Welcome!

From all of us at Bainbridge Pediatrics, we want to welcome you and your family to our clinic. We are dedicated to providing compassionate, collaborative, high-quality care as your patient centered medical home.

Once you have called and registered with our office and prior to scheduling your first appointment, we require that the following forms be completed and returned to our office:

Consent for Treatment
Authorization to Release Patient Health Information
Authorization for Credit Card on File (optional but encouraged)
Preferred Contact and Demographic Form
Initial History Questionnaire
Genetic Family Health History Form
Child Health History Form
Copy of Insurance Card
Complete Vaccination Record

When we have received all the necessary paperwork you are welcome to call and schedule an appointment with your primary care provider.

We appreciate the trust you have placed in us and look forward to partnering with you and your family!

Bainbridge Pediatrics

Bainbridge Pediatrics
infancy through adolescence

CONSENT FOR TREATMENT AND AUTHORIZATION FOR PAYMENT

MEDICAL CONSENT: I consent to receive evaluation, care, and treatment from providers working at Bainbridge Pediatrics. I understand such services may include examination, medical and minor surgical treatment, x-ray, laboratory, immunizations and other medical services performed or prescribed. I am aware that the practice of medicine is not an exact science, and acknowledge that no guarantee or promises have been made as to the result of treatment or examination.

FINANCIAL AGREEMENT: I certify that the information given for payment under government or private insurance is correct. I understand that I am financially responsible to Bainbridge Pediatrics for all co-payments, deductibles, and coinsurance. In the event that I have no insurance, or my insurance does not cover products and service provided to me, I am financially responsible to pay for these products and services, which may include fees for medical supplies, after hours and emergency office visits, home visits, missed appointment fees and after-hours phone call charges. Bainbridge Pediatrics reserves the right to impose reasonable financing and late charges as well as reasonable cost, attorney fees and expenses incurred in the collection of my account if it becomes delinquent. Financial responsibility may be waived or reduced if charity care eligibility is determined.

ASSIGNMENT OF INSURANCE BENEFITS: I authorize Bainbridge Pediatrics to request on my behalf, and to collect directly, all public and private insurance coverage benefits (including Medicare, if applicable) due for products and services supplied by Bainbridge Pediatrics. In the event that insurance benefits are paid directly to me, I will endorse to Bainbridge Pediatrics all checks for such payments.

MEDICARE CERTIFICATION (when applicable): I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.

RELEASE OF HEALTH INFORMATION TO PAYERS: I authorize Bainbridge Pediatrics to disclose my health information to my insurers, including the Center for Medicare and Medicaid Services or its representatives if applicable, and others financially responsible for payment, auditing, and coordination of insurance claims

RELEASE OF INFORMATION:

NOTIFICATION: A family member, personal representative, or other person responsible for my care may be notified of my location, general condition, or death.

DISASTER RELIEF INFORMATION: Bainbridge Pediatrics may also disclose information to assist in disaster relief efforts.

NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received Bainbridge Pediatrics' Notice of Privacy Practices. INITIAL_____
State why patient could not initial: ☐ child ☐ under guardianship ☐ unconscious ☐ Incapacitated ☐ _____

Patient Name: _____

_____ _____
Signature of patient or legally responsible party Date

Patient DOB: _____

_____
Relationship to patient, if not signed by patient

State why patient could not sign themselves: _____
☐ child ☐ under guardianship ☐ unconscious ☐ incapacitated

Notice of Privacy Practices
Bainbridge Pediatrics

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Bainbridge Pediatrics respects your privacy. We understand that your personal health information is very sensitive. The law protects the privacy of the health information we create and obtain in providing care and services to you. Your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services.

We will not use or disclose your health information to others without your authorization, except as described in this Notice, or as required by law.

