OXFORD PEDIATRIC GROUP

Patient Demographic Sheet

Chart # (clinic use only) _____

Date: _____ _____ _____ _____ _____ _____ _____

Annual Verification/Date/initials

Best Contact Number to Reach You: _____

Patient Information: **Please List All Children in the Family**

	Last	First	Middle	Birthdate	Gender	Race	Nickname
1.							
2.							
3.							
4.							
5.							
6.							

Guarantor (Parent Responsible for Payment)	**Other Parent**
Full Legal Name _____	_____
Male or Female (circle one)	Male or Female (circle one)
Birthdate _____	_____
Address _____	_____
City, State, Zip _____	_____
Home Phone ( ) _____	**( )** _____
Work Phone ( ) _____	**( )** _____
Cell Phone ( ) _____	**( )** _____
E-mail _____	_____
Employer _____	_____
Occupation _____	_____

Person Child Lives with _____

Emergency Contact _____ **Relationship**_____

Emergency Contact Phone ( ) _____ **Cell ( )** _____

Social Security # _____ **Social Security #** _____

Whom may we thank for referring you to our office? _____

Please list any person other than parents who are allowed to bring your child to the physician visit and whom you give permission to speak to the physician regarding your child's health.

Name: _____ Relationship: _____
Name: _____ Relationship: _____

Guarantor/Patient Confidential Communication Preference (Example: Automated Appointment Reminders or Payment Reminder)

Circle one/or all Text Email Telephone Call

List the number and/or email _____

Authorization for Payment and Financial Responsibility (Please read and sign):

I agree to provide my insurance card at each visit and pay my co-pay/deductible. Co-payments, co-insurance, deductibles, and previous balances are due at the time of service by the parent who accompanies the child. I understand that fees for services rendered are my financial responsibility. I understand that unpaid claims that are not paid by my insurance company within 30 days from the date of service will be transferred to patient responsibility and will be due upon receipt of the statement. I also understand that balances for items that my insurance company deems as "non-covered services" or "not medically necessary" are also my financial responsibility. I understand that if my account is transferred to an outside collection agency I will be dismissed from the practice until the balance is paid in full. Furthermore, I understand that I will be responsible for all fees charged by the agency, including applicable attorney fees and court costs. Oxford Pediatric Group charges **$35.00** for a returned check. **We require a 24 hour cancellation notice to avoid any charges**. **A $30 missed appointment fee may be charged for appointments that are missed or not cancelled more than 24 hours before the scheduled appointment time.**

Authorization to Release Medical Information and Consent to Treatment:

I authorize the release of any medical records in accordance with HIPAA guidelines, via the fax, e-mail, and/or the United Postal Service including the diagnosis, treatment or examination rendered to my child during the period of treatment for the processing of insurance claims, or to satisfy requirements of managed care organizations of which I am a member. I assign to the physician or physician's group all payments for the medical services rendered to my child. I authorize Oxford Pediatric Group to leave or send appointment reminder messages on voicemail, text or email. I also authorize Oxford Pediatric Group to utilize any e-mail address that I provide to them as a form of communication. I understand that if I request any change in this information that I am responsible for notifying this office in writing of such request**. I consent to treatment of my child by the physicians of Oxford Pediatric Group. These policies supersede and replace any prior verbal or written published policies.**

Acknowledgement of Receipt of the Notice of Privacy Practice:

I acknowledge that I have been offered/received the Notice of Privacy Practices from Oxford Pediatric Group. This notice describes how this office may use and disclose my protected health information. I understand that I can obtain additional copies on the website at www.oxfordpediatric.com at any time or request that a copy be provided to me at any visit.

Normal Lab & Test Results Authorization:

I authorize for Oxford Pediatric Group to leave a message on my voice mail/answering machine that my child's test results are normal. I understand that the actual test results will not be left on the message just that they are normal. If you elect not to authorize this then please notify the Nurse so it can be noted on your child's chart.

I understand that by signing below, I, as the parent/guardian authorize and agree to the terms indicated above.

_____ _____
Signature of parent/guardian **Date**

_____
Signature of PAF Witness

OXFORD
PEDIATRIC GROUP

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Authorization to Release Medical Information **to** Oxford Pediatric Group, PLLC

PATIENT'S NAME _____

PATIENT'S DOB_____PHONE (_____)_____

I AUTHORIZE INFORMATION TO BE RELEASED FROM:

PHYSICIAN'S/PRACTICE NAME (PLEASE LIST AS MUCH INFORMATION AS POSSIBLE)

_____

ADDRESS _____

CITY_____STATE_____ZIP_____

PHONE (_____)_____FAX (_____)_____

PURPOSE OF RELEASE

□CHANGING PRIMARY CARE PHYSICIAN/CLINIC □INSURANCE/LEGAL □MOVING
□REFERRAL/CONSULTATION □PERSONAL/OTHER □OPG REQUEST

RECORDS TO BE RELEASED

□ ALL RECORDS □ LABWORK □ X-RAY □ HISTORY & PHYSICAL
□ OFFICE NOTES OR TEST RESULTS (PLEASE SPECIFY DATES/TESTS NEEDED) _____
_____

