

## CHILD PATIENT REGISTRATION AND CONSENT FORM

Today's date:					PCP:				
<b>PATIENT INFORMATION</b>									
Patient's last name:			First:		Middle:			Marital status (circle one)	
								Single / Mar / Div / Sep / Wid	
Need Translator?		If Yes, What language?			Social Security #:		Date of Birth:		Age:
<input type="checkbox"/> Yes <input type="checkbox"/> No							/ /		
									Sex:
									<input type="checkbox"/> M <input type="checkbox"/> F
Email address:					Home phone #:		Cellular phone #:		
_____@_____					( )		( )		
Street Address:			Apt. #:	City:			State:	ZIP Code:	
							CA		
Occupation:			Employer:				Employer phone #:		
							( )		
Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Migrant <input type="checkbox"/> Seasonal Worker		Ethnicity: (select only one)		Race: (select one or more)			
				<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic		<input type="checkbox"/> White <input type="checkbox"/> Black / African American <input type="checkbox"/> American Indian / Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other			
Country of Birth: <input type="checkbox"/> US <input type="checkbox"/> Other: _____			Status at arrival:			About how many years have you lived in the US? _____			
			<input type="checkbox"/> Refugee <input type="checkbox"/> Asylee <input type="checkbox"/> Other						
Income: list immediate family members living in household (spouse & children)				Relationship		Age	Gross Monthly Income	Total Persons	
				Self			\$		
							\$		
							\$		
							\$		
							\$	Total Gross Inc.	
							\$	\$	
<b>INSURANCE INFORMATION</b>									
Person responsible for bill:		Birth date:		Address (if different):			Home phone #:		
		/ /					( )		
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No									
Please indicate primary insurance		<input type="checkbox"/> Medi-Cal		<input type="checkbox"/> Medicare		<input type="checkbox"/> HMO		<input type="checkbox"/> Other	
Medi-Cal ID Number:		Medicare ID Number:		Policy Number			Co-payment:		
							\$		
<b>IN CASE OF EMERGENCY</b>									
Name of local friend or relative (not living at same address):				Relationship to patient:		Home / Cell phone #:		Work / Cell phone #:	
1)						( )		( )	
2)						( )		( )	
<p>I, _____, request &amp; give my permission to La Maestra Community Health Centers and its assigned physicians &amp; auxiliary personnel to render such treatment necessary as determined by my condition. I understand auxiliary personnel include Nurse Practitioner, Nurse, &amp; Medical Assistant.</p> <p>It is further understood that if I refuse any treatment suggested by La Maestra Community Health Centers, I automatically release them from responsibility for damages which may occur because of my refusal. I understand further that it is my responsibility to follow the treatment plan prescribed by the physician. I realize my refusal will be documented and witnessed by no less than two persons, including the physician in charge.</p> <p>I have received information about advance directive and I understand that I have the right to formulate advance directives that would be filed in my medical file. I understand that I can change my instruction if I desire in the future.</p> <p style="text-align: center;"><input type="checkbox"/> I would like to receive more information                      <input type="checkbox"/> No, I would not like to receive more information</p> <p>The above information is complete and correct. I hereby authorize release of information necessary to file a claim with my insurance company and I assign benefits otherwise payable to me to the clinic indicated on the claim. I understand that I am financially responsible for charges not covered by my insurance or by programs that I am determined to be eligible for. <b>Initials</b> _____</p> <p>I hereby give my consent to have photographs, videotaped images, or other images made of myself or my family member and/or consent to interview with a member of the news medical or by La Maestra Community Health Centers for the promotion of the clinic, its program, services or collaborative. <b>Initials</b> _____</p> <p>Payment is expected at time of service.</p>									
_____					_____				
<i>Patient/Guardian signature</i>					<i>Date</i>				
_____					_____				
<i>Registered by</i>					<i>Date</i>				



# Pediatric Health History Form



**ALLERGIES/REACTIONS TO MEDICINES OR VACCINATIONS:** \_\_\_\_\_

### PREGNANCY & BIRTH

Is this child yours by:  birth  adoption  stepchild  other \_\_\_\_\_

Please indicate any medical problems during pregnancy  none  specify: \_\_\_\_\_

Delivery by:  vaginal birth  caesarean If caesarean, why? \_\_\_\_\_

Birth weight: \_\_\_\_\_ Birth length: \_\_\_\_\_ APGAR score 1 min. \_\_\_\_\_ 5 min. \_\_\_\_\_

Please indicate any medical problems during the baby's newborn period  none If premature, how early? \_\_\_\_\_

other problems: \_\_\_\_\_

### NUTRITION & FEEDING

Was your child breastfed?  No  Yes If so, how long? \_\_\_\_\_

Has your child had any unusual feeding/dietary problems?  No  Yes If yes, specify: \_\_\_\_\_

Milk intake now: Type  cow milk  non-fat  1%fat  2%fat  whole milk  soy milk  rice milk

Average ounces per day (Note: 8 ounces are in 1 cup) \_\_\_\_\_

### SLEEP

Hours per night \_\_\_\_\_ Naps (number & length) \_\_\_\_\_ Any sleep problems? \_\_\_\_\_

