**PEDIATRIC INTAKE FORM**

Pajaro Valley Medical Clinic, Inc.

Patient Registration Information

**To avoid any cancellation, please return paperwork to our office two weeks prior to your appointment.**

Patient's Name _____ Today's Date _____

Date of Birth _____ Age ____ Sex ____ S.S. # _____

Mother's Name _____ Father's Name _____

Home Address _____

City _____ State ___ Phone: (Home) _____ (Work): _____

Emergency Contact: _____ Phone: _____

Family Doctor: _____

How where you referred? _____

Email: _____

Age (yrs) _____ (mos) _____ Date of Birth ____-____-____ Sex ____

# of Siblings____

Birth Weight_____ Birth Length _____ Current Weight_____ Present Length_____

Was the Birth:

- Normal Vaginal
- Breech Forceps Cesarean
- Home Birth
- Vacuum Extraction

Where was the Birth:

Birthing Center: _____

Hospital: _____

Any Pregnancy Problems: _____

Congenital Defects/Anomalies: _____

Was There Presence at Birth?

- Meconium
- Cyanosis (blue)
- Jaundice (yellow)

Pediatrician/Family MD: _____Address:_____

Obstetrician/Midwife: _____ Address:_____

Immunization Dates: Measles_____ Chicken Pox_____ Mumps_____ Whooping Cough_____
Other _____

Has This Child Been Treated for an Emergency?

_____

Yes No Describe: _____

Surgeries: _____

Medications and Vitamins:

_____

Accidents (Even Minor): _____

Date and Purpose of Last MD Visit: _____

Has This Child Ever Suffered From: (Circle any that apply)

| | | | |
|---|---|---|---|
| Allergies | Constipation | Hyperactivity | Rheumatic Fever |
| Anemia | Convulsions | Hypertension | Ruptures/Hernias |
| Arm Problems | Diabetes | Joint Problems | Sinus Trouble |
| Asthma | Digestion Problems | Leg Problems | Walking Problems |
| Backaches | Dizziness | Muscle Jerking | |
| Bed Wetting | Fainting | Neck Problems | |
| Behavior Problems | "Growing Pains" | Neuritis | |
| Broken Bones | Headaches | Orthopedic Problem | |
| Earaches | Heart Trouble | Paralysis | |

Diet: _____

Environmental Factors: _____

**Assignment of Benefits/Financial Agreement**

**I hereby give lifetime authorization of insurance benefits to be made directly to PVMC, and any assisting physicians for services rendered. I understand that I am financially responsible for all changes whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.**

Date: _____ Your Signature: _____

**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<br>Pajaro Valley Medical Clinic, Inc | | | |
|---|---|---|---|
| Address<br>65 Nielson ST. Ste# 104 | City<br>Watsonville | Zip<br>95076 | Phone<br>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.