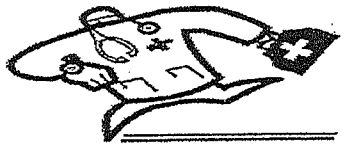
fasttrack pediatrics



PATIENT INFORMATION	RESPONSIBLE PARTY INFORMATION (Parent, Guardian, Spouse, Foster, etc.)
Name First Middle Last	Name First Middle Last
Date of Birth _____ Sex F ☐ M ☐ (month/day/year) Mother's First Name _____ (CAIR Purposes)	Relationship _____ Date of Birth _____ Sex F ☐ M ☐ (month/day/year) Lives in Patients Household: Y ☐ N ☐ (If No, address needed)
Social Security #	Social Security #
Home Address	Same as Patient ☐ Home Address
City State Zip	City State Zip
Mailing Address	Mailing Address
City State Zip	City State Zip
Home Phone Message	Home Phone Message
Employer Name	Employer Name
Address	Address
City State Zip	City State Zip
Work Phone	Work Phone
Email address	Email address

The information below should be completed by the responsible party

Marital Status (please √ one) Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced ☐ Court Order ☐ (provide copy)

Income $ Weekly ☐ Monthly ☐ Yearly ☐ Household size

Employed in Agriculture Yes ☐ No ☐ If "Yes", Seasonal ☐ Migrant ☐

Emergency Contact Relationship (If other than parents) Phone # ( )

Type of Insurance Coverage ☐ Medi-Cal ☐ Medicare ☐ Private Health Insurance ☐ None ☐ Other

Please provide receptionist with a copy of your Insurance ID card

I certify that the information contained on this form is correct to the best of my knowledge. Furthermore, I authorize the release of any medical information necessary to process this claim for treatment, payment, or operations. I authorize payment of medical benefits to CHC, provider or suppliers for services. I the undersigned hereby authorize the provider and whomever else he may designate as his assistant(s), to administer those treatments and procedures which in his/her opinion are deemed necessary. I hereby agree, regardless of insurance coverage, that I am responsible for all charges incurred. Payment is EXPECTED at the time of service. We will bill your insurance as a courtesy. I provide my consent for Community Health Centers of the Central Coast (CHCCC) to share relevant medical information with the California Immunization Registry (CAIR) and its partners.

Patients Signature _____ Date _____

Responsible Party's Signature _____ Date _____

Witness _____ Date _____

For office use only:

Patient Name: _____ Medical Record # _____

fasttrack pediatrics

PEDIATRIC HEALTH HISTORY

(Ages 0-18 years)

Name _____ Date of Birth _____
(month/day/year)

I. ANSWER THE FOLLOWING QUESTIONS (Check Yes or No and fill in the blanks):

#	Yes	No	Questions
1			Where was your child born? _____
2			Were there any problems during your pregnancy? If yes, explain: _____
3			Was your delivery Vaginal or C-Section? Was there any problems? If yes, explain: _____
4			Was your child born premature? If yes, were there any problems? _____
5			What was your child's birth weight? _____ Birth length? _____
6			Does your child have a primary care physician? Who? _____ Date of last exam: _____
7			Does your child have a dentist? Who? _____ Date of last exam: _____
8			Is your child currently taking any medications? List: _____
9			Has your child ever been hospitalized? Why? _____ Where? _____
10			Has your child had any serious injuries? When? _____ Where? _____
11			Has your child had any surgeries? When? _____ Where? _____
12			Does your child have any allergies to medications? _____
13			Does your child have any allergies to food, Asthma, Hives, Eczema, or Hay Fever? Other _____

II. HAS YOUR CHILD HAD OR CURRENTLY HAVE HAD ANY OF THE FOLLOWING? (Check Yes or No)

#	Yes	No	Questions	#	Yes	No	Questions
14			Problems walking	22			Nursed as an infant? How long? _____
15			Problems toilet training	23			Problems with diet
16			Problems with colic	24			Use/d any special diets
17			Problems in school	25			Attended a special school or classes
18			Problems with sleeping	26			Nightmares
19			Problems with bedwetting	27			Discipline or behavior problems
20			Problems with nail biting	28			Ever seen a Psychologist
21			Problems with weight/height	29			Speech Therapist or Speech teacher

III. FOR FEMALES ONLY (Check Yes or No):

#	Yes	No	Questions	#	Yes	No	Questions
30			Does your child have difficult menstrual periods?	32			Is your child taking birth control?
31	At what age did your child start her first period? _____			33			Has your child had a miscarriage or abortion?

