Wholesome Family Medicine

4036 S. 6th St. Ste #2 Klamath Falls, OR 97603
Phone: (541) 851-9320 Fax: (541) 851-9322

Pediatric Patient Health History
Six Years of Age to Eighteen

Name: _____
Last *First* *M.I.*

Date of Birth: _____ **Age**: _____ **Gender**: **F** **M** ____

S.S.#: _____

Name and address of Dr's office/hospital/clinic where your child's health records are kept:

_____
Office/Hospital/Clinic Name *Street/ P.O. Box*

_____
City *State* *Zip Code*

Parent or Guardian: _____ _____ _____
Father *Mother* *Guardian*

Address: _____

City:_____ **State:** _____**Zip Code:**_____

Telephone: Please circle the preferred number to contact you:
Home #:_____Work #:_____Cell #:_____

E-mail:_____**S.S.#**: _____

Insurance Provider: _____

Verification of Naturopathic Coverage?:_____

How did you hear about Wholesome Family Medicine?: _____

ALL RESPONSES WILL BE KEPT CONFIDENTIAL

What are your child's most important health problems?

1) _____ 3) _____

2) _____ 4) _____

MEDICATIONS

Any known drug allergies? If yes, please list drug and reaction: _____

_____

Now = medications currently being taken. Past =medications taken at one time or another

	Now	Past		Now	Past
Aspirin	____	____	*Asthma Medications*	____	____
Ibuprofen	____	____	*Decongestants*	____	____
Inhalers	____	____	*Topical Steroids*	____	____
Antibiotics	____	____	*Other*	_____	
Anti-histamine	____	____		_____	

MEDICAL HISTORY

Does your child have any allergies to foods, drugs or other allergens in your environment (cats, mold, dust)? Yes _____ No _____ If yes, list and explain. _____

_____

_____

Has your child ever had: (Check those that are applicable)

_____*Chicken pox*	____ *Scarlet fever*	____*Bronchitis*	____*Asthma*
_____ *Measles*	____ *Pneumonia*	____*Rubella*	____*Mumps*
_____*Frequent Colds*	____*Eczema*	____*Croup*	
_____*Tonsillitis-How many times?*		____*Ear infections-How many?*	____*Other*_____

X-RAYS AND SPECIAL STUDIES

	When	Where	Results
Electroencephalogram:			
____*Psychological Evaluation:*			
____*Hearing:*			
____*Speech/Language:*			

INJURIES/SURGERIES/HOSPITALIZATIONS

_____

_____

_____

IMMUNIZATIONS

_____ *Varicella*	____*Polio*	_____*MMR*	_____*Rotavirus*	____*Hep B*
____*Mumps*	____*DTaP*	_____*Tetanus*	_____*Influenza*	____*Pneumococal*
___ *Hep A*	___ *HiB*	*Other:* _____		

Any adverse reactions to immunizations? (Please specify)

_____

_____

SYMPTOMS

Please circle: Y=a condition your child has now N=never had P=has had in the past

Hives	Y P N	*Burning of urine*	Y P N	*Bloody urine*	Y P N
Eczema	Y P N	*Frequent urination*	Y P N	*Cries easily*	Y P N
Bleeding gums	Y P N	*Heart Murmur*	Y P N	*Nervous*	Y P N
Nose bleeds	Y P N	*Vomiting spells*	Y P N	*Sleep problems*	Y P N
Acne	Y P N	*Anemia*	Y P N	*Night sweats*	Y P N
High fever	Y P N	*Stomach aches*	Y P N	*Sensitive to light*	Y P N
Chronic rash	Y P N	*Jaundice*	Y P N	*Body/Breath odor*	Y P N
Hearing loss	Y P N	*Easy bruising*	Y P N	*motion/car sick*	Y P N
Diarrhea	Y P N	*Flat feet*	Y P N	*No appetite*	Y P N
Sore throats	Y P N	*Constipation*	Y P N	*Nightmares*	Y P N
Gas	Y P N	*Canker sores*	Y P N	*Wheezing*	Y P N
Joint pains	Y P N	*Cough*	Y P N	*Dizzy spells*	Y P N
Hair loss	Y P N	*Frequent Headaches*	Y P N	*Frequent colds*	Y P N
Unusual fears	Y P N	*Bleeding tendency*	Y P N	*Excessive fatigue*	Y P N

Does your child have any other condition not mentioned? _____
_____

DIET

Please describe your child's typical daily diet: _____
_____
_____

Does your child have any food intolerances that you know of? Yes _____ No _____
If yes, please explain: _____
_____

FAMILY HISTORY (Y or N)

____*Heart Disease* ____*Diabetes* ____*Birth defects* ____*Cancer* ____*Mental Illness*
____*Hypertension* ____*Arthritis* ____*Tuberculosis* ____*Allergies* ____*Hay fever*
____*Eczema* ____*Other (please explain)*_____
_____

BIRTH HISTORY

Previous pregnancies by natural mother, miscarriages or complications: _____
_____

Mother's age at child's birth: _____

Mother's health during pregnancy:

