New Pediatric Patient Questionnaire

Patient’s Name: ____________________________  DOB: __________  Sex:  M  F

Form completed by: _______________  Date completed: _____  Whom may we thank for referring you? ________________________

Household members

Please list all those living in child’s home (if child lives in more than one home, please indicate how the time is split and with whom):

<table>
<thead>
<tr>
<th>NAME</th>
<th>Relationship</th>
<th>Age</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Parent</td>
<td></td>
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<tr>
<td></td>
<td>Parent</td>
<td></td>
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</tr>
</tbody>
</table>

Birth history

Delivery hospital: ____________________________  Delivery by: vaginal _____  cesarean _____  If cesarean, why? ________________________

Problems during pregnancy: ____________________________

During pregnancy, did mother:  Smoke? _____  Drink alcohol? _____  Take drugs or medications? ________________________

Was the baby born:  full term _____  early _____  If early, how early? ________________________

Birth weight: __________  Did baby have any problems in hospital? ________________________

Feeding:  Breast_____  Bottle_____

Medical and developmental history: (may skip if you are completing form for a newborn):

Have you or your child’s previous doctor had any concerns about your child’s development or growth? ________________________

Does your child have any serious illness or medical condition? ________________________

Are your child’s immunizations up-to-date? _____  If not, why not? ________________________

Has your child had any serious injuries, accidents or operations? ________________________

Is your child allergic or had reactions to any medicines or drugs? ________________________

Has your child ever been admitted to the hospital? ________________________

Are there any concerns about your child’s behavior or school performance? ________________________

Current medications: ________________________
### Child's History

Does your child have, or has s/he ever had these concerns? If so please explain (may skip if you are completing form for a newborn):

<table>
<thead>
<tr>
<th>Concern</th>
<th>Yes/No</th>
<th>Explain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anemia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
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<tr>
<td>Chicken Pox</td>
<td></td>
<td></td>
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<tr>
<td>Constipation/bedwetting</td>
<td></td>
<td></td>
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<tr>
<td>Developmental delay</td>
<td></td>
<td></td>
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<tr>
<td>Ear infections/hearing issues</td>
<td></td>
<td></td>
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<tr>
<td>Eczema</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal problems</td>
<td></td>
<td></td>
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<tr>
<td>Heart problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning differences (ADHD, dyslexia etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumonia/bronchitis</td>
<td></td>
<td></td>
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<tr>
<td>Seizures</td>
<td></td>
<td></td>
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<tr>
<td>Urinary tract infections</td>
<td></td>
<td></td>
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<tr>
<td>Other concerns</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Family History

Has anyone in your child's immediate family had chronic medical issues? If so, please explain:

<table>
<thead>
<tr>
<th>Concern</th>
<th>Family member</th>
<th>Explain and indicate maternal or paternal side</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood diseases</td>
<td></td>
<td></td>
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<tr>
<td>Bone diseases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
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<tr>
<td>Cholesterol elevated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal conditions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart attack before age 50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart diseases</td>
<td></td>
<td></td>
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<tr>
<td>High blood pressure</td>
<td></td>
<td></td>
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<tr>
<td>Infectious conditions</td>
<td></td>
<td></td>
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<tr>
<td>Kidney disease</td>
<td></td>
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<tr>
<td>Muscle disease</td>
<td></td>
<td></td>
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<tr>
<td>Psychiatric/psychological problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seizures</td>
<td></td>
<td></td>
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<tr>
<td>Substance abuse</td>
<td></td>
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<tr>
<td>Thyroid diseases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hormone problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other significant concerns</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
University HealthCare Alliance

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of University HealthCare Alliance. Our Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read our full Notice. If you have any questions about our Notice of Privacy Practices that our registration staff cannot answer, please contact our Director of Compliance and Risk Management at 510-731-2635, or send a written inquiry to the Compliance and Risk Management Office, 7999 Gateway Blvd., Suite 200, (MC 5941) Newark, CA 94560

University HealthCare Alliance ("UHA") is a medical foundation affiliated with Stanford Health Care and Stanford Medicine. UHA contracts with a number of physician groups to provide the medical care in the UHA clinics. Neither UHA, Stanford Health Care, nor Stanford University employ the physicians in the clinics and do not exercise control over the professional services provided by the physician groups.