Medical Record Number_____

IV. HAS YOUR CHILD HAD OR CURRENTLY HAVE ANY OF THE FOLLOWING PROBLEMS? (Check Yes or No)

#	Yes	No	Questions	#	Yes	No	Questions
34			Head	40			Kidney/bladder
35			Eyes	41			Lungs/asthma/bronchitis/pneumonia
36			Ears/nose/throat	42			Bones/muscles/joints
37			Heart/murmur/high blood pressure	43			Anemia
38			Stomach/constipation	44			Skin/rashes
39			Wear glasses or contacts?	45			Wear dental bridges/plates/braces?

V. HAS YOUR CHILD HAD OR CURRENTLY HAVE ANY OF THE FOLLOWING PROBLEMS? (Check Yes or No)

#	Yes	No	Questions	#	Yes	No	Questions
46			Hepatitis	49			Diabetes
47			Chickenpox	50			Had a Seizure
48			Dizzy or passed out during or after exercise?	51			Been unconscious/had a concussion

VI. FAMILY HISTORY (Check Yes or No and fill in the blanks):

#	Yes	No	Questions	#	Yes	No	Questions
52			Father health problems	54			Brothers/sisters How many: _____
53			Mother health problems	55			Brothers/sisters health problems

VII. ANY FAMILY HISTORY OF? (Check Yes or No and fill in the blanks)

#	Yes	No	Questions	#	Yes	No	Questions
56			Diabetes	60			Convulsions
57			Allergies	61			Heart Disease
58			TB	62			Cancer
59			A.I.D.S/HIV	63			Hepatitis

VIII. OTHER INFORMATION (Check Yes or No and fill in the blanks)

#	Yes	No	Questions
64			Are you or your children exposed to domestic abuse/violence?
65			Does your child have any other diseases or medical conditions NOT listed on this form? If so, please explain: _____
66			What is your child's last primary care doctors address: _____
67			Where did your child live before coming to this area? _____ When did you move here? _____
68			Is your child able to perform activities of daily living (ADL)? If no, please explain: _____
69			Any special comments about your child? _____
70			Do you have any religious, cultural, physical, or other factors that might influence your care? If so, please list: _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my provider of any change in my health or medications.

Patient or Guardian's Signature (if under 18) _____ **Date** _____

For office use only: Baseline evaluation (all new illnesses are documented on the ongoing problem list).

fasttrack
p e d i a t r i c s

Date (Fecha): ___________

Patient Name (Nombre del Paciente): ______________________________

Date of Birth (Fecha de Nacimiento): ___________ Family Size (Tamaño de familia): ________

Annual income (Ingreso anual de familia): $ ______________

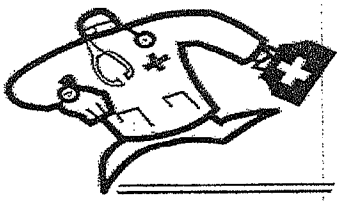
	Check Here (Marque aqui)
Race (Raza)	
American Indian/Alaska Native (Indio Americano/Nativo de Alaska)	o
Asian (Asiatico)	o
Black/African American (Negro/Afroamericano)	o
Hipanic/Latino (Hispano/Latino)	o
Native Hawaiian (Nativo de Hawai)	o
Other Pacific Islander (De las Islas del Pacifico)	o
White (Blanco)	o
Refuse to Report (Se niega a reporter)	o
Migrant Worker (Trabajador Migrante)	
Not a Farmworker (No es campesino)	o
Migrant (Migrante)	o
Seasonal (Trabaja temporadas)	o
Homeless (Estado de Hogar)	
Not Homeless (Tiene hogar)	o
Doubling Up (Vive con otra familia)	o
Shelter (Vive en refugio)	o
Street (Vive en la calle/carro)	o
Transitional (Hogar de transicion/temporal)	o
Public Housing (Asistencia de Vivienda Publica)	
No	o
Tenant Based Voucher (Cupon de Renta (Seccion 8)	o
Public Housing (Programa de Vivienda Publica)	o
Other (Otro)	o
School Based Health Center (Centro Medico Escolar)	
If yes check here Si es Si, marque aqui	o
Veteran (Veterano Militar)	
If yes check here Si es Si, marque aqui	o
Language Barrier (Necesita Interprete)	
If yes check here Si es Si, marque aqui	o

