

Juniper Family Medicine Pediatric Information Sheet

Do you vaccinate your child? YES or NO

Juniper has a vaccination policy. You and your child must have current vaccines to become a patient at Juniper. If you answer no to the above please do not continue.

Child's First & Last Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ M or F

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mother's Name \_\_\_\_\_ Phone \_\_\_\_\_

Father's Name \_\_\_\_\_ Phone \_\_\_\_\_

Insurance \_\_\_\_\_ ID# \_\_\_\_\_

Policy Holder \_\_\_\_\_ Policy Holder DOB \_\_\_\_\_

Person Responsible for Payment? Name \_\_\_\_\_

Address \_\_\_\_\_ Child lives with? \_\_\_\_\_

Other Persons Living in the Home: \_\_\_\_\_

School & Grade (including Preschool) \_\_\_\_\_ Is your child doing well in school? Y/N

How much did your child weigh at birth? \_\_\_\_\_ Lbs \_\_\_\_\_ oz

Were there any complications of pregnancy? Y/N      Were there any complications of Labor or Delivery? Y/ N

Has the child ever had any of the following? (Give dates where possible)

Frequent ear infections \_\_\_\_\_ Asthma \_\_\_\_\_ Kidney or bladder infection \_\_\_\_\_

Serious head injury \_\_\_\_\_ Seizures \_\_\_\_\_ Surgery (type) \_\_\_\_\_

Has your child ever been hospitalized overnight? (give reason and date) \_\_\_\_\_

Are there any medical problems in the family including grandparents?

| <b>Relative</b> | <b>Medical Problem</b> |
|-----------------|------------------------|
|                 |                        |
|                 |                        |

Does the child have any medication allergies? \_\_\_\_\_

- For Parents/Guardians**
- Do you have trouble paying heat, water or electricity bills? Y/N
  - Do you have enough food available? Y/N
  - Do you have problems with transportation? Y/N
  - Do you feel your child is safe? Y/N
  - Do you have a consistent place to live? Y/N

• Child's Name \_\_\_\_\_ Date of birth \_\_\_\_\_

• What concerns or medical problems about your child would you like to discuss with the provider?

\_\_\_\_\_

Where was the child seen before? \_\_\_\_\_

Are the immunizations up to date? \_\_\_\_\_ Records Located? \_\_\_\_\_

By signing below, as this child's parent or guardian, you agree that the above information is true and correct. You authorize Juniper Family Medicine PLLC to leave a voicemail on the phone number(s) above unless otherwise noted. Should there be any missing information, Juniper may refuse service. If you cannot make the child's appointment, please call us as soon as possible to avoid the following: The first No Show Fee is \$25. The second No Show Fee is \$50. If you No Show a third time, you may be discharged from this practice. By signing this, you also acknowledge receipt of Juniper Family Medicine's HIPAA Privacy Act Policy. This policy indicates we participate with the Colorado Prescription Monitoring Program and authorizes JFM to obtain your prescription history. We also may access the Quality Health Network which is a secure, centralized health information data base only for healthcare professionals to obtain past medical records. We will bill your insurance, but if there is a co-pay, it is due at the time of service. If you have not met your deductible, we will also ask you to pay the JFM office visit balance at the time of service.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_