1. Your health information rights.

The health and billing records we create and store are the property of **Bainbridge Pediatrics**. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this Notice.
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request unless the request is to restrict disclosure of your protected health information to a health plan for payment or health care operations and the protected health information is about an item or service for which you paid in full directly.
- Request and receive from us a paper copy of the most current Notice of Privacy Practices ("Notice").
- Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request.
- Have us review a denial of access to your health information—except in certain circumstances.
- Ask us to change your health information that is inaccurate or incomplete. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
- When you request, we will give you a list of certain disclosures of your health information. The list will not include disclosures for treatment, payment, or health care operations. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by another confidential means of communication or at another location. Please sign, date, and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we receive the revocation. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

For help with these rights during normal business hours, please contact:

Jennifer Lacher
Practice Manager
206-780-5437 ext. 5

2. Our responsibilities.

We are required to:

- Keep your protected health information private.
- Give you this Notice.
- Follow the terms of this Notice for as long as it is in effect.
- Notify you if we become aware of a breach of your unsecured protected health information.

We reserve the right to change our privacy practices and the terms of this Notice, and to make the new privacy practices and notice provisions effective for all of the protected health information we maintain. If we make material changes, we will update and make available to you the revised Notice upon request. You may receive the most recent copy of this Notice by calling and asking for it, by visiting our office to pick one up, or by visiting our Web site, if we maintain one.

3. To ask for help or complain.

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact:

Jennifer Lacher, Practice Manager
206-780-5437 Ext. 5

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to **Bainbridge Pediatrics**. You may also file a complaint with the Department of Health and Human Services Office for Civil Rights (OCR).

We respect your right to file a complaint with us or with the OCR. If you complain, we will not retaliate against you.

4. How we may use and disclose your protected health information.

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways we may use and disclose your protected health information without your permission. For each category, we will explain what we mean and give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose health information will fall within one of the categories.

Below are examples of uses and disclosures of protected health information for treatment, payment, and health care operations.

For treatment:

- We may contact you to remind you about appointments.

- We may use and disclose your health information to give you information about treatment alternatives or other health-related benefits and services.
- Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used by members of our health care team to help decide what care may be right for you.
- We may also provide information to health care providers outside our practice who are providing you care or for a referral. This will help them stay informed about your care.

For payment:

- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.
- We bill you or the person you tell us is responsible for paying for your care if it is not covered by your health insurance plan.

For health care operations:

- We may use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may use and disclose your information to conduct or arrange for services, including:
  - Medical quality review by your health plan,
  - Accounting, legal, risk management, and insurance services; and
  - Audit functions, including fraud and abuse detection and compliance programs

For Health Information Exchange (HIE)

- We participate in a health information exchange (HIE). An HIE is an electronic system where hospitals, doctors and other healthcare providers share your health information. Participants in the HIE can access your patient health information as necessary for treatment, payment and healthcare operations. They may also access your information for joint activities with other individuals or organizations like to measure quality and improve services.
- Your health information is automatically included in the HIE. If you choose not to share your health information through the HIE, you must opt out. To learn more, call 206-780-5437 ext. 5.

For fund-raising communications:

- We may use certain demographic information and other health care service and health insurance status information about you to contact you to raise funds. If we contact you for fund-raising, we will also provide you with a way to opt out of receiving fund-raising requests in the future.

Some of the other ways that we may use or disclose your protected health information without your authorization are as follows.

- **Required by law:** We must make any disclosure required by state, federal, or local law.
- **Business Associates:** We contract with individuals and entities to perform jobs for us or to provide certain types of services that may require them to create, maintain, use, and/or disclose your health information. We may disclose your health information to a business associate, but only after they

agree in writing to safeguard your health information. Examples include billing services, accountants, and others who perform health care operations for us.