++

For Office Use Only: Medical Record Number: ____________________

SAS/Forms/UDS demo (header/footer) 8/12, 8/22/12

fasttrack
pediatrics



ACKNOWLEDGEMENT OF RECEIPT PRIVACY PRACTICES NOTICE AND ADVANCE HEALTHCARE DIRECTIVES INFORMATION

RECONOCIMIENTO DE RECIBO DEL AVISO DE LAS PRÁCTICAS DE PRIVACIDAD Y DIRECTIVAS POR ANTICIPADO SOBRE LA ATENCIÓN DE LA SALUD

I, _____ have received a copy of Fasttrack Pediatrics Privacy Practices Notice and Advance Health Care Directives information

_____ _____
Patient's Signature Date

_____ _____
Signature of Parent or Patient's Representative Date

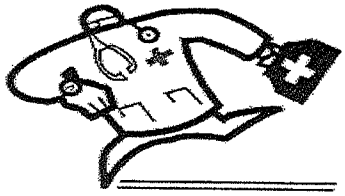
Yo, _____ reconozco que he recibido una copia del aviso de las Practicas de Privacidad Y Directivas por Anticipado sobre la Atención de la Fasttrack Pediatrics.

_____ _____
Firma del Paciente Fecha

_____ _____
Firma del padre del paciente o algun representante Fecha

Patient Name_____ DOB_____

fasttrack
pediatrics



Notice of Privacy Practices

We are committed to protecting your personal Health information in compliance with the Federal law. We may use or disclose your personal health information for these purposes.

For Treatment, Payment, Health Care Operations, Appointment Reminders, Health Related Services and Treatment Alternatives, Fundraising Activities, Individuals Involved in Your Care or Payment for Your Care, Research, Organ and Tissue Donation, As Required By Law, To Avert a Serious Threat to Health or Safety, Military and Veterans, Workers' Compensation, Public Health Activities, Health Oversight Activities, Lawsuits and Disputes, Law Enforcement, Coroners, Health Examiners and Funeral Directors., National Security and Intelligence Activities. Protective Services for the President and Others, and Inmates.

You have certain rights with respect to your personal health information:

Right to Inspect and Request a Copy, Right to Amend, Right to Receive an Accounting of Disclosures, Right to Request Restrictions, Right to Receive Confidential Communications, Right to a Paper Copy of this Notice.

Changes to this Notice:

We reserve the right to change this notice and to make the changed notice effective for all of the health information that we maintain about you, whether it is information that we previously received about you or information we may receive about you in the future. We will have available a copy of our current notice in our facility. Our notice will indicate the effective date on the first page, in the center of page. We will also give you a copy of our current notice upon request.

Complaints:

If you believe your Privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. You may file a complaint by mailing us a written description of your complaint or by telling us about your complaint in person or over the telephone:

T. Odunlami, Office Administrator
Fasttrack Pediatrics
1133 SE 18th Pl. Ste 1
Ocala, FL 3441
(352) 433-2633

Patient name: _____ Date of birth: ____/____/____ (mo.) (day) (yr.)

