Birth: Y N **If yes please explain:** _____

_____

_____

Medications during pregnancy: _____

How many ultrasounds during pregnancy: _____

Birth interventions (circle one): Forceps Vacuum Extraction C-Section Induction None

During pregnancy did any of the following occur?

Smoking: Y N Diabetes: Y N Nausea/Vomiting: Y N

Recreational Drugs: Y N Emotional Stress: Y N Alcohol: Y N

Preeclampsia: Y N Coffee: Y N

Dietary Restrictions during pregnancy: Y N If yes, please explain: _____

_____

HEALTH HISTORY OF CHILD

Gestational age at birth (weeks at birth): _____ **Apgar scores:** _____

Birth Weight: _____ **Birth Length:** _____

Complications after delivery: Y N **If yes, please explain:** _____

_____

Location of Birth (circle one): Hospital Birthing Center Home

Child Breastfed: Y N **For how long:** _____ **When put on formula:**_____

What formula was used: _____ **When was solid food introduced:**_____

When was whole milk introduced:_____

Any food cravings: _____

First foods: _____

When did child walk: _____ **Talk:** _____ **Develop teeth:** _____

Jaundice as a baby	Y N	Colic	Y N
Cradle Cap	Y N	Anemia	Y N
Eczema or Psoriases	Y N	Stomach Aches	Y N
Diarrhea	Y N	Asthma	Y N
Constipation	Y N	Warts	Y N
Finicky eating	Y N	Nightmares	Y N
Poor teeth	Y N	Bed-Wetting	Y N
Chronic sniffles	Y N	Excessive Tantrums	Y N
Bad foot odor	Y N	Defiant	Y N
Very sweaty	Y N	Fears/Phobias	Y N
Hyperactivity	Y N	Diaper rash	Y N
Growing pains	Y N	Early Puberty	Y N

Any particular household stressor child has witnessed or gone through:

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

ENVIRONMENTAL EXPOSURE

Has the child ever lived near a refinery, polluted area or in a home with lead paint? If so, what sort of pollution were they exposed to: _____

_____

_____

Has the child ever lived in a house that had new carpeting, paint, cabinets or any other refurbishing that seemed to affect their health? _____

_____

Does the child seem particularly sensitive to perfumes, gasoline or other vapors? _____

_____

Do you spray pesticides, herbicides or other chemicals around your home? _____

_____

What year was your home/apartment built? _____

Do you have vinyl blinds, and what year were they put in? _____

TYPICAL DAY'S DIET

Breakfast: _____

_____

Lunch: _____

_____

Dinner: _____

_____

Snacks: _____

_____

OTHER QUESTIONS:

Please list any questions you would like the acupuncture physician to address during this appointment:

_____

_____

_____

_____

_____

_____

_____

Please fill out the **Authorization and Release of Medical Records** and fax to each physician your child has seen or had care from. This will allow our Acupuncture Physician's to have complete records to ensure quality care. Also, please list in the space provided below these physicians' contact information so that we may follow up with this request.

1) _____

2) _____

3) _____

4) _____

5)_____

6)_____

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize ROSE CITY BABY to administer care to my Son/Daughter as they deem necessary. I clearly understand that I have the right to refuse care and that I am personally responsible for payment of all costs associated with the treatment of care:

Parent or Guardian: _____ Date: _____

Witnessed: _____ Date:_____

Informed Consent for Acupuncture Treatment

1. Sometimes after receiving an acupuncture treatment you may feel a little bit light-headed. If that is the case, please sit down for a while in the waiting room. In a few minutes you will feel relaxed and clear-headed.

2. Occasionally you may get a small hematoma (a small dime sized bruise under the skin) after an acupuncture needle is removed. This is not a cause for concern – it will go away in a few days. Gentle pressure applied to the site will stop any bleeding that is occurring under the skin.

3. We use only sterile disposable needles that are used once on each patient.

4. Occasionally after the cupping procedure is performed there may be bruising at the site of the cups. This is will fade after a few days and is purely cosmetic in nature.