- **Notification of family and others**: Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital.
- **Public health and safety purposes:** As permitted or required by law, we may disclose protected health information:
  - To prevent or reduce a serious, immediate threat to the health or safety of a person or the public.
  - To public health or legal authorities:
    - To protect public health and safety.
    - To prevent or control disease, injury, or disability.
    - To report vital statistics such as births or deaths.
    - To report suspected abuse or neglect to public authorities.
- **Research:** We may disclose protected health information to researchers if the research has been approved by an institutional review board or a privacy board and there are policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
- **Coroners, medical examiners, and funeral directors:** We may disclose protected health information to funeral directors and coroners consistent with applicable law to allow them to carry out their duties.
- **Organ-procurement organizations:** Consistent with applicable law, we may disclose protected health information to organ-procurement organizations (tissue donation and transplant) or persons who obtain, store, or transplant organs.
- **Food and Drug Administration (FDA)**: For problems with food, supplements, and products, we may disclose protected health information to the FDA or entities subject to the jurisdiction of the FDA.
- **Workplace injury or illness:** Washington State law requires the disclosure of protected health information to the Department of Labor and Industries, the employer, and the payer (including a self-insured payer) for workers' compensation and for crime victims' claims. We also may disclose protected health information for work-related conditions that could affect employee health; for example, an employer may ask us to assess health risks on a job site.
- **Correctional institutions:** If you are in jail or prison, we may disclose your protected health information as necessary for your health and the health and safety of others.
- **Law enforcement:** We may disclose protected health information to law enforcement officials as required by law, such as reports of certain types of injuries or victims of a crime, or when we receive a warrant, subpoena, court order, or other legal process.
- **Government health and safety oversight activities:** We may disclose protected health information to an oversight agency that may be conducting an investigation. For example, we may share health information with the Department of Health.
- **Disaster relief:** We may share protected health information with disaster relief agencies to assist in notification of your condition to family or others.
- **Military, Veteran, and Department of State:** We may disclose protected health information to the military authorities of U.S. and foreign military personnel; for example, the law may require us to provide information necessary to a military mission.
- **Lawsuits and disputes:** We are permitted to disclose protected health information in the course of judicial/administrative proceedings at your request, or as directed by a subpoena or court order.
- **National Security:** We are permitted to release protected health information to federal officials for national security purposes authorized by law.

- **De-identifying information:** We may use your protected health information by removing any information that could be used to identify you.

5. Uses and disclosures that require your authorization.

Certain uses and disclosures of your health information require your written authorization. The following list contains the types of uses and disclosures that require your written authorization:

- **Psychotherapy Notes:** if we record or maintain psychotherapy notes, we must obtain your authorization for most uses and disclosures of psychotherapy notes.
- **Marketing Communications**: we must obtain your authorization to use or disclose your health information for marketing purposes other than for face to face communications with you, promotional gifts of nominal value, and communications with you related to currently prescribed drugs, such as refill reminders.
- **Sale of Health Information:** disclosures that constitute a sale of your health information require your authorization.

In addition, other uses and disclosures of your health information that are not described in this Notice will be made only with your written authorization. You have the right to cancel prior authorizations for these uses and disclosures of your health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we receive the revocation. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

6. Web site

We have a Web site that provides information about us. For your benefit, this Notice is on the Web site at the following address: **www.bainbridgepediatrics.com**.

7. Effective date

This Notice is effective as of **9/1/2022**.

AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

Patient Name _____ **Date of Birth:** ____/____/____ **Medical Record #**_____

I authorize the following organization to release information as stated below from the patient health information record:

Information to be Released FROM:	**Information to be Released TO:**
☐ Bainbridge Pediatrics or ☐ _____ Organization _____ Street Address City, State, Zip _____ Phone *Fax	☐ Bainbridge Pediatrics or ☐ _____ Organization _____ Street Address City, State, Zip _____ Phone *Fax

Bainbridge Pediatrics Address: 1298 Grow Ave NW, Bainbridge Island, WA 98110; Phone: 206.780.5437; Fax 206.780.5438
*Please mail (not fax) records if over 20 pages. Thank you!

Information to be Released

Dates of service for records request: Beginning _____ **Thru**_____

☐ **Limited** transfer of Medical Records to include the following information:

- Problem List, Medication List, Allergies
- Chart notes for past 12 months
- Vaccination records, Growth charts
- Outside notes / Correspondence
- Lab & Radiology Reports

☐ **Complete** Medical Record (Please check this box if your child has more ***complex medical problems***)

Purpose of Release

☐ Legal ☐ Insurance ☐ Continuing Care ☐ Copies for Own Use ☐ Transfer to Another Provider
☐ Coordination with School ☐ Other_____

Authorization for General Release of Information

I understand that:

- Authorizing the disclosure of this healthcare information is voluntary. I do not need to sign this form in order to assure treatment or payment.
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- Once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.
- This authorization expires 90 days from the date of signature and does not permit disclosure of health information created more than 90 days after the date it is signed.
- There may be a charge for the requested records.