Screening Checklist for Contraindications to Vaccines for Children and Teens

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Is the child sick today?	☐	☐	☐
2. Does the child have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3. Has the child had a serious reaction to a vaccine in the past?	☐	☐	☐
4. Has the child had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?	☐	☐	☐
5. If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	☐	☐	☐
6. If your child is a baby, have you ever been told he or she has had intussusception?	☐	☐	☐
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	☐	☐	☐
8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
9. In the past 3 months, has the child taken medications that weaken their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?	☐	☐	☐
10. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
11. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐	☐	☐
12. Has the child received vaccinations in the past 4 weeks?	☐	☐	☐

Form completed by: _____ Date: _____

Form reviewed by: _____ Date: _____

Did you bring your child's immunization record card with you? yes ☐ no ☐

It is important to have a personal record of your child's vaccinations. If you don't have one, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep it in a safe place and bring it with you every time you seek medical care for your child. Your child will need this document to enter day care or school, for employment, or for international travel.

IMMUNIZATION ACTION COALITION Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org

Technical content reviewed by the Centers for Disease Control and Prevention

www.immunize.org/catg.d/p4060.pdf • Item #P4060 (1/15)

Nombre del paciente: _____ Fecha de nacimiento: ____/____/____
(mes) (día) (año)

Cuestionario de contraindicaciones para vacunación de niños y adolescentes

A los padres/tutores: Las siguientes preguntas nos ayudarán a determinar cuáles vacunas le podremos dar hoy a su hijo. Si contesta "sí" a alguna pregunta, eso no siempre quiere decir que no deben vacunar a su hijo. Simplemente quiere decir que hay que hacerle más preguntas. Si alguna pregunta no está clara, pida a su profesional de la salud que se la explique.

	Sí	No	No sabe
1. ¿Está enfermo hoy el niño?	☐	☐	☐
2. ¿Es alérgico el niño a algún medicamento, alimento, a algún componente de las vacunas o al látex?	☐	☐	☐
3. ¿Tuvo alguna vez el niño alguna reacción seria a una vacuna en el pasado?	☐	☐	☐
4. ¿Ha tenido el niño algún problema de salud como enfermedad de los pulmones, del corazón, de los riñones o metabólica (como diabetes), asma o un trastorno de la sangre? ¿Está en terapia de aspirina a largo plazo?	☐	☐	☐
5. Si el niño que va a ser vacunado tiene entre 2 y 4 años de edad, ¿le dijo algún profesional de la salud en los últimos 12 meses que el niño tuvo sibilancias o asma?	☐	☐	☐
6. Si el niño es bebé, ¿le dijeron alguna vez que tuvo intususcepción?	☐	☐	☐
7. ¿El niño, uno de sus hermanos o padres, ha tenido convulsiones; ha tenido el niño problemas del cerebro o algún otro problema del sistema nervioso?	☐	☐	☐
8. ¿Tiene el niño cáncer, leucemia, VIH/SIDA o algún otro problema del sistema inmunológico?	☐	☐	☐
9. En los últimos 3 meses, ¿ha tomado el niño medicamento que debiliten su sistema inmunológico, tales como cortisona, prednisona, otros esteroides o medicamentos contra el cáncer, o le han hecho tratamientos de radiación?	☐	☐	☐
10. Durante el año pasado, ¿le hicieron al niño una transfusión de sangre o de productos de la sangre, o le dieron inmunoglobulina o gamaglobulina o algún medicamento antiviral?	☐	☐	☐
11. ¿Está la niña/adolescente embarazada o hay alguna posibilidad de que quede embarazada durante el próximo mes?	☐	☐	☐
12. ¿Le aplicaron alguna vacuna al niño en las últimas 4 semanas?	☐	☐	☐

Formulario llenado por: _____ Fecha: _____

Formulario revisado por: _____ Fecha: _____

¿Trajo el comprobante de vacunación de su hijo? **sí** ☐ **no** ☐

Es importante que tenga un comprobante de vacunación personal de las vacunas de su hijo. Si no lo tiene, pídale al profesional de la salud de su hijo que le dé uno con todas las vacunas de a su hijo. Guárdelo en un lugar seguro y llévelo todas las veces que su hijo reciba atención médica. Su hijo necesitará este documento importante por el resto de su vida para ingresar a la guardería o a la escuela, para empleos o para viajar al extranjero.

