

**Cypress Physicians Association**  
**Pediatric Medical Questionnaire – BIRTH TO AGE 5**

Date of Birth: \_\_\_\_\_ Previous medical care Dr. \_\_\_\_\_ Last Well Exam: \_\_\_\_\_

Reason for today's visit	Date Began (if applicable)
Pregnancy/Birth history	
Any illnesses during pregnancy?	Medication during pregnancy?
Smoking Alcohol Drugs – during pregnancy?	
At birth, how many gestational weeks was your child (full term = 40 weeks)?	
Type of delivery? Vaginal C-section	Birth weight: Birth length:
Single pregnancy Multiple (twin/triplet/etc.) Any Complications?	
Did baby receive the Hepatitis B vaccine in the hospital? Yes No Not sure	

Past Medical History:
Immunizations up to date? Yes No Unsure – Please have your shot record available
Hospitalizations (when-where-why)
Serious injuries or ER visit (when-what)

<i>Please mark (X) if your child has had problems below.</i>							
Asthma/Wheezing		Thyroid problems		Diabetes		Joint problems	
Pneumonia		Headaches		Jaundice		Urinary infections	
Heart problems		Seizures		Reflux		Hearing problems	
Heart murmur		Bleeding tendency		Eczema		Vision problems	
Learning disability		Blood transfusion		Skin infections		Sleep problems	
ADHD/ADD		Anemia		Ear infections		Other:	
Developmental delay		Allergies/hay fever		Cancer			

Past Surgical History: (please indicate year)			
Appendix		Bone surgery	Ear tubes
Tonsils/Adenoid		Circumcision	Other:

Medications: list all prescription and over-the-counter medications or supplements			
Name	Dosage	Frequency	Indications/Use

Allergies to Medication/Food/Other (PLEASE DESCRIBE REACTION – i.e. rash, nausea, etc.)
Pharmacy (location/phone):

**Pediatric Medical Questionnaire – BIRTH TO AGE 5 (page 2)**

**Family Medical History** list all blood relatives of your child who have these problems – use abbreviations (F) father, (M) mother, (MGM) mother’s mother, (MGF) mother’s father, (PGM) father’s mother, (PGF) father’s father, (B) brother, (S) sister, (C) cousin

Anemia		High blood pressure		Seizures	
Asthma		High cholesterol		Mental retardation	
Allergies		Diabetes		Cancer	
Heart disease		Tuberculosis		Sudden infant death	
Arthritis		Birth defects		Thyroid problems	
Migraines		Psychiatric illness		Other:	

**Social History**

	First and Last Name	Age	Occupation	Lives with child?
Mother				Yes No
Father				Yes No
Siblings	(First name/age/sex)			
Other people living in household:				
Child care: Home Daycare Nanny Family members Other				
At home are there Smokers Pets Guns Swimming pool Smoke detectors Fire extinguishers?				

**Feeding and Nutrition**

Current nutrition:	Breastfeeding	Formula	Table Food	Cow Milk (Whole/2%/1%/skim?)
If breastfeeding, how much/often?				
If formula, what brand?		Amount?	oz. every	hours
If regular milk, circle which type – whole/2%/1%/skim		Amount per day?	oz.	
Is your child receiving vitamins?				

**Developmental History**

At what age did your child sit alone?	Walk alone?
Did your child say any words by 15 months old?	
At what age was your child potty trained during the day?	
Compared to other children his/her age, is your child advanced same behind	

**REVIEW OF SYSTEMS: Mark (x) if your child CURRENTLY has any of the following:**

<input type="checkbox"/>	Fever	<input type="checkbox"/>	Thrush	<input type="checkbox"/>	Diaper rash	<input type="checkbox"/>	Itching
<input type="checkbox"/>	Weight loss	<input type="checkbox"/>	Sore throat	<input type="checkbox"/>	Pain with urination	<input type="checkbox"/>	Jaundice/yellow skin
<input type="checkbox"/>	Vision problems	<input type="checkbox"/>	Cough	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	Rash
<input type="checkbox"/>	Red/pink eye	<input type="checkbox"/>	Turning blue	<input type="checkbox"/>	Scrotal swelling	<input type="checkbox"/>	Fainting
<input type="checkbox"/>	Eye drainage	<input type="checkbox"/>	Stop breathing	<input type="checkbox"/>	Vaginal discharge	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	Hearing problems	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	Ear drainage	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Problems walking	<input type="checkbox"/>	Swollen glands
<input type="checkbox"/>	Nasal congestion	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Birthmark	<input type="checkbox"/>	Behavior problems
<input type="checkbox"/>	Runny nose	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	Easy bruising	<input type="checkbox"/>	Snoring
<input type="checkbox"/>	Allergies/sneezing	<input type="checkbox"/>	Food intolerances	<input type="checkbox"/>	Easy bleeding	<input type="checkbox"/>	