Initials_____

Appointment Cancellation Policy

No shows and late cancellations less than 24 hours before appointment time are subject to a $50 cancellation fee.

initial _____

My signature authorizes Sivan Dirks L.Ac to treat me (or the patient for whom I am legally responsible) with Acupuncture & Chinese Herbal Medicine within the licensure granted by the Medical Quality Assurance Board of the State of California and the California Acupuncture Board. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based on the facts known, is in my best interests. I intend for this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient_____

Signature_____ Date _____
(of patient or legal guardian of patient)

Acupuncture Fee Agreement

CANCELING OR CHANGING APPOINTMENTS:
We will set a specific course of treatment for you. A certain number of visits in a set amount of time are required to get results. If you need to change or cancel an appointment, be sure to make up the appointment within a week. If, for some reason, you need to cancel an appointment, please call ahead and let us know so that we may accommodate another patient at that time. A no show without cancellation notice 24 hours prior to the scheduled appointment is subject to a cancellation fee. $50

PAYMENT DUE AT TIME OF SERVICE
Payment is due at the time services are rendered. If you have limited insurance coverage, it makes the most sense to for us to provide you with a superbill for you to mail to your insurance company with their appropriate claim form. Your insurance company will reimburse you directly. We will be glad to provide you with whatever paperwork your insurance company needs to reimburse you. However, it is your responsibility to follow-up with your insurance company should there be any delay in payment to you.

ADVANCED PAYMENT ARRANGEMENTS
In cases where payment arrangements have been made with our office and your account becomes past due, we reserve the right to add a financial charge at an interest rate of per month for every month that an account remains overdue, after 30 days.

FEES
The fees charged at this office are comparable to those charged by other specialists with similar qualifications in this geographic area. The fees for office services are payable at the time of the visit, except in certain cases where arrangements have been made with our office. Our standard fees are billable to insurance, however, if you do not have adequate insurance coverage we offer a significant discount as noted below.

For your information, some of our fees are as follows:

Service	Standard
New Patient Consultation & Treatment!	$100
Acupuncture Pediatric Treatment	$55

Add-On Services to Acupuncture: In order to have adequate time to address your needs, the following services will require a longer session time

_____ _____

Patient Signature Date

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

At Rose City Baby we are committed to treating and using protected health information about you responsibly. This Notice of Privacy Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your PHI. This Notice is effective 7/23/07, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Information

Our office is permitted by federal privacy laws to make uses and disclosure of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of Disclosures for Treatment, Payment, and Health Operations

Rose City Baby collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of our medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. *Treatment:* We may disclose your health information to a physician or other healthcare provider providing treatment to you, or who will provide services which we do not provide. We may also share information with a laboratory that performs a test.
2. *Payment:* A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.
3. *Healthcare operations:* We may obtain services from business associates, such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide. We may use or disclose your health information to provide you with appointment reminders via phone, e-mail or letter.
4. *Notification and communication with family:* We may disclose health information to a family member, or your personal representative or another person responsible for your care about your care, location, and general condition. Using our best judgment, we will only disclose health information that is directly relevant to the person's involvement in your care.
5. *Required by law:* We may also use or disclose your health information when we are required to do so by law. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products or reactions to medications.

When Rose City Baby May Not Use or Disclose Your Health Information

Most uses and disclosures that do not fall under treatment, payment, and healthcare operations will require your written authorization. Upon signing, you may revoke your authorization (in writing) through our practice at any time.

Your Health Information Rights

You have the right to:

- **Restrict the disclosure of your protected health information by written request. The request for restriction may be denied if the information is required for treatment, payment of healthcare operations;**
- Received confidential communications regarding your protected health information;
- Inspect and copy your protected health information with written request to our office using the form we provide upon request;
- Request that your protected health information be amended to correct incomplete or incorrect information (in writing);
- Receive an account of disclosures of your protected health information upon written request; and
- Obtain a paper copy of this Notice of Privacy Practices upon request.

Our Responsibilities

Our office is required to:

- Maintain the privacy of your protected health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request;
- Accommodate your reasonable requests regarding methods to communicate health information with you; and
- Accommodate your request for an accounting of disclosures.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and to make the new provisions effective for all protected health information we maintain. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

For More Information or to Report a Problem

If you have questions and would like additional information, please contact us at the following address or phone number:

425-445-5893

sivan@rosecitybaby.com

www.rosecitybaby.com

If you believe your privacy rights have been violated, you may file a written complaint with our office. You may also file a complaint by mailing it to the Secretary of Health and Human Services at the following address:

U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services as a condition of receiving treatment from the office.

We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Print Name_____ Date_____

Signature_____

Primary Care Physician

Name/Office_____

Phone Number_____

Address_____

_____

Specialists

(OB, Gastroenterologist, Psychiatrist, Counselor, etc)

Specialty/Seen for:_____

Name/Office_____

Phone Number_____

Address_____

_____

Specialty/Seen for:_____

Name/Office_____

Phone Number_____

Address_____

_____

Specialty/Seen for:_____

Name/Office_____

Phone Number_____

Address_____