Sensitive Records may require specific patient authorization. Please check applicable box(s) below to request the following records:

☐ **Mental Health Treatment** ☐ **Sexually Transmitted Diseases** ☐ **Aids/HIV Treatment** ☐ **Alcohol/Drug Abuse**

Signature of Patient/Legal Representative

_____	_____	_____
Date	Signature of Patient/Legal Guardian	Relationship to the Patient

Signature of Minor Patient Required for the Following Records

Parents/Legal guardians have the right to full disclosure of their minor child's medical record with the exception of the following which requires authorization of the minor child. Age of Confidentiality Entitlement per RCW 70.02.1230: 1) Information related to reproductive care such as birth control, pregnancy-related services and Sexually Transmitted Diseases, including HIV/AIDS(age 14 and older); 2) Substance abuse and mental health treatment (age 13 and older). If I am a minor patient and would like my parent or guardian to have access to my confidential health care information, my parent's information must be completed in the "Released TO" portion of this release at the top of the page.

_____	_____
Date	Signature of Minor Patient

Authorization for Credit Card on File Program

Thank you for choosing Bainbridge Pediatrics as your Pediatric provider. We are excited to offer our families the ability to save time with the Credit Card on File Program. With this program, we will process any amounts that your insurance carrier deems as your responsibility to the credit or debit card of your choosing. You will be asked to volunteer a credit card at the time you check in and the information will be held securely. Your credit card information is not stored in this office. We use a secure clearinghouse that meets the industry standards set forth from the Payment Card Industry Data Security Standard (PCI-DSS). You may request a receipt at any time from our office.

This program will be an advantage to you, since you will no longer have to write out and mail us checks or worry about late fees and you can authorize copays at the time of the visit. It will be an advantage to us as well, as it will greatly decrease the number of statements we have to generate and send out.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment. If you have any questions about this payment method, do not hesitate to ask.

Best,

Bainbridge Pediatrics, PLLC

AUTHORIZATION

I understand that once my health insurance has processed my child's claim, Bainbridge Pediatrics will charge my credit card on file for my balance due*. I further understand that if payment is denied by the credit card on file, I will not be able to schedule any further appointments until the balance has been paid in full.

*If the balance due is more than $200.00, you will receive a courtesy call prior to the card being charged.

I authorize Bainbridge Pediatrics to charge all balances on my account to the following credit card:

Circle one: Visa MasterCard Discover American Express

Last 4 digits of credit card: _ _ _ _ Expiration Date: _____

Signature: _____ Date: _____

Print Name: _____ Relationship to Patient: _____

Patient Name – please list all children that are patients at Bainbridge Pediatrics

_____ DOB: _____
_____ DOB: _____
_____ DOB: _____
_____ DOB: _____

Preferred Contact and Demographics Form

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

Parent 1: _____	**Parent 2:** _____
Address:_____	Address:_____
_____	_____
Cell: _____	Cell: _____
Email: _____	Email: _____
Date of Birth: _____	Date of Birth: _____
Preferred contact method for reminders (circle one): Text Email Call	**Preferred contact method for reminders (circle one):** Text Email Call

In order to comply with Federal Regulations, we ask that you answer the following questions:

What is your primary language? _____

If your primary language is other than English, do you desire an interpreter? ☐ Yes ☐ No

What is your child's race?

American Indian or Alaska Native

Asian

Black or African American

Hawaiian Native or Other Pacific Islander

White

Other Race

What is your child's ethnicity?

Hispanic or Latino

Not Hispanic or Latino

Initial History Questionnaire

Form Completed By: _____
Initial Date Completed: _____
Date(s) Updated: _____

Name of Child: _____
Birth Date: _____
Age: _____ Sex: ☐M ☐F ☐Other
Preferred Pronouns: _____

General

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ Unknown Explain: _____
Does your child have any special health care needs? ☐ Yes ☐ No ☐ Unknown Explain: _____
Has your child ever been hospitalized? ☐ Yes ☐ No ☐ Unknown Explain: _____
Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ Unknown Explain: _____

Social History

Please list all those living in the child's home.

Name	Relationship to Child	Birth Date/Age

Please list other siblings not living in the home.

Name	Birth Date/Age	Where are they living now?

Please check any of the below that apply for your child:
☐ Single parent custody
☐ Joint custody
☐ Adoptive family
☐ Sperm donor
☐ Egg donor
☐ Foster care

What is the child's current living situation?
☐ Single-parent custody ☐ Joint custody ☐ Adoptive family
☐ Other family members: _____ ☐ Foster care

What is the living arrangement/parenting plan?

