# AGES 0-2: HEALTH QUESTIONNAIRE

**PATIENT INFORMATION:**

First: _____ Middle: _____ Last: _____

Date of Birth: _____ / _____ / _____ SS#: _____ - _____ - _____ Gender: _____

Person Filling Out Form: _____ Relation: _____

**CONTACT INFORMATION:**

Address / City / State / Zip: _____

Phone: _____ Email Address: _____

**EMERGENCY CONTACT:**

Name: _____ Relation: _____ Phone: _____

**PARENT OR FINANCIALLY RESPONSIBLE PARTY (if different than patient):**

First: _____ Middle: _____ Last: _____

Date of Birth: _____ / _____ / _____ SS#: _____ - _____ - _____ Gender: _____

Address / City / State / Zip: _____

Phone: _____ Relationship to Patient: _____

**PRIMARY INSURANCE:**

Insurance Name: _____ ID #: _____

Cardholder's Relationship to Patient: _____ Co-Pay Amount: _____

**SECONDARY INSURANCE: (if applicable)**

Insurance Name: _____ ID #: _____

Cardholder's Relationship to Patient: _____ Co-Pay Amount: _____

***Please present insurance cards and picture ID at reception desk***

**BIRTH HISTORY**

| | |
|---|---|
| Type of Delivery: | Where Did You Deliver (Setting/City): |
| Born at: _____ weeks + _____ days | APGAR Scores: |
| Did the baby have to stay in hospital for extended time? | |
| Was Mother GBS Positive? | If yes, was she treated with antibiotics? |
| Mother's Blood Type: | Was PKU Testing Completed? |
| If child is male, is he circumcised? | Was the Newborn Hearing Screening Performed? |
| Did the baby receive any of the following at birth: ☐ Vitamin K ☐ Erythromycin ☐ Hepatitis B | |

**VACCINE HISTORY**

| | |
|---|---|
| Up To Date: | Yes ◯ No ◯ |
| Delayed Schedule: | Yes ◯ No ◯ |
| Do you have any questions / concerns regarding vaccines: | Yes ◯ No ◯ |
| Concerns: | |

**SURGICAL HISTORY**

| Surgery / Hospitalization | When / Why: |
|---|---|
| | |
| | |
| | |

**PREFERRED PHARMACY:**

Name of Pharmacy: _____

Address / Street: _____

***Please list any medication allergies*: _____

**CURRENT MEDICATIONS / SUPPLEMENTS:**

| Medication / Supplement | Dosage / Reason: |
|---|---|
| | |
| | |
| | |

**FAMILY HISTORY – Specify who in family – Father, Mother, Sibling, Grandparent:**

| | | | |
|---|---|---|---|
| Asthma | | Seizures | |
| Allergies | | Breast Cancer | |
| Melanoma | | Diabetes | |
| Colon Cancer | | Heart Disease | |
| Prostate Cancer | | Other Significant: | |

**SOCIAL HISTORY:**

| Household Members: | | | | | |
|---|---|---|---|---|---|
| Smoking in Home? | ◯ Yes | ◉ No | Firearms in Home? | ◯ Yes | ◉ No |
| Pets in Home? | ◯ Yes | ◉ No | History of Physical / Sexual Abuse: | ◯ Yes | ◉ No |
| Is the child in daycare? | ◯ Yes | ◉ No | Is the child potty trained? | ◯ Yes | ◉ No |
| Infants: _____ wet diapers + _____ bowel movements / daily | | | | | |

**DEVELOPMENTAL HISTORY:**

| | |
|---|---|
| Do you have concerns about your child meeting milestones? (Ex: walking, talking, utensils, reading, etc.) | Yes ◯ No ◉ |
| If yes – explain: | |

**DIETARY HISTORY:**

| | | | |
|---|---|---|---|
| Breastfeeding | _____ min every _____ hours | Formula Type | |
| How often switching sides? | | Formula Amount | _____ oz. every _____ hours |

| | | |
|---|---|---|
| Cereal | ◯ 1x day ◯ 2x daily ◯ 3x daily ◉ 4+ daily | |
| Baby Foods | Vegetables: Type: | _____ times per day |
| | Fruits: Type: | _____ times per day |
| | Meats: Type: | _____ times per day |
| Drinks | Types: | _____ oz daily |
| Favorite Foods / Snacks: | | |

***Please list any other concerns or questions you would like to discuss with your health care provider during today's visit:***

_____

_____

_____


**CONSENT TO TREAT & MEDICAL RECORDS RELEASE AUTHORIZATION**

**Patient Name:** _____ **Date of Birth:** _____

I authorize Cole Family Practice practitioners to provide treatment that they may deem advisable for my dependants and me. I understand that these services are voluntary and I have the right to refuse these services. In the event of a life-threatening emergency, I consent for the provider to administer emergency treatment. I authorize Cole Family Practice to conduct urine drug screens as part of my assessment per the office policy. I authorize Cole Family Practice to obtain any previous medical records, for my dependants or myself, including lab and imaging results, if my providers feel it is necessary for the care of my dependants or me.

**I have read and understand the above items regarding insurance, finance, responsibility, authorization of charges, consent, and medical records and agree to the terms and conditions related to each item.**

_____ _____

Patient (or Responsible Party) Signature Date


## HIPAA / PERMISSION FORM

The Health Insurance Portability and Accountability Act (HIPAA) require Cole Family Practice to notify patients regarding how their Protected Health Information is handled. Our HIPAA policy is posted in the Lobby. You have the right to review policy and take a copy of the policy. With your permission, we may disclose your Protected Health Information to a family member, close friend, or any other person that you identify.