Translation by Transcend, Davis, CA

www.immunize.org/catg.d/p4060-01.pdf • Item #P4060-01 Spanish (5/14)

Decision to Not Vaccinate My Child

I am the parent/guardian of the child named at the bottom of this form. My healthcare provider has recommended that my child be vaccinated against the diseases indicated below. I have been given a copy of the Vaccine Information Statement (VIS) that explains the benefits and risks of receiving each of the vaccines recommended for my child. I have carefully reviewed and considered all of the information given to me. However, I have decided not to have my child vaccinated at this time. I have read and acknowledge the following:

- I understand that some vaccine-preventable diseases (e.g., measles, mumps, pertussis [whooping cough]) are infecting unvaccinated U.S. children, resulting in many hospitalizations and even deaths.
- I understand that though vaccination has led to a dramatic decline in the number of U.S. cases of the diseases listed below, some of these diseases are quite common in other countries and can be brought to the U.S. by international travelers. My child, if unvaccinated, could easily get one of these diseases while traveling or from a traveler.
- I understand that my unvaccinated child could spread disease to another child who is too young to be vaccinated or whose medical condition (e.g., leukemia, other forms of cancer, immune system problems) prevents them from being vaccinated. This could result in long-term complications and even death for the other child.
- I understand that if *every* parent exempted their child from vaccination, these diseases would return to our community in full force.
- I understand that my child may not be protected by "herd" or "community" immunity (i.e., the degree of protection that is the result of having most people in a population vaccinated against a disease).
- I understand that some vaccine-preventable diseases such as measles and pertussis are extremely infectious and have been known to infect even the very few unvaccinated people living in highly vaccinated populations.
- I understand that if my child is not vaccinated and consequently becomes infected, he or she could experience serious consequences, such as amputation, pneumonia, hospitalization, brain damage, paralysis, meningitis, seizures, deafness, and death. Many children left intentionally unvaccinated have suffered severe health consequences from their parents' decision not to vaccinate them.
- I understand that my child may be excluded from his or her child care facility, school, sports events, or other organized activities during disease outbreaks. This means that I could miss many days of work to stay home with my child.
- I understand that the American Academy of Pediatrics, the American Academy of Family Physicians, and the Centers for Disease Control and Prevention all clearly support preventing diseases through vaccination.

Vaccine / Disease	VIS given (✓)	Vaccine recommended by doctor or nurse (Dr./Nurse initials)	I decline this vaccine (Initials of parent/ guardian)
Diphtheria-tetanus-pertussis (DTaP)			
Haemophilus influenzae type b (Hib)			
Hepatitis A (HepA)			
Hepatitis B (HepB)			
Human papillomavirus (HPV)			
Influenza			
Measles-mumps-rubella (MMR)			

Vaccine / Disease	VIS given (✓)	Vaccine recommended by doctor or nurse (Dr./Nurse initials)	I decline this vaccine (Initials of parent/ guardian)
Meningococcal (MCV)			
Varicella (Var)			
Pneumococcal conjugate (PCV)	✓		
Polio, inactivated (IPV)			
Rotavirus (RV)			
Tetanus-diphtheria (Td)			
Tetanus-diphtheria-pertussis (Tdap)			

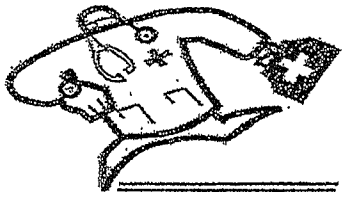
In signing this form, I acknowledge I am refusing to have my child vaccinated against one or more diseases listed above; I have placed my initials in the column titled "I decline this vaccine" to indicate the vaccine(s) I am declining. I understand that at any time in the future, I can change my mind and vaccinate my child.

Child's name: _____ Date of birth: _____

Parent/guardian signature: _____ Date: _____

Doctor/nurse signature: _____ Date: _____

fasttrack
p e d i a t r i c s



Please fill in Patients Information and at least phone number of your preferred Pharmacy.

Patient's Name: _____ **DOB:** _____

Pharmacy Name: _____

Address: _____

_____

_____

Phone Number: _____

PARENT/ GUARDIAN EMAIL: _____