Cypress Physicians Association
Pediatric Medical Questionnaire – OVER AGE 5

Date of Birth:_____ Previous medical care Dr. _____ Last Well Exam: _____
Last Vision Exam: Last Dental Exam:

Reason for today's visit	**Date Began**

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

Please mark (X) if your child has had problems below.							
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?

Developmental History
Did your child have any developmental problems?
Compared to other children his/her age, is your child advanced same behind
Problems with bedwetting tantrums hyperactivity speech learning difficulties
For Females: Age at first menstrual period _____ Last menstrual period _____

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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 patient?
Mother				Yes No
Father				Yes No
Siblings	(name/age/sex)			
Other people living in household:				
School Name/Grade:			Has your child repeated any school years?	
Extracurricular activities or sports:				
At home are there Smokers Pets Guns Swimming pool Smoke detectors Fire extinguishers?				

Feeding and Nutrition
How many servings does your child receive per day? Meat ___ Dairy ___ Bread ___ Fruits/Vegetables ___
Is your child receiving vitamins?
How much milk does your child drink? _____ oz per day Whole/2%/1%/skim?

REVIEW OF SYSTEMS: Mark (x) if your child CURRENTLY has any of the following:			
☐ Fever	☐ Nasal congestion	☐ Pain with urination	☐ Itching
☐ Weight loss	☐ Sore throat	☐ Blood in urine	☐ Acne
☐ Abnormal weight gain	☐ Cough	☐ Scrotal swelling	☐ Rash
☐ Vision problems	☐ Difficulty breathing	☐ Breast pain	☐ Fainting
☐ Red/pink eye	☐ Wheezing	☐ Menstrual cramps	☐ Headaches
☐ Eye drainage	☐ Constipation	☐ Vaginal discharge	☐ Seizures
☐ Hearing problems	☐ Diarrhea	☐ Joint pain	☐ Swollen glands
☐ Ear drainage	☐ Vomiting	☐ Easy bruising	☐ Behavior problems
☐ Ear pain	☐ Stomach pain	☐ Easy bleeding	☐ Snoring
☐ Runny nose	☐ Nausea	☐ Irregular periods	☐ Allergies/sneezing

Any other concerns?

OFFICE USE ONLY:

Wt	**Ht**	**BP**
HR	**T**	**O2**

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:_____

Cypress Physicians Association

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 form 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: _____

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
-A 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:

_____

(Signature) (Date)

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

_____

(Name of authorized person/relationship) (Contact info - phone/email)

_____

(Name of authorized person/relationship) (Contact info - phone/email)

_____

(Name of authorized person/relationship) (Contact info - phone/email)

_____

(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.

_____ _____

(minor patient's name) (minor patient's date of birth)

_____

(name of authorized person/relationship) (contact info - phone/email)

_____

(name of authorized person/relationship) (contact info - phone/email)

_____

(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 it's 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)