Other concerns?
☐ Rent or housing costs
☐ Transportation
☐ Food
☐ Language

Birth History

Birth Weight: _____
☐ Full-term ☐ Pre-term ___weeks ☐ Post-term ___weeks
Delivery: ☐ Vaginal ☐ Cesarean Reason: _____
Any complications during birth or after birth? ☐ No ☐ Yes
Explain: _____
Did the baby need to go to the NICU (neonatal intensive care unit)?
☐ No ☐ Yes Explain: _____

During pregnancy, did the mother:
Take prenatal vitamins? ☐ Yes ☐ No ☐ Unknown
Smoke or use e-cigarettes? ☐ Yes ☐ No ☐ Unknown
Drink alcohol? ☐ Yes ☐ No ☐ Unknown
Use marijuana? ☐ Yes ☐ No ☐ Unknown
Use illicit drugs? ☐ Yes ☐ No ☐ Unknown
Take other medications? ☐ Yes ☐ No ☐ Unknown
If yes, please list: _____
_____

Blood type:
Mother: _____ ☐ Unknown
Baby: _____ ☐ Unknown

Mother's lab results:
Hepatitis B ☐ Pos ☐ Neg ☐ Unknown
HIV ☐ Pos ☐ Neg ☐ Unknown
Group B streptococcus(GBS) ☐ Pos ☐ Neg ☐ Unknown

After birth, did the baby get:
Vitamin K shot? ☐ Yes ☐ No ☐ Unknown
Erythromycin eye ointment? ☐ Yes ☐ No ☐ Unknown
Hepatitis B shot? ☐ Yes ☐ No ☐ Unknown

How was the baby fed? ☐ Bottle formula ☐ Bottle breast milk
☐ Breastfed How long was baby breastfed? _____

Did baby go home with biological mother from hospital after birth?
☐ Yes ☐ No Explain: _____

Genetic Family Health History Form

Form completed by: _____ Name of Child: _____ Today's Date: _____
Height of Mother: _____ Height of Father: _____
Reviewed by (Provider): _____

Please mark all that apply

	Genetic Mother	Genetic Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Sister	Brother	Maternal Aunt	Maternal Uncle	Paternal Aunt	Paternal Uncle	Cousin	Notes
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Elevated Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Liver Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Constipation	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Allergies	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Hearing Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Vision Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Headaches	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Scoliosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Seizures/Epilepsy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Diabetes – Type 1 (insulin required)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Diabetes – Type 2 (adult onset)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Cardiac Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Death from Cardiac Cause before age 50	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Blood Clotting Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Anxiety	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
ADHD	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Developmental Delay	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Autism Spectrum	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Learning Differences	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Alcohol Misuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Substance Misuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
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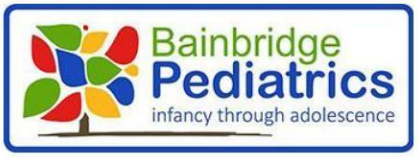

Child Health History Form

Form Completed By: _____ Name of Child: _____ Today's Date: _____
Reviewed by (Provider): _____

Please mark all that apply to your child's medical history.

Child's Past Medical History	No	Yes	Unknown	Details
Vision Impairment				
Hearing loss or concerns				
Multiple cavities or dental problems				
Frequent ear infections				
Nasal allergies (dust, pets, trees, grass)				
Frequent colds or sore throats				
Asthma, wheezing, or breathing problems				
Pneumonia, bronchitis, or breathing problems				
Heart murmur or other heart issue				
High blood pressure				
Frequent stomach aches				
Constipation needing medical treatment				
Food allergies or intolerances				
Feeding issues (underweight)				
Overweight or obesity				
Urinary tract infections				
Bedwetting after age 5				
Kidney, ureter, or bladder problems				
Serious injuries or fractures				
Bone, joint, or muscle problems				
Frequent headaches				
Head injury or concussion				
Seizures or convulsions				
Sleep problems (getting to/staying asleep)				
Snoring				
Skin rashes, eczema, hives				
Acne				
Thyroid problems				
Diabetes				
Metabolic or genetic problems				
Anemia or bleeding problems				
Cancer or chemotherapy				
Bone marrow or organ transplant				
HIV or AIDS				
Developmental delays (speech or motor)				
School problems or learning differences				
ADHD or behavioral concerns				
Anxiety, depression, or mood problems				
Tobacco, alcohol, or drug use				
Exposure to family violence				
Sexually transmitted infections				
Pregnancy or miscarriage				
Age at first period				
Issues with periods				

Child Health History Form

Surgeries and Procedures

Please list surgery performed:	
Date of Surgery:	
Age of Child:	
Where was surgery performed?	