I, _____, authorize Cole Family Practice to release any personal information relating to my health care –

☐ To No One

To: _____ Relationship to Patient: _____

To: _____ Relationship to Patient: _____

To: _____ Relationship to Patient: _____

To: _____ Relationship to Patient: _____

I have reviewed the HIPAA Notice of Privacy Practices for Cole Family Practice. I hereby acknowledge that I am familiar with and understand the terms of this policy.

Print Patient Name: _____ Print Guardian Name (if applicable): _____

Patients / Guardian Signature: _____ Date: _____

**CONSENT TO LEAVE MESSAGES / VOICEMAILS**

☐ Leave a detailed message with my health information -- Phone Number: _____

☐ Leave a message with *call back information only* -- Phone Number: _____

**Office Hours:**
Monday – Friday
7:30am – 4:30pm, lunch 12:30pm-1:30pm

**New Patients:**

- You can download, print, and complete the forms prior to your appointment by going to our website www.colefamilypractice.org or fill out and email.
- You will also need to bring your insurance card and valid picture ID to every appointment.
- ALL patients are asked to arrive 15 minutes prior to your appointment time to register.
- New patients are asked to arrive 30 minutes before appointment time.

**Appointment Policy:**

- Our goal is to meet your family's medical needs in a caring and efficient manner. We value your time and will make every effort to accommodate you as soon as possible.
- Office visits are by appointment only. Same-day appointments are available for urgent or sudden illness.
- Patients are asked to arrive 15 minutes prior to your appointment time to complete paperwork and verify insurance.
- We allow a 15-minute grace period from the time of your scheduled appointment. After that time, you will be responsible for $25 fee and asked to reschedule. If there is an opening in the schedule, we will do our best to move your appointment.
- When scheduling an appointment, please tell the scheduler everything you would like to be seen for so that the correct amount of time may be reserved for you. We make every attempt to see you with the shortest wait possible. If an appointment is made for one or two issues and several other issues are brought up it is not fair to other patients and providers. If you have multiple problems you wish to discuss, let the scheduler know in advance. In that instance, a longer visit time can be scheduled depending on the complexity of the problem(s) or separate appointments may be necessary.
- Bring a list of all medications and supplements you are taking, including the dosage, to every visit.
- Appointments for routine care and physicals are best arranged well in advance, preferably at the end of the previous appointment.

**Co-Payments:**

- Co-payments and past due balances will be collected when you arrive, prior to your visit.
- We accept cash, credit cards, and debit cards.
- Insurance is not a substitute for payment. We will bill your insurance company for covered services, but you are responsible for co-payments, deductibles, and non-covered services at the time of service.
- You are responsible for updating insurance at every visit. If not updated, you will be responsible for service.

**Cancellation and/or No-Show Policy _____ (*Initials)***

- Please note that we charge a fee of $25 for any same day cancellations and no-show appointments. The second time another $25 fee will be charged, and the third time a $25 fee will be charged, and you may be dismissed from our care.
- This fee must be paid prior to scheduling another appointment with our office.
- Insurance companies will not cover this, and the fee will be the responsibility of the patient.

**Disability Forms & FMLA:**

- An appointment is required for any forms that require review and signature by a provider. A fee of $30 is required at time of service.

**Telephone Call Policy:**

- Every phone call is important to us, and we will attempt to answer your calls and return your messages as promptly as possible.
- Please be aware that the providers will not leave their scheduled patients to return routine phone calls; these are generally answered after the patient care is completed for the day and make take 24-48 hours.
- Good medical care cannot always be accomplished over the phone, so we may advise you to schedule an office visit or telemedicine visit to discuss your concerns, problems, or test results.

**Refill Requests:**

- We typically give routine medication refills to cover until your next office visit. ******That means if you are out of refills, it's because you are due for a visit. ******
- We typically see our patients yearly for a general physical with fasting bloodwork, then every 3 months or 6 months depending on your condition or medications.
- Please allow for 24-48 hours for your prescription to be called into the pharmacy.
- Antibiotic prescriptions require an appointment.
- Pain medication prescriptions will not be called in.
- If you are interested in a new medication, please schedule an appointment to speak with a provider. We do not call in any medications that have not been previously prescribed by this office.

**Lab Results**

- No news is good news for physical exam labs. We do not call if everything is within normal range. You are welcome to request a printout at your next visit.
- The medical assistant may call to give recommendations from the provider for slight abnormal values.
- An office visit or telemedicine visit is required to review any abnormal labs requiring treatment or a change in treatment.

**After Hours:**

- If you are experiencing a medical emergency, dial 911.
- While we encourage you to call our office during regular business hours for routine care, medication refills, and to schedule appointments, we understand that health emergencies not requiring an emergency room can occur at any time. That's why we always have a provider on call.
- If you need to contact us during the evening or on weekends, please call (615) 874-3422 to be directed to the provider on call.
- Medication refills will be issued only during office hours.
- Antibiotics are not called in after hours.
- Please disable any call-blocking features, or the provider may be unable to reach you.

**I have read, understand, and agree with the policies of Cole Family Practice.**

Printed Name

Signature

Date