TAHOE FOREST
MULTISPECIALTY CLINICS

PATIENT REGISTRATION

PATIENT NAME________________________ GENDER __M __F WHERE DID YOU HEAR OF US?__________

DATE OF BIRTH ______________ SS# __________________ DRIVERS LICENSE #(16 and over)__________

MAILING ADDRESS____

CITY______________________________ STATE________________ ZIPCODE______________

PHYSICAL ADDRESS____

CITY______________________________ STATE________________ ZIPCODE______________

HOME PH (_____)_____-_______ WORK PH (_____)_____-_______ CELL PH (_____)______-______

SCHOOL: ______________ PREFERRED PHARMACY:__________ RELIGIOUS PREFERENCE:__________

FATHER'S NAME________________________ DOB ______ SS# ________ DRIVERS LICENSE #________

ADDRESS ____

EMPLOYER ________________________ OCCUPATION ______________________________

MOTHER'S NAME ________________________ DOB ______ SS# ________ DRIVERS LICENSE #________

ADDRESS ____

EMPLOYER ________________________ OCCUPATION ______________________________

MAY WE LEAVE A MESSAGE ON YOUR HOME PHONE REGARDING YOUR CARE? YES / NO

PRIMARY INSURANCE COMPANY______________________________________

COPAY$______ DEDUCTIBLE$__________

•Please provide the following information:

POLICY HOLDER'S NAME________________________________ BIRTHDATE______________

SS# ________________________ PHONE (_______)_______-________

MAILING ADDRESS ____

RELATIONSHIP TO PATIENT __________ EMPLOYER______________________________

SECONDARY INSURANCE COMPANY__________________________

•Please provide the following information:

POLICY HOLDER'S NAME________________________________ BIRTHDATE______________

SS# ________________________ PHONE (_______)_______-________

MAILING ADDRESS ____

RELATIONSHIP TO PATIENT __________ EMPLOYER______________________________

EMERGENCY CONTACT________________________________ PHONE (_____)______-________

ADDRESS____ RELATIONSHIP______________

WE REQUIRE THAT YOU PRESENT YOUR INSURANCE CARD(S) FOR PHOTOCOPYING. IF YOU DO NOT HAVE YOUR INSURANCE CARD(S) YOU WILL BE BILLED FOR ALL SERVICES PROVIDED UNTIL SUCH TIME AS WE RECEIVE A VALID INSURANCE CARD.

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO Tahoe Forest MultiSpecialty Clinics and their representatives by my insurance company or other entity responsible for payment of my medical claims. I understand and acknowledge that this assignment in no way releases me from my part of the financial responsibility for services rendered. I further understand and acknowledge that the financial responsibility for services rendered rests with the patient and/or his family regardless of insurance coverage. I further understand and acknowledge that services are to be paid for in full within 30 days by the patient or his/her insurance carrier.

Signature____ Date______________

Christopher Arth, M.D.
Deborah Brown, M.D.
Else Uglum, M.D.
Pediatrics and Adolescent Medicine

New Patient Medical Questionnaire

CHILD'S NAME ______________________ TODAY'S DATE __________
DOB ______________
PREVIOUS DOCTOR ____________________ DENTIST ____________

1. PREGNANCY AND BIRTH

Any problems/medications/smoking/drugs and alcohol during pregnancy or delivery?

____
____
____

Any problems with your baby after his/her birth? ________________________
____
____

2. FAMILY PROFILE

Parent's Married __________ Separated __________ Divorced __________
Siblings (Name and Age) ______________________________
____

3. FAMILY MEDICAL HISTORY

LIST GRANDPARENTS, AUNTS/UNCLES, PARENTS, SIBLINGS HEALTH PROBLEMS:

Anemia/ Blood Disorder ______________________________

Asthma/ Other Allergies______________________________

Developmental Delay/Genetic Disorders ______________________

Drug Problems/ Alcoholism ___________________________

Cancer/ AIDS ______________________________________

Cystic Fibrosis/ Musc. Dystrophy ________________________

Tuberculosis ______________________________________

Arthritis ____

Epilepsy/Seizures ___________________________________

Heart Disease/ Sudden Death __________________________

High Blood Pressure/ Cholesterol Problems __________________

Migraines ____

Birth Defects/ Infant Death ___________________________

Early Deafness _____________________________________

Diabetes ____

New Patient Medical Questionnaire (Continued)

