INITIAL PEDIATRIC HEALTH ASSESSMENT

Name of Child	Today's Date	Chart#
Date of Birth	Mother Age:	Historical Source
Age Now: Sex:	Father Age:	Siblings:

BIRTH HISTORY

Hospital, City, State		Pregnancy/delivery problems?
Delivery Type		Post Partum complications?
Was baby discharged with mother? [ ] Yes [ ] No		Why not?
Birthweight lbs. oz.	Length	[ ] Breast [ ] Formula

MEDICAL HISTORY

** Allergies to food, medications, or environmental antigens?	
Hospitalizations	
Surgeries	
Injuries/ Accidents	
Significant Illnesses	

Child has had:

- ☐ Chicken Pox
- ☐ Mumps
- ☐ Measles
- ☐ TB
- ☐ Hearing Problems
- ☐ Vision Problems
- ☐ Any other problems _____
- ☐ Colic / Abdominal Pain
- ☐ Seizures
- ☐ Headaches
- ☐ Pneumonia
- ☐ Bladder Infections
- ☐ Sickle Cell Disease/Trait
- ☐ Heart Murmur
- ☐ Sinus Problems
- ☐ Ear Infections
- ☐ Hay Fever
- ☐ Eczema
- ☐ Anemia

Present Medications:	Other Concerns:
Language spoken at home	Exposure to tobacco smoke ?
Primary Caretaker of child	Alcohol, other drug contacts ?

FAMILY MEDICAL HISTORY

Blood relative has had:

- ☐ Anemia
- ☐ Sickle Cell Disease/Trait
- ☐ Stroke
- ☐ Kidney Disease
- ☐ Seizures
- ☐ Drug Abuse
- ☐ Alcoholism
- ☐ Other _____
- ☐ Heart Disease
- ☐ Tuberculosis
- ☐ Birth Defects
- ☐ Deafness
- ☐ Mental Retardation
- ☐ Hay Fever
- ☐ Thyroid Problems
- ☐ Diabetes
- ☐ Asthma
- ☐ Eczema
- ☐ High Blood Pressure
- ☐ Cancer

Premier Pediatrics
Patient Registration

Mailing Address:

_____

(Street or PO Box) (City) (State & Zip)

Home Phone: (_____) _____ - _____ Pharmacy Phone: (_____) _____ - _____

Who lives at this household? _____

Child 1: Last Name: _____ First Name: _____ MI: _____

D.O.B.: _____/_____/_____ Sex: _____ Primary Language: _____

Ethnicity: Hispanic / Non-Hispanic / Unknown

Race: Asian / Black / Hawaiian / White

Child 2: Last Name: _____ First Name: _____ MI: _____

D.O.B.: _____/_____/_____ Sex: _____ Primary Language: _____

Ethnicity: Hispanic / Non-Hispanic / Unknown

Race: Asian / Black / Hawaiian / White

Child 3: Last Name: _____ First Name: _____ MI: _____

D.O.B.: _____/_____/_____ Sex: _____ Primary Language: _____

Ethnicity: Hispanic / Non-Hispanic / Unknown

Race: Asian / Black / Hawaiian / White

Insurance:

Primary Policy: Policy Holder's Name: _____

Policy Holder's Birth Date: _____ Policy Holder's Sex: Male / Female

Insurance Carrier: _____

ID# _____ Group # _____

Secondary Policy: Policy Holder's Name: _____

Policy Holder's Birth Date: _____ Policy Holder's SSN: _____

Insurance Carrier: _____

ID# _____ Group # _____

Contact Questions:

Who should receive billing statements? _____

May all contacts have access to the patient's records electronically? Yes / No _____

Emergency Contacts, other than parents: Name & Relationship

1: _____ Phone: (_____) _____ - _____

2: _____ Phone: (_____) _____ - _____

Main Contact: Name: _____ Relation to Patient: _____

Lives with patient? Yes / No Date of Birth: ___ / ___ / ___ Social Security #: ___ - __ - ____

Work Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Home Email: _____ Work Email: _____

Employer: _____ Occupation: _____

How would you ideally prefer to be contacted regarding (circle **ONE**):

Medical Issues: Home Phone / Work Phone / Cell Phone / Home Email

Appointment Reminders: Home Phone / Cell Phone / Home Email / Work Email

Recall Notices: Home Address / Home Phone / Work Phone / Cell Phone / Home Email

Billing Statements: Home Address / Home Email / Work Email

General Practice Notices: Home Address / Home Phone / Cell Phone / Home Email

Patient Portal Notifications: Cell Phone / Home Email / Work Email

Contact #2: Name: _____ Relation to Patient: _____

Lives with patient? Yes / No Date of Birth: ___ / ___ / ___ Social Security #: ___ - __ - ____