ACKNOWLEDGEMENT OF RECEIPT: I acknowledge receipt of the Notice of Privacy Practices of University HealthCare Alliance.

Signature: ______________________ Date: ______________________

(patient/ parent/personal representative)

If other than the patient, specify relationship: ____________________________________________

For Internal Use Only: Inability To Obtain Acknowledgement

If University HealthCare Alliance or its member medical group is not able to obtain the patients acknowledgement, record the good-faith effort made to obtain acknowledgement, and the reason acknowledgement was not obtained:

Effort to obtain acknowledgement:

☐ In-person request
☐ Request via mail (send copy of letter to Medical Records for inclusion in patient’s record)
☐ Request via e-mail
☐ Other: __________________________________________________________

Reason acknowledgement was not obtained:

☐ Patient refused to sign
☐ Patient unable to sign
☐ Patient did not return acknowledgment via mail, e-mail
☐ Other: __________________________________________________________

Staff Print Name/Title/Supervisor:

________________________________________/____________________________

Staff Signature: __________________________ Date: ________________
University HealthCare Alliance

Please read this document carefully. University HealthCare Alliance requires the Terms and Conditions of Service to be signed in its entirety, on an annual basis, without alteration.

1. MEDICAL CONSENT.
   I, the undersigned patient or legal representative, consent to the general treatment and procedures that may be performed. These procedures may include but are not limited to laboratory procedures, x-ray examinations, medical or surgical treatment or procedures provided to the patient under the general and special instructions of the patient’s physician or surgeon. I understand that it is the responsibility of the patient’s physician to obtain the patient’s informed consent when required for specific medical or surgical treatment and special diagnostic or therapeutic procedures. I understand and agree that at the request of the attending physician, health practitioners (such as physician assistants and nurse practitioners) may participate in the patient’s care.

2. TEACHING INSTITUTION.
   University HealthCare Alliance is affiliated with Stanford Hospital and Clinics, which is a teaching facility, training physicians, surgeons, nurses, and other health care personnel. At the request, and under the supervision, of the attending physician, that residents, interns, medical students, postgraduate fellows and other health care personnel in training may participate in the care of the patient as part of their medical program. □ I agree □ I disagree

3. FINANCIAL AGREEMENT.
   For the services to be rendered, I agree to accept full financial responsibility for the patient’s account in accordance with the regular rates and terms of University HealthCare Alliance. This includes financial responsibility for all deductibles and co-payments that may be required by the patient’s insurance or health plan. This also includes services or supplies not covered by the patient’s health insurance plan and or Medicare. Should the patient’s account(s) be referred to an attorney or a collection agency for collection, I further agree to pay actual attorneys’ fees and lawsuit-related expenses incurred in addition to other amounts due. When the services are to be billed to insurance, a health plan or another payment source, paragraphs 4 (Contracted Health Plan Patients and Other Sources) and 5 (Assignment of Insurance Benefits) will also apply.

4. CONTRACTED HEALTH PLAN PATIENTS AND OTHER SOURCES.
   I understand that the patient may be eligible for certain health care coverage through a health plan (HMO, PPO) on the list of health plans with which University HealthCare Alliance contracts, or through some other source (e.g., clinical trial sponsor, employer’s workers’ compensation insurance). I agree to be responsible under paragraph 3 (Financial Agreement) for paying the patient’s account: (a) if University HealthCare Alliance does not contract with the health plan; (b) for any co-payment and deductible; (c) for services not approved by the health plan or other source (d) for services not covered and/or paid for by the patient’s health plan or other source to the extent allowed by law or contract.
University HealthCare Alliance

