UnityPoint Clinic

Pediatric Health Questionnaire

Clinic _____

Today's Date: / /

Child's Name _____ Birthdate _____ Age _____

Mother's Name _____Father's Name _____

Siblings (names & ages) _____

_____

Legal Guardian (if other than parents) _____

Who does child live with? _____

Is this child adopted? _____ a foster child? _____

List any medicine your child takes on a regular basis (include over the counter and herbals)

Medication	Dose	How often?

Is your child **allergic to any medications**? _____ Please list _____

_____

Does your child have a **latex allergy**?_____

Are your child's **immunizations** up to date? (Please provide us with a copy)

Does anyone your child lives with smoke cigarettes in the home? _____

Birth History

Birth length: _____ Birth weight _____ Birth head circ _____

Discharge weight _____ Gestational age _____ Delivery method _____

Duration of labor _____

Hospital Information: Days in hospital _____ Hospital name _____ Hospital location _____

APGAR Scores: APGAR 1 _____ APGAR 5 _____ APGAR 10 _____

Feeding Method _____ Additional Comments: _____

UnityPoint Clinic

MEDICATION LIST

Patient Name: _____ Date: _____

Name of Medication, Over-the-Counter Medications, Vitamins or Herbals	Dosage/Strength	How Often Taken

Past Medical History (please circle)

ADD/ADHD	yes	no	Headaches	yes	no	Pneumonia	yes	no
Allergies	yes	no	Hearing loss	yes	no	Scoliosis	yes	no
Asthma	yes	no	Heart murmur	yes	no	Seizures	yes	no
Cancer	yes	no	HIV/AIDS	yes	no	Sickle cell anemia	yes	no
Chronic Encephalopathy	yes	no	Inflammatory bowel Disease	yes	no	Sleep apnea	yes	no
Congenital Malformation	yes	no	Jaundice	yes	no	Strep throat (recurrent)	yes	no
Constipation	yes	no	Lead poisoning	yes	no	UTI	yes	no
Diabetes mellitus	yes	no	Meningitis	yes	no	Varicella	yes	no
Eczema	yes	no	Obesity	yes	no	Vision problems	yes	no
GI disorders	yes	no	Otitis media	yes	no			

Other medical history: _____

_____

Surgical History (please circle)

Adenoidectomy	yes	no	Fracture surgery	yes	no	Strabismus surgery	yes	no
Appendectomy	yes	no	Gastrostomy	yes	no	Tear duct surgery	yes	no
Circumcision	yes	no	Heart surgery	yes	no	Tonsillectomy	yes	no
Cleft lip	yes	no	Inguinal hernia	yes	no	Umbilical hernia	yes	no
Cleft palate	yes	no	Lymph node Biopsy	yes	no	VP shunt	yes	no
Ear tubes	yes	no	Orchiopexy	yes	no			

Other surgical history: _____

_____

_____

FAMILY HISTORY

Relationship	ADHD	Adverse Reaction	Allergies	Anemia	Anxiety disorder	Arrhythmia	Arthritis	Asthma	Behavior problem	Birth defects	Blood disorders	Cancer	Cardiomegaly	COPD	Depression	Diabetes	Early death	Fainting	GI problems	Hearing loss	Heart disease	High cholesterol	Hypertension	Inflam bowel	Intellectual disease	Kidney disease	Learning disability	Mental illness	Migraines	Rheumatologic disorder	Seizures	Stroke	Substance abuse	Thyroid disease	Vision loss
Mother																																			
Father																																			
Sister																																			
Brother																																			
Daughter																																			
Son																																			
Maternal Aunt																																			
Maternal Uncle																																			
Paternal Aunt																																			
Maternal Uncle																																			
MGM																																			
MGF																																			
PGM																																			
PGF																																			
Cousin																																			
Other																																			

Passive Smoke:

Tobacco Use _____
Packs/day: _____
Years _____
Smokeless Tobacco _____Current user _____ Former user _____ Never used _____ Unknown _____
Ready to Quit Yes _____ No _____

Comment: _____

Additional Social History (please circle)

Adopted	yes	no	Military service	yes	no
Are you having sex	yes	no	Bike helmet	yes	no
Are you trying to get pregnant	yes	no	Occupational exposure	yes	no
Caffeine use	yes	no	Other	yes	no
Exercise	yes	no	Seat belt/car seat	yes	no
Hobbies	yes	no	Special diet	yes	no
Living arrangement	yes	no			

Comment: _____

UnityPoint Clinic

General Patient Information

Patient Name:	***Date of Birth:***	***Gender:***	***Social Security Number:***
Address:	***City:***	***State:***	***Zip:***