**OFFICE USE ONLY:**

<b>Wt</b>	<b>Ht</b>	<b>HC</b>	<b>HR</b>	<b>T</b>	<b>O2</b>
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**Cypress Physicians Association**

**Patient Information**

Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

DOB: \_\_\_\_\_ Marital Status: Married Divorced Widowed Single Gender: Male Female

Social Security Number: \_\_\_\_\_ Driver's License Number: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Patient Cell Phone: \_\_\_\_\_ Spouse Cell Phone: \_\_\_\_\_

Other: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

**Please give us as many phone numbers as possible in case we need to reach you regarding lab/test results.**

Patient Employed by: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Position: \_\_\_\_\_

**Pharmacy Names and Numbers:**

Local \_\_\_\_\_ MailOrder \_\_\_\_\_

**Insurance Policy Holder's Information (Patient's spouse or responsible party)**

Insurance Company Name: \_\_\_\_\_

Patient relationship to insurance policy holder:  Self  Spouse  Child  Other \_\_\_\_\_

Insured's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Insured's DOB: \_\_\_\_\_ Insured's Social Security Number: \_\_\_\_\_

Insured's Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ E-Mail \_\_\_\_\_

Employer Information: Company Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**In case of emergency, please list a family member and a non-relative person in which we may contact.**

Family Member: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Non-relative Person: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Name of Spouse: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone No: \_\_\_\_\_

Number of Children: \_\_\_\_\_

Child's Names: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

\_\_\_\_\_ Date of Birth: \_\_\_\_\_

# Cypress Physicians Association

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Ethnicity and race is a major factor affecting the health of individuals and communities. New health guidelines are requiring us to document your ethnicity and race. Please choose a race and an ethnicity from the list below:

**Race:**

- American Indian or Alaska Native
- Asian
- Black or African American
- Hispanic
- Native Hawaiian or Other Pacific Island
- White
- Other Race
- Declined**

**Ethnicity:**

- Not Hispanic or Latino
- Hispanic or Latino
- Other
- Declined**

**Preferred Language:** \_\_\_\_\_

**Print Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

## Cypress Physicians Association

### No Show Policy

Appointments are in high demand, and your early cancellation will give another patient the chance to have access to timely medical care.

This policy does not apply to patients who call to patients who have sudden emergencies less than 24 hours before their appointment.

For missed appointments, a “**No Show Fee**” charge of \$20 will be charged to the patient after the second “No Show”. This charge is **NOT** billable to the insurance company and, therefore, will be due before future services are rendered. After 3 (three) “No Show” in 12 months from the 1st “No Show”, the patient may be dismissed from the practice.

initials

### Preclinical Laboratory/Imaging and health optimization policy

In order to provide you the best possible medical care for chronic and routine medical conditions, you **MUST** have your **LABS** drawn and **RADIOLOGY** imaging performed 1 week prior to your office visit. Our practice policy is that lab or imaging results will be only be discussed during an office visit. This allows you to ask questions and address any concerns that you may have regarding your care. It also allows us to appropriately adjust your medications and/or other treatments and work towards achieving your optimal health. If you **DO NOT** have your labs drawn **AHEAD** of time, you may be asked to **RESCHEDULE** your appointment.

Additionally, it is encouraged that you bring your following to your appointment:

- You're actual medication bottles (or at least a list of your current medications and doses) to ensure that the accuracy of our documentation and to verify medications from other medical providers.
- For high blood pressure
- A logbook of your blood pressure readings and your bp machine.
- For diabetes
- logbook of your blood sugar readings and a log of your insulin dosing (if applicable)

initials

### Preventive Care Exam information

Your preventive care exam (aka "annual physical exam", well women and well child) is a specific service designed to screen for and prevent health issues. It may include a clinical examination, laboratory tests, procedures, counseling, and/or immunizations depending on your age, gender and other risk factors.

In most cases, the preventive care exam is free to you. The Affordable Care Act obligates most insurance plans to pay for this service without charging you a co-payment, co-insurance, or deductible.