5. ASSIGNMENT OF INSURANCE BENEFITS (INCLUDING MEDICARE BENEFITS).
I authorize direct payment to University HealthCare Alliance of any insurance benefits otherwise payable to or on behalf of the patient for services, at a rate not to exceed the actual charges. I understand and agree that I am financially responsible under paragraph 3 (Financial Agreement) for charges not paid in accordance with this assignment. If applicable, I further attest that information given to University HealthCare Alliance to assist the patient in applying for payment under Medicare is correct.

University HealthCare Alliance ("UHA") is a medical foundation affiliated with Stanford Health Care and Stanford Medicine. UHA contracts with a number of physician groups to provide the medical care in the UHA clinics. Neither UHA, Stanford Health Care, nor Stanford University employ the physicians in the clinics and do not exercise control over the professional services provided by the physician groups.

The undersigned certifies that he/she has read the Terms and Conditions of Service, has received a copy of it, and is the patient or is duly authorized by or on behalf of the patient to execute and accept its terms.

**PATIENT OR RESPONSIBLE PERSON SIGNATURE**

**WITNESS SIGNATURE**

**INTERPRETER SIGNATURE**

**PRINT NAME**

**POSITION/RELATIONSHIP TO PATIENT**

**RELATIONSHIP TO PATIENT**

**DATE**

**DATE**

**LANGUAGE**

**RELEASE OF INFORMATION**

In compliance with the federal Health Insurance Portability and Accountability Act (HIPAA), University HealthCare Alliance provides patients with a Notice of Privacy Practices, which describes how medical information about you may be used and disclosed, and how you can get access to this information. Additional copies of the Notice of Privacy Practices are available at any reception desk or registration office or by calling the University HealthCare Alliance’s Director of Compliance and Risk Management, Beth Delair, at 510-731-2635.
You must submit form in-person to a clinic at Stanford Hospital & Clinics or University Health Care Alliance/Menlo Medical Clinic. Photo ID will be verified upon submission.

MyHealth Proxy Access Request Form

Request for Online Access to Medical Records for a Minor Child

I hereby request Stanford Hospital & Clinics (SHC) and Clinics of University Healthcare Alliance (UHA) provide access to the health information in MyHealth allowable by law, of the patient named below to the following proxy representative.

Please note the following age range limitations for MyHealth. These age range limitations do not affect any legal right you have to access your child’s record by other means. To request a paper copy of your child’s record, contact the medical records department.

- If your child is age 0-11: You will be granted full access to your child’s MyHealth record.
- If your child is age 12-17: You will be granted partial access to your child’s MyHealth record. (e.g. immunizations, messaging)
- Once your child reaches age 18, you will no longer have access to your child’s MyHealth record.

Please print legibly and complete all fields to ensure timely processing.

**Patient Name** __________________________________________________________

(Under age 18) Last First MI

**Medical Record Number (MRN):** ________________________

**Phone** __________________________  **Date of Birth** _________________

**MM/DD/YYYY**

**Street Address** __________________________________________________________

City ____________________________ State __________ Zip Code _________________

**Phone** __________________________  **Date of Birth** _________________

**MM/DD/YYYY**

**Email** _________________________________________________________________

Your Relationship to child*:  

- Parent
- Guardian
- Conservator
- Stepparent

*Legal documents may be required, e.g., birth certificate, guardianship papers, power of attorney, marriage certificate.

Your Affiliation with SHC/UHA:

- I am a patient with MyHealth log-in
- I am a patient without MyHealth log-in
- I am not a patient

**Your Signature** __________________________  **Date** __________________________

**HIMS USE ONLY**

Date Request Received: ______________  Patient Relationship Verified By: __________________________

Proxy MRN: ______________  Proxy Access Approved: □ Yes □ No  Letter Sent: □ Yes □ No Date Sent: ______________