□OTHER_____

PARENT OR LEGAL GUARDIAN

SIGNATURE_____DATE_____

PRINTED_____ DATE_____

RELATIONSHIP TO PATIENT: _____

CHART #

Pediatric Health History Form – Initial Visit

Child's Name _____ Date of Birth _____Age _____ Male _____ Female _____

Mother's Name _____ Father's name _____

Form filled out by _____ Date _____

Child's Past Medical History

Pregnancy/Neonatal Period

Where was your child born? _____

Is the child yours by ☐birth ☐adoption ☐stepchild ☐other

Pregnancy complications _____

Delivery by ☐vaginal ☐c-section

Reason for c-section _____

Complications _____

Was your child premature ☐No ☐Yes, born at _____ weeks

Complications _____

Apgar scores 1 minute _____ 5 minutes _____

Birth weight _____ Length _____

Other problems in the newborn period _____

_____

Infancy/Childhood/Adolescence

Has your child ever been treated for or diagnosed with: (explain)

- ☐ Asthma or reactive airway disease _____
- ☐Wheezing or bronchiolitis _____
- ☐ Seasonal allergies or eczema _____
- ☐ Food allergy _____
- ☐ Recurrent ear infections _____
- ☐ Pneumonia _____
- ☐ Urinary tract infections _____
- ☐ Genetic syndrome _____
- ☐ Seizures _____
- ☐ Anemia _____
- ☐ Broken bone _____
- ☐ Mental retardation or learning disability _____
- ☐ Depression/anxiety _____

Other chronic medical conditions _____

_____

Has your child ever been hospitalized ☐No ☐ Yes (explain)

_____

_____

Previous surgeries and dates _____

_____

Previous pediatrician _____

Please list any specialist your child is currently seeing and reason:

_____

_____

Medications

ALLERGIES to medicine/vaccines (list and describe reaction)

_____

_____

Current medications and dose: _____

_____

_____

Vitamins _____

Herbal supplements _____

Over-the-counter meds _____

Development/Nutrition

At what age did your child:

Walk alone _____ Sit alone _____

Toilet train(day) _____ Say words _____

1st period (females) _____

Was your child breastfed ☐ No ☐Yes, how long? _____

Has your child had any unusual feeding/dietary problems? Explain.

_____

_____

Social History

Who lives in the child's household? ☐ Mom ☐ Dad ☐ Step_____

☐ Siblings (# _____) ☐ Grandparents ☐ Other _____

Mother's occupation _____

Father's occupation _____

Child's parents are ☐ married ☐ unmarried ☐ divorced ☐ other

Childcare ☐ parents ☐ relatives ☐ daycare ☐ babysitter/nanny

Days per week in childcare (not with parents) _____

School's name _____ Grade _____

Any concerns about school performance? ☐ No ☐ Yes, explain

_____

Do any household members smoke ☐ Yes ☐ No

How many hours per day does your child spend:

Watching TV _____Computer _____Video games _____

Sports/exercise: Type _____

How often? _____ How long _____min

Family History

Do any family members have any of the following conditions:

Condition	Mother	Father	Sibling	Grandparent
Asthma	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Blood disorder	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Heart attack/disease	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Depression/anxiety	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐
_____	☐	☐	☐	☐

Please explain all positives. _____

_____

_____

_____

Review of Systems (*Check all that apply*)

Constitutional
☐ Fever, chills ☐ Fatigue
☐ Unexplained weight loss/gain
☐ Excessive thirst

Ear, Nose, and Throat
☐ Loud voice, hearing problem
☐ Mouth-breathing, snoring
☐ Ear pain
☐ Frequent runny nose

Respiratory
☐ Cough, short of breath
☐ Chest tightness, wheeze

Musculoskeletal
☐ Muscle pain, weakness
☐ Joint pain, swelling
☐ Bone pain

Other (eye,skin,blood)
☐ Blurry vision ☐ Squinting
☐ "Crossed" eyes ☐ Itchy eyes
☐ Rashes ☐ Abnormal moles
☐ Abnormal bruising, bleeding

Gastrointestinal
☐ Nausea, vomiting, diarrhea
☐ Constipation, blood in stool
☐ Abdominal pain

Cardiovascular
☐ Chest pain, palpitations
☐ Tires easily with exertion
☐ Fainting

Genitourinary
☐ Frequent or painful urination
☐ Bedwetting, frequent accidents
☐ Vaginal or penile discharge

Neurologic
☐ Headaches ☐ Seizures
☐ Clumsiness ☐ Milestone delay

Psychiatric/emotional
☐ Anxiety/stress ☐Depression
☐ Sleep problem ☐ Anger concern
☐ Concerns with attention, impulsivity

Reviewed by _____MD date _____

OPG MISSED APPOINTMENT POLICY

Beginning January 1, 2018 OPG has established a Missed Appointment Policy. If a patient misses three (3) appointments in a year's time without advanced notice (phone call prior to appointment time), that patient will be dismissed from our clinic.

This policy is necessary because of a high incidence of missed appointments without prior notification. Our desire is to provide service to all our patients. If you are unable to keep an appointment, please call the clinic as soon as you are aware that you can't make it so we may offer that appointment to another child.

As a courtesy reminder, we attempt to call patients the day prior to each scheduled appointment. Therefore, it is very important you ensure we always have your current phone number.

Thank you for your understanding.