Work Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Home Email: _____ Work Email: _____

Employer: _____ Occupation: _____

How would you ideally prefer to be contacted regarding (circle **ONE**):

Medical Issues: Home Phone / Work Phone / Cell Phone / Home Email

Appointment Reminders: Home Phone / Cell Phone / Home Email / Work Email

Recall Notices: Home Address / Home Phone / Work Phone / Cell Phone / Home Email

Billing Statements: Home Address / Home Email / Work Email

General Practice Notices: Home Address / Home Phone / Cell Phone / Home Email

Patient Portal Notifications: Cell Phone / Home Email / Work Email

If parents are divorced or separated please fill out this section:

Who has custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

_____

_____

Vaccine Policy Statement

- We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives.
- We firmly believe in the safety of our vaccines.
- We firmly believe that all children and young adults should receive all of the recommended vaccines according to the schedule published by the Centers for Disease Control and Prevention and the American Academy of Pediatrics.
- We firmly believe, based on all available literature, evidence, and current studies, that vaccines do not cause autism or other developmental disabilities. We firmly believe that thimerosal, a preservative that has been in vaccines for decades and remains in some vaccines, does not cause autism or other developmental disabilities.
- We firmly believe that vaccinating children and young adults may be the single most important health-promoting intervention we perform as health care providers, and that you can perform as parents/caregivers. The recommended vaccines and their schedule given are the results of years and years of scientific study and data gathering on millions of children by thousands of our brightest scientists and physicians.

These things being said, we recognize that there has always been and will likely always be controversy surrounding vaccination. Indeed, Benjamin Franklin, persuaded by his brother, was opposed to smallpox vaccine until scientific data convinced him otherwise. Tragically, he had delayed inoculating his favorite son Franky, who contracted smallpox and died at the age of 4, leaving Ben with a lifetime of guilt and remorse. Quoting Mr. Franklin's autobiography:

> *"In 1736, I lost one of my sons, a fine boy of four years old, by the smallpox . . . I long regretted bitterly, and still regret that I had not given it to him by inoculation. This I mention for the sake of parents who omit that operation, on the supposition that they should never forgive themselves if a child died under it, my example showing that the regret may be the same either way, and that, therefore, the safer should be chosen."*

The vaccine campaign is truly a victim of its own success. It is precisely because vaccines are so effective at preventing illness that we are even discussing whether or not they should be given. Because of vaccines, many of you have never seen a child with polio, tetanus, whooping cough, bacterial meningitis, or even chickenpox, or known a friend or family member whose child died of one of these diseases. Such success can make us complacent or even lazy about vaccinating. But such an attitude, if it becomes widespread, can only lead to tragic results.

After publication of an unfounded accusation (later retracted) that MMR vaccine caused autism in 1998, many people in Europe chose not to vaccinate their children. As a result of underimmunization, there were large outbreaks of measles, with several deaths from complications of the disease. In 2010 there were more than 3000 cases of whooping cough in California, with nine deaths in children less than six months of age. Again, many of those who contracted the illness (and then passed it on to the infants, who were too young to have been fully vaccinated) had made a conscious decision not to vaccinate.

Furthermore, by not vaccinating your child you are taking selfish advantage of thousands of others who do vaccinate their children, which decreases the likelihood that your child will contract one of these diseases. We feel such an attitude to be self-centered and unacceptable.

We are making you aware of these facts not to scare you or coerce you, but to emphasize the importance of vaccinating your child. We recognize that the choice may be a very emotional one for some parents. We will do everything we can to convince you that vaccinating according to the schedule is the right thing to do. However, **should you have doubts, please discuss these with your health care provider in advance of your visit.** In some cases, we may alter the schedule to accommodate parental concerns or reservations. **Please be advised, however, that delaying or "breaking up the vaccines" to give one or two at a time over two or more visits goes against expert recommendations, and can put your child at risk for serious illness (or even death) and goes against our medical advice as providers at Anjali Monga, M.D., Inc.** Such additional visits will require additional co-pays on your part. Furthermore, please realize that you will be required to sign a "Refusal to Vaccinate" acknowledgement in the event of lengthy delays.

All patients in the practice are required to receive a minimum of DTaP, Hib, polio, and pneumococcal vaccines by three months of age, all AAP-recommended immunizations by two years of age, and meningococcal vaccine and booster doses of Tdap and varicella vaccines by age 12 years.

Finally, if you should absolutely refuse to vaccinate your child despite all our efforts, we will ask you to find another health care provider who shares your views. We do not keep a list of such providers, nor would we recommend any such physician. Please recognize that by not vaccinating you are putting your child at unnecessary risk for life-threatening illness and disability, and even death.