### DEVELOPMENT

At what age did your child: sit alone \_\_\_\_\_ walk alone \_\_\_\_\_ say words \_\_\_\_\_ toilet train (daytime) \_\_\_\_\_

Girls only: Age at first menstrual period \_\_\_\_\_

**DENTAL HISTORY:** Has child been seen by a dentist?  No  Yes If so, how often \_\_\_\_\_ Date of last visit \_\_\_\_\_

**IMMUNIZATIONS/INFECTIOUS DISEASES:** Please bring your child's immunization records to your appointment.

Has your child had:  chickenpox  measles  mumps  rubella  meningitis  tuberculosis (TB)

**EXPOSURES/HABITS:** Any concerns about lead exposure? (old home/plumbing/peeling paint)  No  Yes

Do any household members smoke?  No  Yes

TV --hours per day \_\_\_\_\_ Computer-hours per day \_\_\_\_\_ Video Games-hours per day \_\_\_\_\_

**PAST MEDICAL HISTORY:** Please describe any major medical problems and their dates

\_\_\_\_\_  
\_\_\_\_\_

Hospitalizations/Operations (with dates): \_\_\_\_\_

Broken bones or severe sprains \_\_\_\_\_

**FAMILY HISTORY:** Please circle any family history of the following (indicate who has/had the condition):

Alcoholism/drug abuse	Heart disease or stroke before age 60	Seizures	Cholesterol Problems
Psychiatric disorders	Thyroid disease	Kidney disease	Bleeding/clotting problems
High blood pressure	Asthma/hayfever/eczema	Birth defects	Inherited/genetic diseases
Diabetes			

### SOCIAL HISTORY:

Birthplace \_\_\_\_\_ Current (or upcoming) grade: \_\_\_\_\_

Who lives at home?

<u>Name</u>	<u>Age</u>	<u>Relationship</u>	<u>Highest Education Level</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are the child's parents  married  unmarried  separated  divorced If divorced, when? \_\_\_\_\_

Parents' occupations: Mother \_\_\_\_\_ Father \_\_\_\_\_

Reviewed By : \_\_\_\_\_ MD/RN/MA On: \_\_\_\_\_

# Historia de Salud Pediátrica



**ALERGIAS / Reacciones a los medicamentos o vacunas:** \_\_\_\_\_

**EMBARAZO Y NACIMIENTO**

Este niño es suyo por:  parto  adopción  hijastro  Otro \_\_\_\_\_

Por favor, indique cualquier problema de salud durante el embarazo  Ninguno  Especifique: \_\_\_\_\_

Parto por:  parto vaginal  Si cesárea, Razon? \_\_\_\_\_

Peso al nacer: \_\_\_\_\_ longitud al nacimiento: \_\_\_\_\_ APGAR score 1 min. \_\_\_\_\_ 5 min. \_\_\_\_\_

Por favor, indique cualquier problema de salud durante el período de recién nacido del bebé  ninguno / prematuro, que tan temprano? \_\_\_\_\_

otros problemas: \_\_\_\_\_

**NUTRICIÓN Y ALIMENTACIÓN**

leche materna?  No  Si, por cuánto tiempo? \_\_\_\_\_

Su hijo ha tenido alimentación inusuales o problemas alimenticios?  No  Si En caso afirmativo, especifique: \_\_\_\_\_

leche injeata ahora: Tipo  leche de vaca  Baja grasa  1%Grasa  2%Grasa  leche entera  leche de soya  leche de arroz

Promedio de onzas al día (Nota: 8 onzas en 1 taza) \_\_\_\_\_

**Sueño**

Horas por noche \_\_\_\_\_ Siestas (número y duración) \_\_\_\_\_ problemas del sueño? \_\_\_\_\_

**Desarrollo**

¿A qué edad su hijo: se sento solo \_\_\_\_\_ Camino solo \_\_\_\_\_ dejeo palabras \_\_\_\_\_ hizo del baño solo \_\_\_\_\_

Niñas solamente: Edad en la primera regla \_\_\_\_\_

**HISTORIA DENTAL:** ¿Ha sido niño atendido por un dentista?  No  Si con qué frecuencia \_\_\_\_\_ Fecha de ultima visita \_\_\_\_\_

**VACUNAS / ENFERMEDADES INFECCIOSAS:** Favor de traer los registros de vacunación de su hijo a su cita.

Ha tenido su hijo:  Viruela  Viruela loca  Paperas  Rubeola  meningitis  tuberculosis (TB)

**EXPOSICIONES / HÁBITOS:** Tiene preocupaciones sobre la exposición al plomo? (hogar antiguo / plomeria / pintura descascarada)  No  Si

¿Algún miembro del hogar fuma?  No  Si

TV - horas al día \_\_\_\_\_ Computadora hora al día \_\_\_\_\_ Juegos video horas al día \_\_\_\_\_