However, there are important exceptions to this rule: the evaluation and management of new or existing health issues is **NOT** covered under the preventive care exam. Thus, the evaluation and management of new or existing health issues during the preventive care exam will generate charges that will be your responsibility (including but not limited to co-payment, co-insurance and deductible.) Please note that a medication refill falls responsible for any additional charges incurred if new or existing health issues are evaluated and managed during the preventive care exam.

initials

## Consent for Treatment

Cypress Physicians Association has on staff Physicians Assistants and advanced Nurse Practitioners to assist in the delivery of medical care.

A physician assistant is a graduate of an accredited Physician Assistant program, certified by the NCCPA Board and licensed by the Texas Medical Board. An advanced nurse practitioner is a graduate of an accredited Advanced Practice Nursing program, licensed by the Texas Nursing Board. Under the supervision of a physicians, a physician assistant can diagnose, treat and monitor acute and chronic diseases as well as provide health maintenance care. Supervision does not require the constant physical presence of a supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided. A physician assistant may provide such medical services that are within his/her education, training and experience. These services may include: obtaining histories and performing physical exams; ordering and/or performing diagnostic and therapeutic procedures; formulating a working diagnosis; developing and implementing a treatment plan; monitoring the effectiveness of therapeutic interventions; assisting at surgery; supplying sample medications and writing prescriptions; making appropriate referrals.

My initial below signifies that I have read the above and hereby consent to the services of a physician assistant or advanced nurse practitioner for my health care needs. I understand that I can refuse to see a physician assistant or advanced nurse practitioner and request to see a physician. I understand that this refusal may cause a delay in the time of my appointment.

**initials**

## Acknowledgement Notice of Privacy Practices

My signature below signifies that **Cypress Physicians Association's** Notice of Privacy Practices describes the types of uses and disclosures of protected health information (PHI) that will occur in patient treatment, payment of bills or in the performance of health care operations of **Cypress Physicians Association**. The Notice of Privacy Practices of **Cypress Physicians Association** is also provided at the front desk. This Notice of Practices also describes patient rights and **Cypress Physicians Association's** duties with respect to protect patient health information.

**Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

## Confidential Communication Request

Cell phone number: \_\_\_\_\_  
Work phone number: \_\_\_\_\_  
Home phone number: \_\_\_\_\_  
E-Mail address: \_\_\_\_\_

Cypress Physician's Association will only release or discuss your health information with your written consent.

If you **DO NOT** want your information released to **ANYONE** else, please sign below:

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(Signature)

(Date)

If you would **LIKE** to have anyone else be able to discuss/receive your health information, please list their names below and sign:

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(Name of authorized person/relationship)

(Contact info - phone/email)

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(Name of authorized person/relationship)

(Contact info - phone/email)

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(Name of authorized person/relationship)

(Contact info - phone/email)

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(Patient/guardian signature)

(Date)

## **Consent to Minor Treatment**

If a parent or legal guardian is not present, I/we authorize the following person to act on our behalf for medical care for the minor name below. Minor patients **CANNOT** be treated without a parent or guardian present if this consent has not been filled out.

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(minor patient's name)

(minor patient's date of birth)

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(name of authorized person/relationship)

(contact info - phone/email)

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(name of authorized person/relationship)

(contact info - phone/email)

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(parent/guardian signature)

(date)

# Cypress Physicians Association

## Assignment and Release

I, the undersigned, have coverage with \_\_\_\_\_ and assign directly to Cypress Physicians Assoc. all medical benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the use of this signature for all insurance submissions.

I further authorize the use of this signature as Treatment Authorization and give permission to Cypress Physicians Assoc. to give me reasonable and proper medical care based on today's standards.

I further authorize the use of this signature as Lab and Insurance Submission Consent and give permission to Cypress Physicians Assoc. to submit blood specimens to the lab of choice for analysis and study. I also authorize the submission for payment to my insurance for charges incurred for said labs and further agree to full responsibility for payment of any non-covered services.

Medicare Participants: I request that payment of the authorized Medicare benefits be made on my behalf to Cypress Physicians Assoc. for any services rendered by the physicians of this group. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits of the benefits payable for related service. I understand that my signature request that payment be indicated in item 9 of the HCFA-1500 form, or elsewhere on other claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. The Physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

As responsible party for this account I agree to pay the balance due. Should the billing department need to contact me in regards to this account and are unable to reach me by mail or home phone, then I may be reached at the work place.

**Patient name (printed):** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

(Patient or person authorized to give consent)