Pediatrics MAYFLOWER MEDICAL GROUP

Today's Date _____/_____/_____ **PEFERRED LANGUAGE:**_____

PATIENT INFORMATION

Patient's Last Name	First name	Middle name

Birth Date: / /	Age:	Sex	Social Security ( )	**Home /Cell Phone No.** ( )

Street Address	City	State	ZIP Code

Chose Office Because/Referred to Office by (Please check one box) ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Google ❑ Facebook ❑ Yelp ❑Word of Mouth ❑ Other _____

PHARMACY INFORMATION

PHARMACY NAME: PHONE NUMBER:

STREET ADDRESS: CITY: STATE: ZIP

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Father's/ Guardian

Name:	Address: (If Different)	Home Phone no: ( ) Work Phone no: ( )

Do you have insurance for minor/ child? ❑ Yes ❑ No

Insurance Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Pay $

Mother's/ Guardian

Name:	Address: (If Different)	Home Phone no: ( ) Work Phone no: ( )

Do you have insurance for minor/ child? ❑ Yes ❑ No

Insurance Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Pay $

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone no. ( )	Work Phone no. ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Mayflower Medical Group, Inc. I understand that I am financially responsible for any balance. I also authorize Mayflower Medical Group, Inc. or insurance company to release any information required to process my claims.

X _____

PATIENT/GUARDIAN SIGNATURE DATE

PATIENT CELL PHONE NUMBER: _____EMAIL:_____

Pediatrics MAYFLOWER MEDICAL GROUP

INITIAL HEALTH ASSESSMENT

Date: _____/_____/_____
NAME: _____ Birthdate: _____/_____/_____ Last First M. I.
Reason for today's appointment:

HISTORY OF PREGNANCY WITH THIS CHILD:

During which month of pregnancy did you first see the doctor? *(months)*	
Did you have any illnesses or problems during pregnancy (including sexual transmitted or other communicable diseases)	Yes No
Did you have any medications prescribed by your doctor or non-prescribed drugs?	Yes No
Type of delivery (check appropriate square)	☐ Normal Vaginal ☐ C-section ☐ Premature ☐ Prolonged ☐ Induced ☐ Other complications, please mention_____
If baby was born at home, were blood tests for newborn screening done?	Yes No
Is this child adopted?	Yes No

BIRTH HISTORY:

Place of Birth:	Obstetrician:
Birth Weight: (pounds)	Birth Length: (inches)
Developmental History (months/years):	
Walked:	Rolled Over:
Crawled:	First word:
Toilet Trained:	

FAMILY HISTORY: Does mother (M), father (F), sister (S), brother (B), aunt (A), uncle (U), or grandparents (GP) have:

			Which family member?				Which family member?
Yes	No	Arthritis		Yes	No	High Blood Pressure	
Yes	No	Asthma/Breathing problems		Yes	No	Hemophilia/Bleeding disorder	
Yes	No	Cancer		Yes	No	Kidney or urinary disorder	
Yes	No	Convulsions/Epilepsy		Yes	No	Migraine	
Yes	No	Diabetes		Yes	No	Tuberculosis	
Yes	No	Eye/Vision Problems					
Yes	No	Ear/Hearing Problems					
Yes	No	Heart diseases					

MEDICAL HISTORY: Has your child ever had:

Chicken Pox (date and/or age):	Injuries/Accidents
Mumps(date and/or age):	Asthma or breathing complaints
Measles (date and/or age):	Diarrhea/Constipation
Rubella (date and/or age):	Skin problems
TB (date and/or age):	Headaches or dizziness
Tonsillitis/sore throat	Convulsions, seizures, epilepsy
Allergies to food, medications or others	Diabetes
Heart Problems	Anemia/Blood Transfusions
Eye/Vision Problems	Ear/hearing problems
Muscle, joint or bone problems	Surgery or hospitalizations
Bladder Problems, bed wetting	Thyroid Problems
Has she started her periods? (Female only)	Are her periods regular? (Female only)

HOUSEHOLD INFORMATION:

No. of people living in home:	**Parents Information**	
Does anyone in the house smoke, or use drugs or alcohol? ☐ Yes ☐ No	Mother	Father
Language spoken at home:	Age: _____	_____
Do you live in a: ☐ House ☐ Apartment ☐ Mobile home ☐ Shelter ☐ Homeless	Height: _____	_____
	Occupation: _____	_____