**Antecedentes personales:** Por favor describir los principales problemas médicos y sus fechas

\_\_\_\_\_

Hospitalizaciones / Operaciones (con fechas): \_\_\_\_\_

Los huesos rotos o esguinces graves \_\_\_\_\_

**HISTORIA FAMILIAR:** Por favor marque algún antecedente familiar de los siguientes (indicar quién tiene o ha tenido la enfermedad):

Alcoholismo / abuso de drogas	Las enfermedades del corazón o un derrame cerebral antes de los 60	Convulsiones	Problemas de colesterol
Trastornos psiquiátricos	Enfermedad de la tiroides	Enfermedad de los riñones	Sangrado o problemas de coagulación
hipertensión	Asma y fiebre del heno / eczema	Defectos de nacimiento	Las enfermedades hereditarias / genéticos
Diabetes			

**HISTORIA SOCIAL:**

Lugar de nacimiento \_\_\_\_\_ Grado de escuela actual (o futuro): \_\_\_\_\_

Mencione quien vive en casa?

<u>Nombre</u>	<u>Edad</u>	<u>Relacion</u>	<u>Nivel de educación</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Los padres del niño  casados  solteros  seperados  divorciados En caso de divorcio, cuando? \_\_\_\_\_

Ocupaciones de los padres: Madre \_\_\_\_\_ Padre \_\_\_\_\_

Reviewed By : \_\_\_\_\_ MD/RN/MA On: \_\_\_\_\_



## Notice of Privacy Practices

### Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of La Maestra Community Health Centers. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice by: contacting La Maestra Community Health Centers at **(619) 280-4213**.

If you have any questions about our *Notice of Privacy Practices*, please contact:

The Privacy officer at **(619) 578-2584**

I acknowledge receipt of a copy of the *Notice of Privacy Practices* of La Maestra Community Health Centers.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(patient/parent/conservator/guardian)

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### Inability to Obtain Acknowledgement

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reason why the acknowledgement was not obtained:

Signature of provider representative: \_\_\_\_\_ Date: \_\_\_\_\_



## Notificación de los Procedimientos de Privacidad

### Recibo de Enterado

Al firmar este recibo usted afirma haber recibido copia de la *Notificación de los Procedimientos de Privacidad*. Nuestra *Notificación de Procedimientos de Privacidad* le da información de cómo podemos utilizar y dar información de su salud, información que está protegida. Le recomendamos que lea pro completo este aviso.

Nuestra *Notificación de los Procedimientos de Privacidad* esta sujeta a cambios. Si esto ocurre, usted puede obtener una copia actualizada llamando al siguiente número de teléfono de la clínica médica **(619) 280-4213**.

Si usted tiene alguna pregunta en relación a esta notificación de los procedimientos de privacidad, por favor comuníquese al **(619) 578-2584**.

Me doy por informado al recibir esta copia de la *Notificación de los Procedimientos de Privacidad* de La Maestra Community Health Centers.

Firma: \_\_\_\_\_ Fecha: \_\_\_\_\_  
(Paciente/Padre/Tutor)

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### Inhabilidad para Obtener esta Notificación

Para completar si no es posible de obtener la firma individual. Si no es posible obtener la firma describa el esfuerzo hecho para informar de este aviso y la razón por la cual la firma no fue obtenida.

Firma del representante del proveedor: \_\_\_\_\_ Fecha: \_\_\_\_\_



## **Notice of Advance Health Care Directive** **(California Probate Code Section 4701 Acknowledgement of Receipt)**

### **Acknowledgement of Receipt**

By signing this form, you acknowledge receipt of the notice of Advance Directive of La Maestra Community Health Centers. This information is about your decision in advance of what medical treatments you want to receive in the event you become physically or mentally unable to communicate your wishes.

If you have any questions or need additional information about our notice of Advance Directive, please contact our administration office at **(619) 578-2584**.

I acknowledge receipt of the Notice of Advance Directive of La Maestra Community Health Centers.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*(patient/parent/conservator/guardian)*

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### **Inability to Obtain Acknowledgement**

To be completed only if no signature is obtain. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reason why the acknowledgement was obtained.

Signature of provider representative: \_\_\_\_\_ Date: \_\_\_\_\_



## **Notificación de Instrucciones Anticipadas** **(Código 4701)**

### **Recibo de Enterado**

Al firmar este recibo usted afirma haber recibido copia de la *Notificación de Instrucciones Anticipadas*, esta información es referente a su decisión anticipada de que los tratamientos médicos que usted desea recibir en caso que no pueda comunicarse o se encuentra demasiado enfermo física o mentalmente para hacer sus propias decisiones.

Si usted tiene alguna pregunta en relación a esta notificación de los procedimientos de privacidad, por favor comuníquese al **(619) 578-2584**.

Me doy por informado al recibir esta notificación de La Maestra Community Health Centers.

Firma: \_\_\_\_\_ Fecha: \_\_\_\_\_  
(Paciente/Padre/Tutor)

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### **Inhabilidad para Obtener esta Notificación**

Para completar si no es posible de obtener la firma individual. Si no es posible obtener la firma describa el esfuerzo hecho para informar de este aviso y la razón por la cual la firma no fue obtenida.

Firma del representante del proveedor: \_\_\_\_\_ Fecha: \_\_\_\_\_