CHILD'S NAME ______________________________ TODAY'S DATE __________
DOB ____________________

COMPLETE REMAINDER AS APPROPRIATE FOR YOUR CHILD'S AGE

4. PAST MEDICAL HISTORY

Previous Hospitalizations or Surgeries ______________________________

____

Previous Injuries ______________________________

____

Allergic Reactions ______________________________

____

Medications ______________________________

Immunizations up to date ______________________________

Recurrent Illnesses ______________________________

____

5. NUTRITION

Food Intolerances/ Allergies ______________________________

____

Appetite/ Feeding Problems ______________________________

____

6. DEVELOPMENTAL AND BEHAVIOR

AGE AT WHICH CHILD:

Sat Alone ____________________ Walked ____________________

Used Sentences ______________________________

Toilet Trained ______________________________

Development Compared To Other Children ______________________________

____

Grade in School ______________________________

Any Learning/ Behavior Problems ______________________________

____

Patient Name: ______________________________

Date of Birth: ____________________ Today's Date: ____________________

SHOULD YOUR CHILD BE TESTED FOR TUBERCULOSIS (TB)?

Testing used to be done often for children, since the TB infection doesn't always make children sick. Now your child will have the routine TB tests done between the ages of 4-5 and 13-16 years old. Doctors also know that some children are more likely to be at risk for TB when certain conditions are present. Answering the questions below will help the doctor see if your child is at risk and should have a TB test today.

Please fill out this questionnaire to help your doctor determine if testing is needed.

Circle One

Y N 1. Were the parents or the child born in an area with high rates of TB (Mexico, Central and South America, Africa, Asia or Eastern Europe)?

Y N 2. Have the parents or the child lived in an area with high rates of TB?

Y N 3. Does the child live with or have regular contact with someone (for example, a child care provider) who:

- Has an HIV infection or is suspected of having an HIV infection?
- Has AIDS?
- Is a user of street drugs?
- Has been in jail/prison?
- Recently moved from an area with high rates of TB?
- Lives in a nursing home?
- Has a history of confirmed or suspected TB?

Y N 4. Is the child suspected of having or does the child have HIV infection?

Y N 5. Is the child part of a family of migrant workers?

Y N 6. Has the child been homeless at any time?

Y N 7. Are there <u>current</u> family members with a history of confirmed or suspected TB?

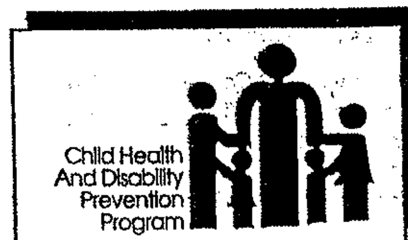
Y N 8. Is the child a foster child?

Y N 9. Has your child traveled outside of the U.S.?

Thank you for answering these personal and sensitive questions. Your responses will help the doctor provide your child with the best health care.

Developed By:

Placer County Health and Human Services
Child Health and Disability Prevention (CHDP) Program
For More Information, Please Call Placer County
CHDP Program (530) 886-3620
TB Coordinator (530) 889-7141



TAHOE FOREST
MULTISPECIALTY CLINICS

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Dear Patient,

As part of the hospital system, we are now required to ask questions that may seem intrusive and we apologize for this necessity.

Race, Ethnicity and Language
The US Department of Health and Human Services and the U.S. Centers for Disease Control and Prevention (CDC), working with several Accrediting organizations – Joint Commission, the National Committee for Quality Assurance and URAC – have set standards requiring the collection of race, ethnicity and language data in order to track health care disparities and help promote equity.

Details about this requirement can be found on www.hhs.gov or www.ahrq.gov.

While it is compulsory that we ask these questions, you may decline to answer.

Please Complete and return to Receptionist BEFORE you see the Provider

Race ____________ Ethnicity _____________ Primary Language __________

Decline to answer____________________

Name ______________________________