____*Bleeding* ____*Hypertension* ____*Illness* ____*Cigarettes, alcohol, drugs*
____*Nausea* ____*Diabetes* ____*Thyroid Problems*
____*Physical or emotional trauma*

Term:

____*Full* ____*Premature* ____*Late* _____*Weight at Birth*
____*Length of labor* *Complications?* _____*Yes* _____*No*

Wholesome
FAMILY MEDICINE
Naturopathic Primary Care for the Whole Family

•Laura Blevins, ND Crystal Yarnall, FNP•4036 S. 6th St. Ste.#2 Klamath Falls, OR 97603
•
Phone: (541) 851-9320 •Fax: (541) 851-9322

No Show Policy

We strive to provide the best service possible to our patients. When someone doesn't show up for an appointment it provides a major inconvenience not only to our providers and staff, but also harms other patients who may be waiting for cancellations to get an earlier appointment. **Please** be respectful and always call at least 24 hours before your appointment if you need to reschedule. By signing the authorization below, you indicate understanding that **should you no-show a new patient appointment** you may be prevented from scheduling **AT ALL** in the future. Established patients may be charged up to $50 for no-showing follow-up visits. Cancellations made less than 24 hours in advance, should an emergency situation occur, are subject to provider review for reason to determine whether a fee will be charged.

Patient Name (Printed): _____

Date: _____

Patient/Parent/Guardian signature:

_____

Wholesome FAMILY MEDICINE
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•Laura Blevins, ND •4036 S. 6th St. Klamath Falls, OR 97603 •Phone: (541) 851-9320 •Fax: (541) 851-9322

Medical Records Request Form

By signing this form, I authorize release of confidential health information about me, by releasing a copy of my medical records, or a summary/narrative of my protected health information, to the clinic/practitioner listed above.

HIV/AIDS: I consent to the release of any positive/negative test result for AIDS/HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records: Initial: _____ Date: _____

Limitations on the information to be released subject to this form are as follows:

_____

I grant permission to release my protected health information from the following provider:

Name: _____

Address: _____

Phone: _____

Fax: _____

_____ _____

Patient Signature (or parent/guardian/legal representative) Today's Date

_____ _____

Printed Name Date of Birth

This form will be considered valid for 90 days from date of signing unless authorization is revoked by patient in writing.

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Financial Agreement Policy

Patient Name:_____

Patient DOB:_____

Thank you for choosing Wholesome Family Medicine for your family's medical care. We are committed to providing you with quality personal healthcare. As a part of our professional relationship, it is important you have an understanding of our financial policy. Other than for true medical emergencies, agreement with this policy is required for all medical care.

Payments Co-Payments Policy

- All co-payments, current balances are due and payable Prior to services being rendered and is required by your insurance to be paid at each visit. Patients who do not have their copayment may have their appointment rescheduled.
- Deductibles and co-insurance are due and payable at checkout after services provided on the day of service.
- If you do not know your co-pay we may collect a minimum fee of $30.00. Our billing department will bill or credit your account accordingly after your insurance pays their portion.

Cancellation/No Show Policy

- While understanding that there may be times when you miss an appointment due to emergencies or obligations, our office requires at least 24 hours prior notice on all cancelled appointments to avoid a $50 no-show fee ($200 for new patient visits).
- New prescriptions will not be issued without seeing your provider
- Refill prescriptions may require an office visit or labs before further prescriptions are authorized.

Form Completion Policy

- All forms requiring physician signature and medical review- i.e., school, daycare, camp physicals; prior authorizations; FMLA; disability or other paperwork- will be assessed and may be charged a $25 fee or require a visit. Patient is responsible for payment.

Return Check Policy

- There is a $35 charge for returned checks added to your original balance. In addition, we may seek all additional legal remedies provided to us under Oregon law.

Patient Balance Policy

- Wholesome Family Medicine, after filing with insurance companies will mail you a Patient Balance Statement. Payment in full is due upon receipt of this statement. If you have any questions or dispute the balance it is your responsibility to contact the billing office within 30 days. Past due accounts will be subject to a 5% monthly late fee (minimum of $5 per month) and may be referred to a collection agency.
- If you are not able to pay your balance in full, you must contact our billing office to discuss a payment schedule. Any late fees already incurred on past due balances will be included in any mutually agreed upon arrangements.

Insurance

1. Bring your valid and up-to-date proof of insurance coverage and a valid ID to each appointment.
2. Complete patient information form as needed at each appointment.
3. Notify our office of any changes to your insurance.
4. Be familiar with your co-pay, benefits, and be prepared to pay co-pay at each visit.
5. Determine if office/physicians are network providers prior to your visit.
6. It is your responsibility to know coverage of your particular plan. Although we are happy to check benefits there is never a guarantee of payment. We participate in most managed care plans and will file your insurance plan as may be necessary; however, patients are required to pay for their portion of their health plan benefits at the time services are provided.

Thank you for understanding our payment policy. Please let us know if you have any concerns. I have read and understand the Financial Policy Agreement and agree to abide by its guidelines.

Patient signature: _____ Date: _____

If applicable, Legal Representatives sign below:

_____ Date:_____

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof if requested (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.