PLEASE NOTE OUR PRACTICE BELIEVES IN VACCINATIONS AND THEREFORE ALL PATIENTS IN OUR PRACTICE MUST ADHERE TO THE CURRENT VACCINE SCHEDULE. IF YOU DO NOT BELIEVE IN VACCINATIONS, THIS PRACTICE IS NOT FOR YOU

Quality Kids Kare, P.C.

Comprehensive Pediatric Care

Sahdev Passey,MD Shay Darcey,NP Kate Wolf,NP Sarah Logan,NP Dawn Torres,NP

10 Winthrop St. Worcester, MA 016044438

Tel: 508-754-4200 Fax: 508-753-3296

www.qualitykidskarepc.com

Patient Name: _____

Sex: Male / Female / Transgender Pronouns:_____

Address: _____

Date of Birth: _____ Hospital Born In: _____

E-Mail: _____

Parent/Guardian: _____ Date of Birth: _____

Relationship to patient:_____ Phone:_____

Employer:_____

Parent/Guardian: _____ Date of Birth: _____

Relationship to patient:_____ Phone:_____

Employer:_____

Text Messages: Yes / No Preferred Number:_____

<u>Emergency Contact</u> (besides parent/guardian)

Name: _____ Relationship: _____

Phone Number: _____

Preferred Pharmacy and Address: _____

Insurance Name:_____ ID#:_____

Policy Holder Name:_____ DOB:_____

Race: American Indian/Alaska Native, Asian, Black/AfricanAmerican
Hispanic/Latino, Native American, Middle Eastern, White

Ethnicity: Not Hispanic/Latino Hispanic/Latino

Preferred Language:_____

<u>Birth History</u>: Please circle one:
Vaginal / C-Section
Full-term / Preterm (Weeks):_____
Birth Weight:_____ **Any complications?**_____
_____

Does the child have any siblings? (Name/Age)

_____

_____

_____

Any Pets? _____

What school does the child attend? _____ **Grade:**_____

Any guns at home? Yes / No

<u>Past Medical /Surgical History</u>

ADD/ADHD	Yes / No
Allergic Rhinitis	Yes / No
ALLERGIES	Yes / No TO WHAT?
Asthma	Yes / No
Autism	Yes / No
Anemia	Yes / No
Diabetes	Yes / No
Developmental Delays	Yes / No
GERD/GE REFLUX	Yes / No
Hearing Loss	Yes / No
Heart Murmur	Yes / No
HIV/AIDS	Yes / No
Lead Poisoning	Yes / No
Otitis Media(Recurrent)	Yes / No
Scoliosis	Yes / No
Seizures	Yes / No

Vision problems	Yes / No Wears Glasses Yes / No
Past Surgeries	Yes / No
Circumcision	Yes / No Month/Year _____
Adenoid Removal	Yes / No Month/Year _____
Ear Tubes	Yes / No Month/Year _____
Heart Surgery	Yes / No Month/Year _____
Tongue Tie Repair	Yes / No Month/Year _____
Appendix Removal	Yes / No Month/Year _____
Inguinal Hernia Repair	Yes / No Month/Year _____
Tonsil removal	Yes / No Month/Year _____
Other surgeries	

Family History

	Circle any that apply
Mother Birth year_____	Heart Disease Diabetes Asthma Depression Cancer Other_____ Alive/Deceased
Father Birth year_____	Heart Disease Diabetes Asthma Depression Cancer Other_____ Alive/Deceased
Sister Birth year_____	Heart Disease Diabetes Asthma Depression Cancer Other_____ Alive/Deceased
Brother Birth year_____	Heart Disease Diabetes Asthma Depression Cancer Other_____ Alive/Deceased
Mother's sister Birth year_____	Heart Disease Diabetes Asthma Depression Cancer Other_____ Alive/Deceased
Mother's brother Birth year_____	Heart Disease Diabetes Asthma Depression Cancer Other_____ Alive/Deceased
Father's sister Birth year_____	Heart Disease Diabetes Asthma Depression Cancer Other_____ Alive/Deceased
Father's brother Birth year_____	Heart Disease Diabetes Asthma Depression Cancer Other_____ Alive/Deceased
Maternal GM Birth year_____	Heart Disease Diabetes Asthma Depression Cancer Other_____ Alive/Deceased
Maternal GF Birth year_____	Heart Disease Diabetes Asthma Depression Cancer Other_____ Alive/Deceased
Paternal GM Birth year_____	Heart Disease Diabetes Asthma Depression Cancer Other_____ Alive/Deceased
Paternal GF Birth year_____	Heart Disease Diabetes Asthma Depression Cancer Other_____ Alive/Deceased

Authorization For Release of Information

I hereby authorize Quality Kids Kare, P.C. to release information requested by my insurance company or Worker's Compensation carrier. I also authorize Quality Kids Kare, P.C. to release information to any hospital or physician I may be referred to by this office.

Signature: _____ **Date:** _____
Relationship to Patient: _____

Assignment of Benefits

I hereby authorize assignment and payment directly to Quality Kids Kare, P.C. major benefits due to me.

I hereby agree to pay any and all charges that exceed or that are not covered by my insurance.

Signature: _____ **Date:** _____
Relationship to Patient: _____

Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form, you acknowledge that this Medical Practice has given you a copy of its Notice of Privacy Practices. This notice explains how your health information will be handled. HIPAA, the new federal law concerning medical privacy, requires this notice.

I have received a copy of the Notice of Privacy Practices. The medical Practice has given me the opportunity to ask any questions about this notice and all my questions have been answered.

_____ **Parent**
or Guardian's Signature **Date Signed**

Massachusetts Immunization Program
Vaccines for Children Program
Massachusetts Department of Public Health

Patient Eligibility Screening Form

Date: _____

Child's Full Name: _____ **Date of Birth:** _____

Parent,Guardian full name: _____

Health Care Provider's full name: Quality Kids Kare, PC

This form must be completed for all children less than 19 years of age and kept in the child's medical records or on file in the office. The form may be completed by the parent, guardian, or legal representative, or by the health care provider. This form should be completed only once, unless the child's insurance status changes. Verification of responses is not required.

Check only one circle below
This child:

- O Is enrolled in Medicaid (includes Masshealth, HMO's, etc. if enrolled through Medicaid).
- O Does not have health insurance (also check the circle for children enrolled in the Children's Medical Security Plan)
- O Is Native American (American Indian) or Alaskan Native.
- O Has health insurance and is not Native American (American Indian) or Alaskan native.

Please note that all children seen in Massachusetts practices get the same free vaccines. This form tells us which children get vaccines paid for by the federal VFC Program, (first three circles), and which get vaccines paid for by the state and other federal funds, (last circle).