Home Phone:	*Work Phone:*	*Mobile Phone:*	*Email:*

Marital Status:	☐ ***Hispanic or Latino*** ☐ ***Non-Hispanic or Latino***	***Race:***	***Primary Care Physician:***

Employer:	***Employment Status:*** □ ***Full Time*** □ ***Part Time*** □***Retired***
Emergency Contact: ***Relationship to patient:*** ***Phone:***	*Second Emergency Contact:* *Relationship to patient:* *Phone:*

Guarantor Information *(Only required for patients less than 18 years old.)*

Guarantor's Name (Adult residing with child):	***Date of Birth:***	***Relationship to Patient:***

Social Security Number:	***Employer:***	***Employment Status:*** □ ***Full Time*** □ ***Part Time*** □***Retired***

Insurance Information

Primary Insurance Company:	***ID#:***	*Group No./ Name:*	***Insurance Phone:***
Address:		*City, State, Zip:*	

Subscriber's Name (Policy Holder):	***Date of Birth:***	***Gender:***	***Relationship to Patient:***

Social Security Number:	***Employer:***	***Employment Status:*** □ ***Full Time*** □ ***Part Time*** □***Retired***

Secondary Insurance Company:	***ID#:***	*Group No./ Name:*	***Insurance Phone:***
Address:		*City, State, Zip:*	

Subscriber's Name (Policy Holder):	***Date of Birth:***	***Gender:***	***Relationship to Patient:***

Social Security Number:	***Employer:***	***Employment Status:*** □ ***Full Time*** □ ***Part Time*** □***Retired***

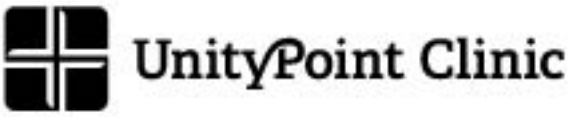
By signing below, I hereby acknowledge receipt of UnityPoint Health – Methodist's Notice of Privacy Practices and consent to the uses and disclosures described in the Notice of Privacy Practices.

_____ _____20_____

Signature of Patient (Legal or Personal Representative) Date of Signature

_____ _____

Print Patient Name Date of Birth



UnityPoint Clinic

FINANCIAL RESPONSIBILITY

Methods of Payment Accepted: Visa, MasterCard, Discover, cash and checks. Payment of co-pays and deductibles are due at the time of service.

Individual/Group Insurance: As a courtesy to you, UnityPoint Clinic will submit the appropriate claims to your insurance company(s). If your insurance requires an employee claim form, or any other information from you, please submit it to them in a timely manner. Your insurance policy is a contract between you and your insurance company. Therefore, you are ultimately responsible for payment of all charges. It is your responsibility to resolve disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, and use of any special forms. UnityPoint Clinic requires that your account be paid in full within 60 days of the date of service, regardless of the status of your insurance claim. If you need an extended payment plan, please contact our Billing Office at (309) 672-4809 or (888) 772-5351

Liability: Services incurred resulting from injury or accident are considered the responsibility of the patient / guarantor. It is your responsibility to ensure that the UnityPoint Clinic is paid promptly regardless of pending disputed or litigated claims. As we are unable to file claims to a third party insurance carrier, services rendered as a result of automobile accidents must be filed with your personal automotive insurance.

Medicare: UnityPoint Clinic is a participating provider and accepts assignment on all Medicare claims. For your convenience, appropriate claims will also be sent to your Medicare Supplemental Insurance. Any deductible, co-payment amounts or routine non-covered services are your responsibility and will be billed to you after Medicare and your supplemental insurance has processed and paid appropriate benefits.

No Insurance Coverage: UnityPoint Clinic requires payment for all charges at the time services are rendered. A self-pay discount is offered when payment is made at the time of service. If you are unable to pay at the time of service, please contact our Billing Office to make payment arrangements.

Worker's Compensation: If you are injured on the job, we will process claims to your employer in compliance with the Illinois law. If your employer or the employer's Worker's Compensation Insurance Carrier determine that your illness or injury is not related to your employment or is otherwise determined not to be covered by the Worker's Compensation guidelines, than all charges will be your responsibility.

Financial Assistance: We will be pleased to assist you with any questions regarding available payment options. UnityPoint Clinic is committed to providing service to those who may need financial assistance. If you have questions regarding financial assistance or would like a Financial Assistance application, please contact our Billing Office at (309) 672-4809 or (888) 772-5351.

ASSIGNMENT OF BENEFITS

Insurance Authorization / Release: I hereby authorize the physician/provider to release any and all information necessary concerning my diagnosis and treatment for the purpose of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the physician for any and all services rendered.