As medical professionals, we feel very strongly that vaccinating children on schedule with currently available vaccines is absolutely the right thing to do for all children and young adults. Thank you for your time in reading this policy, and please feel free to discuss any questions or concerns you may have about vaccines with any one of us.

I HAVE READ, UNDERSTAND AND AGREE TO ABIDE BY THE ABOVE POLICY

Signature: _____ Date: _____

15825 Laguna Canyon Rd., Suite 102, Irvine, CA 92618 Phone: (949) 733-2800 Fax: (949) 733-2810 Email: ocpremierpediatrics@gmail.com

Anjali Monga, M.D., Inc. DBA Premier Pediatrics

OFFICE FINANCIAL POLICY

Thank you for choosing Anjali Monga, M.D., Inc. as your child's healthcare provider; we appreciate the opportunity to serve their healthcare needs. We are committed to their treatment being successful and we value your trust in us.

Please understand that payment of your bill is considered part of the treatment process. We find communication with our patients/parents regarding our policies assists us in providing the best possible service. The following is a statement of our Financial Policy which we require you to read and agree to prior to your treatment:

- We are happy to file your insurance claim for you. In order to work with your insurance carrier, we must have **complete and current registration information, a copy of your insurance card, and your signature on file**. If you are unable to verify coverage, you will be considered "self-pay" until the information is received.

- You must inform the office of all insurance changes and authorization requirements. You will be responsible for any charges that are denied by your insurance carrier which result from incomplete and/ or out of date coverage information.

- Patients who are "self-pay" or have no insurance will be required to pay a minimum of $50 at the time of service. However, there may be times when all charges for that visit are not listed on your account at the time of check-out. You will be billed for these additional charges if applicable.

- Please understand there may be charges which your insurance carrier considers "non-covered" or "out of network" and may be excluded from your policy. You are responsible for these fees and you authorize Anjali Monga, M.D., Inc. to bill you for any appropriate services. This is in accordance with your insurance carrier contract. If you receive a bill you disagree with, please contact our biller Stephanie at (949) 733-2800 ext 28 or (949) 207-3377 option 1.

- All co-pays are due at time of service. (A $10 billing fee will be assessed for any co-pay not paid at time of service). Any account balances are also due at time of service. We accept cash, checks, MasterCard, Visa and Discover. **Please note any returned check is subject to an additional $25 fee.**

- We do understand special financial needs and offer payment plans in these circumstances. If you need special payment arrangements, please contact our billing department. For most of our payment plans we do ask that the account balances be paid in full within 3 consecutive monthly payments. If you need further assistance, please contact our biller Stephanie at (949) 733-2800 ext 28 or (949) 207-3377

- We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. **If an appointment is not cancelled at least 24 hours in advance, you will be charged a Twenty-five-dollar ($25) fee; this will not be covered by your insurance company.**

- Past due accounts may be subject to collection proceedings. PATIENTS WHO ARE SENT TO COLLECTIONS WILL BE DISMISSED FROM THE PRACTICE.

I HAVE READ, UNDERSTAND AND AGREE TO ABIDE BY THE ABOVE FINANCIAL POLICY

Signature: _____ Date: _____

(Parent or Guardian only; children under 18 years of age may not sign form)

Premier Pediatrics
Anjali Monga, M.D., INC.
15825 Laguna Canyon Road, Suite #102
Irvine, CA, 92618
(949) 733-2800

We understand that medical information about you and your health is personal. As the custodians of the information in your medical record, we are committed to protecting the privacy of your information as required by law, professional accreditation standards and our internal policies and procedures.

A personal detailed copy of our Notice of Privacy Practices can be given if requested. This notice explains your rights, our legal duties and our privacy practices. It also describes how medical information about you may be used and disclosed and how you can get access to this information.

For your convenience, the following is a summary of the information discussed in the notice.

- Our pledge
- Your Personal Information
- Our Privacy Practices
- How We May Use or Share Your Information for:
  - Treatment
  - Payment
  - Health Care Operations
  - Notifications
  - Marketing
  - Research
  - Special Circumstances and the Law
- Your Written Permission
- Other Restrictions
- Your Rights
- Changes
- Questions or Complaints

Please understand that this summary is not our Notice of Privacy Practices, nor is it a substitute for the notice. The actual notice should have been given to you, as required by law, with this cover letter. If it was not, please contact office manager at the address or phone number shown at the top of this page to receive your copy.

We ask that you sign and return this cover letter to us for our records. Your signature only acknowledges that we have provided you a personal copy of our Notice of Privacy Practices as required by law. The law also requires us to document the fact the we have distributed the notice by collecting and retaining these signed acknowledgments.

If, after reviewing the notice, you decide that you do not want to retain your paper copy, please return it to our receptionist and we will recycle it.

I hereby acknowledge receipt of the Notice of Privacy Practices:

Signature	Printed Name	Date