Hospitalizations

Reason for hospitalization(s):	
Date of hospitalization(s):	
Age of child:	
Location of hospitalization(s):	

Has your child received care from specialists?

Type of Care:	
Name of Provider:	

Type of Care:	
Name of Provider:	

Active Medications (including Over the Counter vitamins, supplements, medications)

Medication Name	Dosage	Frequency

Is there any other information you would like us to know?

Patient Centered Medical Home

At Bainbridge Pediatrics, we provide compassionate, collaborative, high-quality care as your patient centered medical home. Our mission is to build therapeutic relationships with our patients and families. We will work with you, side by side, every step of the way in your healthcare journey. Our practice care team includes registered nurses, medical assistants and administrative staff to support you in taking an active role in your healthcare.

We constantly strive to improve our processes by actively listening to your experiences and combining those with cutting-edge, evidence-based practices. Our aim is to improve your experience not only in our practice, but also across the larger healthcare system through effective community partnerships and coordinated care.

We understand that well-being is more than just physical and mental health. We value your cultural and spiritual beliefs, as well as your child's developmental and emotional health. To better accommodate your busy lifestyle, in addition to our regularly scheduled clinic appointments, we provide daily same-day appointments for acute needs, as well as availability by phone 24 hours a day. Additionally, our patient portal is available to you for requesting non-urgent clinical advice, appointments, prescription refills, test results, and referrals. You may find educational and self-management tools, a symptom-checker, and links to community resources on our website.

We believe your medical home should be just that: A place where you feel welcomed, cared for, and valued as a member of our Bainbridge Pediatrics family.

Appointment Cancellation Policy

Our goal is to provide quality medical care in a timely manner. Our Appointment Cancellation Policy enables us to better utilize available appointments for our patients in need of medical care.

Cancellation of an Appointment:

In order to be respectful of the medical needs of other patients, please call Bainbridge Pediatrics promptly if you are unable to attend an appointment. This allows the appointment time to be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at **least 24 hours in advance**. Appointments that are canceled late (less than 24 hours prior to) will be considered as a "no-show".

How to Cancel Your Appointment:

To cancel appointments, please call 206-780-5437. If you do not reach the receptionist you may leave a detailed message on the voice mail. If you would like to reschedule your appointment, please be sure to leave us your phone number and let us know the best time to return your call.

Missed Appointment Policy and Fees

A "no-show" is someone who misses an appointment without cancelling it prior to 24hours of the appointment. Any "no-show" will result in a fee of $50.00 billed to the patient's account for the first offence. The second offence will be a $100.00 fee and after three offenses your family may be discharged from our practice.

After Hours Care Policy

Even when our office is closed, medical advice is available around the clock from Bainbridge Pediatrics.

FOR MEDICAL EMERGENCIES, PLEASE CALL 9-1-1.

For non-emergency medical problems that occur when our office is closed, we offer several options (please note your good judgment should always take precedence over information in these guidelines):

1. Our website contains a wealth of information intended to help guide you in the care of your child. You can access dosing information for fever medication, home remedies for colds and over the counter cough and cold medications. "Is your child sick" will link you to excellent medical sources on common childhood diseases and their treatments.
2. If you would like to speak with a pediatric triage nurse after hours, please call our main number 206.780.KIDS (5437) and follow the prompts for after-hours medical advice. **Please note: there is a $25.00 fee imposed for each call transferred to the After Hours Triage Team. This amount will be billed to the patient's account and is not billed to insurance.**

Should your child require a hospital visit after hours, the nurse or physician on call will assist you in choosing the most appropriate hospital. We refer most of our pediatric patients to Seattle Children's Hospital, Swedish Medical Center or Mary Bridge Children's Hospital.