Medicare Authorization / Release: I request that payment of authorized Medicare benefits to be made on my behalf to the physician/provider for any and all service provided to me by that physician/provider. I hereby authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

My signature below indicates that I have read and understood the foregoing information relative to my responsibility for the services provided as well as authorizing the release of medical information as required to process claims and benefits to which I am entitled.

Patient Signature_____ Date: _____

Patient Name Printed: _____ DOB:_____

Patient Social Security Number:_____ Patient Acct #_____

Responsible Party: _____ Date: _____
On behalf of a minor child.

Witness: _____ Date: _____

UnityPoint Clinic

Office Use: H P

INFORMED CONSENT TO TREAT

This Informed Consent to Treat Form was signed for treatment at the following UnityPoint Clinic location: _____

General

By signing below, I hereby present for medical treatment with UnityPoint Clinic and I do hereby voluntarily consent to and authorize physicians, nurses or other healthcare professionals to render such medical care, examinations, diagnoses, and treatments as may be ordered or requested by the physicians or other healthcare professionals rendering care and treatment to me and which they, in their professional judgment, deem necessary or beneficial.

I understand that among those who attend patients at UnityPoint Clinic may be medical, nursing and other healthcare personnel in training who, unless requested otherwise, may be present during patient care as part of their education.

I acknowledge that I have received no warranties or guarantees regarding the results of such care, procedures, examinations or treatment.

I understand that I can revoke this consent at any time by contacting my UnityPoint Clinic provider.

Release of Information

I also understand that, in certain cases, UnityPoint Clinic is required by law to disclose certain patient information and data relating to infectious diseases (including: HIV, tuberculosis, viral meningitis, and certain other diseases) to the designated local, State and Federal entities such as public health departments or the Center for Disease control and Prevention or other governmental agencies.

I CERTIFY THAT THIS FORM HAS BEEN EXPLAINED TO ME, THAT I HAVE READ IT AND I UNDERSTAND IT.

_____ _____

Signature of Patient/Guardian Today's Date

_____ _____

Printed Name of Patient Patient's Date of Birth

CONSENT TO OBTAIN MEDICATION INFORMATION/HISTORY (REQUIRED)

Consent for Obtaining Medication Information/History

I understand that this medication information/history may include: past and current prescriptions, prescription insurance eligibility, and prescription insurance claims history and prescription formulary files.

I give consent and understand that I can revoke this consent at any time by providing written notice, to my UnityPoint Clinic provider.

_____ _____

Signature of Patient/Guardian Today's Date

_____ _____

Printed Name of Patient Patient's Date of Birth

UnityPoint Clinic

Request of Information/Consent
Locations of Communication

The purpose of this form is to obtain guidance from you (the patient) about how we should communicate about you and to you.

Patient Information

Date of Request:_____/_____/_____

Patient Name: _____ Date of Birth:_____/_____/_____

Patient Address: _____
City State Zip

SECTION 1: Communications to Family Members and Others Involved In My Healthcare

I give my permission to UnityPoint Clinic to communicate information concerning my medical condition and medical treatment to the person(s) listed below. **(*Note: If the patient is a minor, pursuant to Iowa and Illinois law, information generally will be given to both parents unless UnityPoint Clinic otherwise deems the communication inappropriate or if by court order one parent is not to be provided with information concerning the minor.)***

Name 1:_____ Relationship_____ Phone No._____

Name 2:_____ Relationship_____ Phone No._____

Name 3:_____ Relationship_____ Phone No._____

I understand that it is my responsibility to update the above information if I want it changed. This communication information will be used for all medical conditions and treatment obtained at UnityPoint Clinic or at the request of one of the physicians employed at UnityPoint Clinic.

I understand that mental health, substance abuse treatment and/or HIV information may **not** be disclosed pursuant to this form and that consent compliant with the Illinois Mental Health and Developmental Disabilities Confidentiality Act must be completed to disclose any mental health, substance abuse treatment and/or HIV information. Additionally, I understand that if there are exceptions to the communications permitted pursuant to this form, it is my responsibility to notify UnityPoint Clinic.

Note: This form does not provide the above-named person(s) with any authority, either implied or direct, over any treatment or direct care decisions. If you wish to designate a health care partner or representative, or if you wish to set up a living will, please discuss this with your primary healthcare physician or your attorney.

SECTION 2: Standard Methods to Communicate to Me (the patient)

Detailed information regarding my medical condition and medical treatment may be left on:

	Circle Yes or No		
My Home Answering Machine	Yes	No	Home Phone: _____
My Work Answering Machine	Yes	No	Work Phone: _____
My Cell Phone	Yes	No	Cell Phone: _____

Exceptions (types of information that cannot be left as messages): _____

_____

This form will be in effect until revoked, but I may be asked to confirm the information with a new dated signature on an annual basis.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Relationship (if not patient)