Cuestionario De Pediatría

Pajaro Valley Medical Clinic, Inc.
65 Nielson St. Ste 104
Watsonville, Ca 95076
831-786-8595

Para evitar cancelación, por favor regrese documentos dos semanas antes de su cita

Fecha: _____

Nombre: _____ S.S#_____ Sex: M__F__

Domicilio: _____ Fecha de Nacimiento: _____

Ciudad: _____ Estado: _____ Zona Postal: _____

Nombre de la Madre: _____ Empleador de la Madre: _____

Teléfono de la Madre (C): _____ (Celular):_____ (Trabajo):_____

Nombre del Padre: _____ Empleador del Padre: _____

Teléfono del Padre (C): _____ (Celular):_____ (Trabajo):_____

Contacto de Emergencia: _____ Número de Teléfono: _____

Doctor Familiar: _____ Número de Teléfono: _____

¿Quién lo refirió? :_____

E-mail: _____

Edad (anos) _____ (meses) _____ Cuantos hermanos y hermanas tiene? _____

Ha sido su hijo/a tratado por una emergencia? ( ) Si ( ) No Describa:_____

_____

Peso al nacer: _____ Medida al nacer_____ Peso actual _____

Fue el nacimiento: ( ) Normal vaginal ( ) Cesaría

¿En cual hospital nació su bebe? _____

¿Tuvo algún problema durante el embarazo? _____

¿Nació el bebe con un defecto? _____

Nació el bebe con: ( ) Ictérica (color amarillo) ( ) Meconio ( ) Cianosis (azul)

¿Quien era su pediatra anterior? _____

¿Quien fue su doctor/a? _____

Cuando recibió estas vacunas: Hepatitis B _____Polio _____ Sarampión _____
Tétano_____ Haemophilus _____ Viruela _____

Su hijo/a a tenido las siguientes enfermedades: ( ) Sarampión ( ) Varicela ( ) Paperas
( ) Tos ferina ( ) otro _____

Fecha y propósito de la última visita al médico? _____
_____

Cirugías: _____

Medicinas Y Vitaminas: _____

Accidentes: _____

¿ Su hijo ha sufrido alguna vez?

( ) alergias ( ) anemia ( ) problemas en el brazo ( ) artritis ( ) asma ( ) dolor de espalda

( ) orinarse en la cama ( ) problemas de conducta ( ) hueso/s roto ( ) dolor de oídos

( ) estreñimiento ( ) convulsiones ( ) diabetes ( ) diarrea ( ) problemas de digestión

( ) mareos ( ) desmayo ( ) dolores de crecimiento ( ) dolor de cabeza ( ) problemas de corazón

( ) hiperactividad ( ) hipertensión ( ) problemas de articulación ( ) problemas en las piernas

( ) espasmos musculares ( ) problemas en el cuello ( ) neuritis ( ) problemas ortopédicos

( ) parálisis ( ) falta de apetito ( ) fiebre reumática ( ) hernias ( ) problemas de sinusitis

( ) problemas al caminar

Por favor explique si marco algún problema: _____

_____

Dieta: _____

Factores ambientales: _____

Si después de 90 días, la aseguranza(s) no ha pagado a ***Pajaro Valley Medical Clinic, Inc***. Soy responsable por el balance o pago total. Como cortesía a otros pacientes, debo notificar la cancelación de la cita por lo menos 24 horas de anticipación para evitar cualquier cargo.

Fecha: _____

Su Firma: _____

PAJARO VALLEY MEDICAL CLINIC, INC.
65 Nielson St. Ste. 104
Watsonville, CA 95076
Phone # 831-786-8595
Fax # 831-786-8557

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, **Pajaro Valley Medical Clinic, Inc.** may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to **Pajaro Valley Medical Clinic, Inc.** Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice and Privacy Practices prior to signing this consent. **Pajaro Valley Medical Clinic, Inc.** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Pajaro Valley Medical Clinic, Inc., Attn. Privacy Officer 65 Nielson St. Ste 104 Watsonville, CA 95076.**

With my consent, **Pajaro Valley Medical Clinic, Inc.** may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, **Pajaro Valley Medical Clinic, Inc.** may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

Pajaro Valley Medical Clinic, Inc. is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to **Pajaro Valley Medical Clinic, Inc.** use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, **Pajaro Valley Medical Clinic, Inc.** may decline to provide treatment to me.

_____ _____

Patient Name Date

_____

Signature

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

_____ _____

Personal Representative's Name Relationship to Patient

Authorization for Release of Medical Records
Pajaro Valley Medical Clinic, Inc.
Phone # (831)786-8595
Fax # (831)786-8557

Please send a copy of this release with the requested records.

PATIENT INFORMATION (Please print)			
Patient Name	Date of Birth	Social Security Number	
Address	City	Zip	Phone

RELEASE FROM: [Name of physician or facility releasing information]			
I authorize release of my medical record from			
Physician/Facility		Fax#	
Address	City	Zip	Phone

RELEASE TO: [Name of physician or facility receiving information]			
Please send my medical record to:			
Physician/Facility Pajaro Valley Medical Clinic, Inc			
Address 65 Nielson ST. Ste# 104	City Watsonville	Zip 95076	Phone 786-8595

RELEASE INFORMATION		
Reason: [ ] Change of insurance	[ ] Transfer of care	[ ] Personal file
[ ] Moving out of area	[ ] Specialist consultation	[ ] Legal

Please release the following (check all that apply)

RECENT H&P		LAST THREE VISITS	
LAB REPORTS		X-RAY REPORTS	
HOSPITAL REPORTS		OTHER:	

- Please allow 15 days for processing.
- Incomplete information will delay processing.
- Use of this information for any other than the stated purpose is prohibited.
- This information is for the use of the designated recipient only and cannot be provided to any other agency.

CONSENT

I authorize the release of all information indicated, and I am aware that the records released may contain information relating to psychiatric or psychological testing, physical abuse, or drug and alcohol abuse.

Signature of patient, parent, guardian, conservator, or patient representative (Please circle.)	Date

Note: This consent is valid for 90 days. It may be revoked by the signer at any time.