Patient Identification:

Signature: _____ **Date:** _____

Relationship to Child: _____

Reviewer's Signature: _____ **MD** **Date:** _____

Pediatrics MAYFLOWER MEDICAL GROUP

HISTORY OF MAJOR ILLNESS

_____

_____

_____

_____

ALLERGIES

_____

_____

_____

_____

PROBLEM LIST

_____

_____

_____

_____

_____

SURGERY & HOSPITALIZATION

_____

_____

_____

_____

_____

HABITS

_____

_____

CURRENT MEDICATIONS		
Please list any medications that the patient is taking now. Include non-prescription medications & vitamins or supplements:		
Name of drug	**Dose (include strength & number of pills per day)**	**How long have you been taking this?**
1.		
2.		
3.		
4.		
5.		

Pediatrics
MAYFLOWER
MEDICAL GROUP

CONSENT TO THE TREATMENT OF A MINOR

I (we) being the parent(s) or guardian of _____(a minor) hereby consent, authorize and request **DR**._____ to administer such treatment deemed as advisable, necessary or requested on the above- named minor.
I (we) agree to hold him/her free and harmless from my claims, suits, for damages or complication which may result from such treatments.

Signature of Patient/ Parent/ Guardian: _____
Date: _____

Patient Financial Responsibility and Authorization Form

1. The information I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it's my responsibility to inform this office of any changes in my minor/child's medical status. I certify that my minor/child is covered by insurance with _____.

2. I _____, hereby authorize the doctors of Mayflower Medical Group, Inc. to be attending physicians and to administer to my child/ minor any examination, treatment , and medications he/ she deems therapeutic to my presenting complaint.
3. I _____, fully understand that the insurance carrier may not be available to verify the coverage or has not authorized this visit, procedure or medication for the minor/ child. In the event that the insurance carrier denies payment of all services rendered to my minor/ child, I am financially responsible for all charges whether or not paid by the insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.
4. I _____, fully understand that the copay for my child/ minor is being waved because as he/she is here only for a Well Child Visit. Any additional problems I ask to be addressed for my child/ minor will change my Well Child Visit into a regular visit and I will have to pay the copayment for my child/ minor.

Signature of Patient/ Parent/ Guardian: _____
Date: _____

AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF MEDICAL RECORDS

Please request Medical Information from:

MAYFLOWER MEDICAL GROUP, INC.

Please send Medical Information to:

_____
Medical provider

_____
Street Address/Suite No.

_____
City, State, Zip Code

I hereby authorize Mayflower Medical Group to release or disclose the Medical information including but not limited to Lab results/X-ray/Other test results as indicated above to a healthcare provider/medical office/hospitals for continuum of care.

Name of Patient: _____ Date of Birth: _____

Address: _____

Telephone No. _____

RECORDS TO BE RELEASED
All medical records including Lab results/X-ray/Other test results/others from _____ to _____

DURATION: This authorization shall become effective immediately and shall remain in effect _____ (enter date) or for one year from the date of signature.

REVOCATION: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party.

REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless authorization is obtained from me or unless disclosure is required or permitted by law.

I HAVE THE RIGHT TO RECEIVE A COPYOF THIS AUTHORIZATION:

Signature of Patient **Date**

AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF MEDICAL RECORDS

Please request the Medical Information from: _____. I hereby authorize Mayflower Medical Group to release/ request and / or disclose the Medical information including but not limited to Lab results/X-ray/ Other Test Result as indicated above from/to a Healthcare Provide/ Medical office/ Hospitals for continuum of care.
Duration: This Authorization shall become effective immediately and shall remain in effect for one year from the date of signature
Revocation: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party
REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is requires or permitted by law.
Name of the patient:_____. Date of Birth:_____. Signature of Patient/ Parent/ Guardian: _____ Date: _____

AUTHORIZATION FOR RELEASE AND/OR DISCLOSUREOF MEDICAL RECORDS

Please request Medical Information from:

_____
Medical provider

_____
Street Address/Suite No.

_____
City, State, Zip Code

Please send Medical Information to:

MAYFLOWER MEDICAL GROUP, INC.

I hereby authorize _____ to release or disclose the Medical information including but not limited to Lab results/X-ray/Other test results as indicated above to a healthcare provider/medical office/hospitals for continuum of care.

