Mountain West Pediatrics

2356 North 400 East, Suite 202, Tooele, Utah 84074
Office: 435.843.8380 Office Fax: 435.843.8382

PATIENT DEMOGRAPHICS

Patient Last Name: _____ First Name:_____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Sex: Male and Female

Parent Information: (Please circle) Mother Other (Guardian, Foster parent, etc.)

Last: _____ First: _____MI: _____

Date of birth: _____ SSN: _____ Email: _____

Cell Phone: _____ Work Phone: _____

Employer: _____

Address: _____City: _____State: _____Zip: _____

Parent Information: (Please circle) Father (Guardian, Foster parent, etc.)

Last: _____ First: _____MI: _____

Date of birth: _____ SSN: _____ Email: _____

Cell Phone: _____ Work Phone: _____

Employer: _____

Address: Same as patient yes/no (If no, please list below)

Address: _____City: _____State:_____Zip_____

Emergency Contact:

Name: _____ Relationship to patient _____Phone: _____

Signature of Parent/Legal Representative:

_____ **Date:** _____

Printed Name: _____

Insurance Information

Please complete all the information so we can bill your insurance correctly. A copy of your current insurance card(s) is **REQUIRED** for each appointment.

Patients with no insurance are required to pay 100% of charges at time of service.

Co pays or patient responsibility percentages are due at time of service.

Thank you for your cooperation.

Primary Insurance Company:

_____

Name of Insurance Holder: _____

Address of Primary insurance holder: (If different from the patient)

_____

Relationship to patient: _____DOB: _____SSN:_____

Policy #: _____Group #_____Effective: _____

Copy of insurance card given to clinic: (Initials): _____

Secondary Insurance Company: _____

Name of Insurance Holder: _____

Address of Primary insurance holder: (If different from the patient)

_____

Relationship to patient: _____DOB: _____SSN: _____

Policy #: _____Group #_____Effective Date: _____

Copy of insurance card given to clinic: (Initials): _____

Patient Name: _____ Patient Date of birth: _____

Signature of responsible party: _____ **Date:** _____

Relationship to patient: _____

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PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Sex: M F

Are you the parent or legal guardian of the child being seen today? Y N

(If NO, do you have written permission allowing us to treat the child?) Y N

Is the child currently taking any medications (prescribed or over the counter.)? Y N

Medication: _____Dosage: _____

Medication: _____Dosage: _____

Medication /food allergies and reactions: (If no known allergies, write NONE.)

_____

Siblings of patient:

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

Name(s) of people living in the same household with the patient:

Name: _____

Neonatal History:

Did labor last longer than 24 hours? Y N

Delivery: Full Term: _____ Pre-term: _____ post-term: _____

Child born: C-Section: ____ Headfirst: ____ Feet First: ___ Buttocks First: _____

Child require: Photo therapy: _____ IV/Fluids: _____ Oxygen: _____ NICU stay: _____

Birth Weight: _____ Birth length: _____

Nutritional History:

Breast fed: ____ (until age: _____) Bottle Fed: ____Formula Fed: ___

(Brand of formula): _____

Any feeding problems? Y N

(if yes, please explain): _____

_____

Child have constipation? Y N Diarrhea? Y N

Any current concerns about the patient's nutrition? Y N

(If yes, please explain)

_____

_____

Developmental History:

Did the patient develop normally? Y N (If No, please explain)

_____

Any history of speech/language delay? Y N

Any concerns with patients' current development? Y N (If yes, please explain.)

_____

Immunization History:

Is the patient current with immunizations? Y N

Any adverse reactions to previous immunizations? Y N

Social History:

These questions pertain to the household in which the patient lives:

Number of siblings: _____ Birth order (First, middle, other) _____ Smokers in the home: Y N

Number of dogs: _____ Number of Cats: _____ Other pets: _____

Substance abuse: Y N Discipline problems : Y N Temper Problems : Y N

Deceased Parents: Y N Divorced Parents: Y N State Custody: Y N

I certify the above information is true and correct to the best of my knowledge.

Print Name: _____ **Relationship to patient:** _____

Signature: _____ **Date:** _____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION.

I hereby give my consent for Mountain West Pediatrics (MWP) to use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and Healthcare Operations (TPHO).

I have the right to review the Notice of Privacy Practices, which provides a more complete description of such uses and disclosures, prior to signing this consent. MWP reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by sending a written request to MWP at the above address.

With this signed consent, MWP may call my home and any other locations for which I have provided contact information to relay or gather information to assist MWP in carrying out TPHO; including, but not limited to, appointment reminders, insurance and billing items, calls regarding my clinical care and laboratory results. MWP may give the message in person, leave a message on voicemail or send the message via email to any email address I have provided to them.

I have the right to request MWP restrict how it uses or discloses my PHI to carry out TPHO. Any such request must be submitted in writing to MWP. I understand that MWP is not required to agree to my requested restrictions, but if they do so in writing, they are bound to such an agreement.

By signing this form, I am consenting to MWP the use and disclosure of my PHI to carry out TPHO. I may revoke my consent at any time in writing, to the extent that MWP has already made disclosures in reliance upon my prior consent. If I do not sign this form, or revoke it later, MWP may decline to provide treatment to me.

Signature of Parent or Legal Guardian	Date	Patients Name (Please Print)

Name of Parent or Legal Guardian (Please Print)	Relationship to Patient