Name of Patient: _____ Date of Birth: _____

Address: _____

Telephone No. _____

RECORDS TO BE RELEASED
All medical records including Lab results/X-ray/Other test results/others from _____ to _____

DURATION: This authorization shall become effective immediately and shall remain in effect _____ (enter date) or for one year from the date of signature.

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REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless authorization is obtained from me or unless disclosure is required or permitted by law.

I HAVE THE RIGHT TO RECEIVE A COPYOF THIS AUTHORIZATION:

Signature of Patient **Date**

HIPPA Privacy Rule of Patient Authorization Agreement

Mayflower Medical Group, Inc.

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I, _____ (Patient's Name) understand that as part of my health care, Mayflower Medical Group, Inc. originates and maintains health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information service as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services were actually provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

I have been provided with a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review Mayflower Medical Group, Inc. notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review Mayflower Medical Group, Inc. Notice of Information practices prior to signing this consent;
- That Mayflower Medical Group, Inc. reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Mayflower Medical Group, Inc. is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that Mayflower Medical Group, Inc., has already taken action in reliance thereon.

Signature of Patient or Legal Representative Witness _____ Date: _____

Printed Name of Patient or Legal Representative Witness _____ Date: _____

HIPPA Privacy Rule Receipt of Notice of Privacy Practices

Written Acknowledgement Form

Mayflower Medical Group, Inc.

Acknowledgement of receipt of Information Practices Notice (§164.520(a))

I, _____ (Patient's Name) understand that as part of my health care, Mayflower Medical Group, Inc. originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that Mayflower Medical Group, Inc. Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review Mayflower Medical Group, Inc. Notice of Privacy Practices prior to signing this acknowledgement;
- that Mayflower Medical Group, Inc. reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Signature of Individual or Legal Representative Witness _____

Printed Name of Individual or Legal Representative Witness _____

Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- ▫ Individual refused to sign
- ▫ Communication barrier prohibited obtaining the acknowledgement
- ▫ An emergency situation prevented us from obtaining acknowledgement
- ▫ Others (please specify)

_____

_____

_____ _____

Site Manager Date

Privacy Official

Los Angeles County Pediatrics Tuberculosis Risk Assessment

- Use this tool to identify asymptomatic **children** for TB infection testing.
- Re-testing should only be done in persons who previously tested negative, and have **new** risk factors since the last assessment.
  If initial negative screening test occurred prior to 6 months of age, repeat testing should occur at age 6 months or older
- For children with TB symptoms or abnormal chest x-ray consistent with active TB disease → Evaluate for active TB disease
  Evaluate for active TB disease with a chest x-ray, symptom screen, and if indicated, sputum AFB smears, cultures and nucleic acid amplification testing. A negative tuberculin skin test or interferon gamma release assay does not rule out active TB disease.
- Do not treat for TB infection until active TB has been excluded.

Check appropriate risk factor boxes below.

TB infection testing is recommended if any of the 3 boxes below are checked.

If TB infection test result is positive and active TB disease is ruled out, TB infection treatment is recommended.

☐ **Birth, travel, or residence** in a country with an elevated TB rate for at least 1 month

- Includes any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe
- Interferon Gamma Release Assay is preferred over Tuberculin Skin Test for Non-U.S.-born persons ≥2 years old

☐ **Immunosuppression,** current or planned

- HIV infection, organ transplant recipient, treated with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone ≥2 mg/kg/day, or ≥15 mg/day for ≥2 weeks) or other immunosuppressive medication

☐ **Close contact** to someone with active TB disease at any time

- The Centers for Disease Control and Prevention indicates that the investigation of contacts and treatment of infected contacts is an important component of the U.S. strategy for TB elimination.

☐ None; no TB testing is indicated at this time

See the **Pediatric TB Risk Assessment User Guide** for more information about using this tool.

Provider: _____

Assessment Date: _____

Person Name: _____

Date of Birth: _____

(Place sticker here if applicable)

To ensure you have the most current version, go to the PEDIATRIC TB RISK ASSESSMENT at: http://publichealth.lacounty.gov/tb/providertoolkit.htm
Adapted for LAC use from the California Pediatric TB Risk Assessment available on the PROVIDERS page at www.ctca.org

CTCA California Tuberculosis Controllers Association

CDPH California Department of Public Health

Curry International Tuberculosis Center

County of Los Angeles Public Health