CONSENT TO MEDICAL OR SURGICAL CARE AND TREATMENT

NOTE TO PATIENT: There are risks involved in any procedure or treatment. It is not possible to guarantee or give assurance of a successful result. It is important that you clearly understand and agree to the planned surgery or treatment.

I authorize Dr. ______________________ and such physicians, associates, assistants and other personnel or the hospital or medical facility chosen by him or her to perform the following (IN MEDICAL TERMS KNOWN AS):

____

____

____

(IN COMMON TERMS KNOWN AS):

____

____

____

and/or to do any other procedures that in their judgment may be advisable to my well-being, including such procedures as are considered medically advisable to remedy conditions discovered during the above procedure.

- **GENERAL RISKS AND COMPLICATIONS.** I am satisfied with my understanding of the more common risks and complications of the treatment or procedure which are described generally on the back of this form. These risks include the risk of bleeding, infection, pain, anesthesia risks and death.
- **SPECIFIC RISKS AND COMPLICATIONS.** I am satisfied with my understanding of specific risks of this procedure or treatment including (Doctor to describe specific risks where applicable):

____

____

____

- **ALTERNATIVE METHODS OF TREATMENT.** I am satisfied with my understanding of alternative procedures or treatments and their possible benefits and risks including (Doctor to describe specific alternative procedures and complications where applicable):

____

____

____

- **NO TREATMENT.** I am satisfied with my understanding of the possible consequences, outcomes or risks if no treatment is rendered.
- **SECOND OPINION.** I have been offered the opportunity to seek a second opinion concerning the proposed treatment or procedure.
- **ADDITIONAL OR DIFFERENT PROCEDURES DURING CARE AND TREATMENT.** I understand that conditions may arise which are unforeseen at this time and that it may be necessary and advisable to perform operations and procedures different from, or in addition to, the procedure described. I authorize and consent to the performance of such additional or different operations and procedures as are considered necessary and advisable.
- **OTHER SERVICES.** I consent to the performance of pathology and radiology services as needed and I further authorize the disposal of any severed tissue or member in accordance with customary hospital or medical facility practice.
- **PHOTOGRAPHY.** I consent to the photographing, filming or videotaping of the treatment or procedure for educational or diagnostic use.
- **NO GUARANTEES.** I understand there are risks involved in any procedure or treatment, and it is not possible to guarantee or give assurance of a successful result.
- **OTHER QUESTIONS.** I am satisfied with my understanding of the nature of the procedure or treatments and all of my additional questions about the treatment or procedure have been answered.

I have read and been given a copy of this form.

DATE: ______________________ TIME ______________________ AM/PM

PRINT PATIENT NAME: ______________________

SIGNATURE: ______________________

(PATIENT, PARENT OR LEGAL GUARDIAN)

TRANSLATED BY (IF APPLICABLE): ______________________

PHYSICIAN: ______________________

WITNESS: ______________________

PLEASE READ THE GENERAL INFORMATION ON BACK.

LONG BEACH PEDIATRIC CLINIC
REGISTRATION FORM

Today's Date: PCP:

Patient Information

Patient's last name: First: Middle Initial: Marital status:

Birth Date: / / | Sex: ☐ Male ☐ Female | Allergies? Taking medication?______

Address: ____
Address City Zip code

Home Phone No:______________________ Cell phone: _____________________ Social Sec. #: ______________

Email address:____ (you will be emailed and called for appointments)

Chose clinic because/referred to clinic by (Please choose one option) ○ Doctor Name ______________________
○ Referred ______________________

Any prior surgeries/difficulties during birth? ____

Other Family members seen here: ____

Guarantor Information

Mothers Name: (Last, First, MI) Mother D.O.B: Mother SSN:

Fathers Name: (Last, First, MI) Father D.O.B: Father SSN:

Insurance Information

Primary Insurance Co:	Policy Number:	Group Number:
Subscriber Name:	Date of birth:	Employer:

In Case of Emergency

Name of local friend or relative:	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 the physician. I understand that I am financially responsible for any balance. I also authorize LONG BEACH PEDIATRIC CLINIC or insurance company to release any information required to process my claims.

______________________________ ______________________________
Patient/Guardian signature Date

What Does Your Child Eat?

Circle the foods your child *eats* every day or at least 3 times per week:

Baby Foods

Breast Feeding, Formula with iron, Cereal with iron, Vegetable, Meat, Juice, Egg, Honey, Fruit, Beans, Tofu, Crackers, Corn Syrup

Breads, Grains, and Cereals

Rice, Soup Noodles, Tortilla, Pasta, Cereal with iron, Crackers, Pretzels, Bread/Bagel, Sweet Breads

How does your child feel about mealtimes?

Fruits and Vegetables/Vitamin A, C, Folic Acid, and Fiber Rich Foods

C: 100% Juice, Strawberries, Cantaloupe

A: Mango, Peaches, Watermelon, Pineapple, Apple, Grapes, Pear

Orange, Tomato, Cauliflower, Dark Green Leafy Vegetables, Carrot, Squash (zucchini), Banana, Raisins

Broccoli, Bell Pepper/Chili, Cabbage, Salad, Potatoes/ Sweet Potatoes, Green Beans & Peas, Corn

Milk Products/Calcium Rich Foods

Milk Shake, Whole Milk, 1% Milk/ Skim Milk, Nonfat/Lowfat Cottage Cheese, Cheese, Calcium Fortified 100% Juice, Calcium Fortified Soy Milk, Nonfat/Lowfat yogurt, Ice Cream, Calcium Fortified Tofu

Protein/Iron Rich Foods

Chicken/Turkey, Beef, Fish/Canned Fish, Taco, Ham/Pork, Egg, Peanuts, Spaghetti With Meatballs, Tofu, Liver, Dried beans/Lentils

Other Foods

Hotdog, Hamburger, Chips, Candies, Chocolate Bar, Pizza, Fried Chicken, French Fries, Burrito, Flavored Drink, Cookies

Circle if baby/child uses:

Vitamins

Circle if your baby or child receives food from:

Food Stamps **School Lunch** **Head Start** **WIC**

Circle activities your baby or child does every day.

Drinks water?

Child's name:____________________ **Record #:**__________

Age: ____ **yrs.** ____ **mos. Wt:** ____ **lbs. Ht:** ____ **in. Date:** ___/___/___

Office Use Only

Feeding milestones to check/visit

Baby: Birth to 24 months

Yes / No

- ☐ ☐ Breast-fed 8–12 times/24 hours during early weeks of lactation OR every 3–4 hours/day for older infants?
- ☐ ☐ Formula-fed w/iron no less than 20 ounces/day? Correct dilution?
- ☐ ☐ No honey/Karo Syrup until 1 year?
- ☐ ☐ 4–6 months: Start on baby cereal with iron?
- ☐ ☐ 5–7 months: Start on pureed vegetables and fruits?
- ☐ ☐ 6–7 months: Drink from a cup?
- ☐ ☐ 6–8 months: Start on pureed or ground meat, i.e., poultry, beef, pork, fish, egg yolk, beans, tofu?
- ☐ ☐ 7–9 months: Eats finger foods and mashed/chopped foods, NO grapes, nuts, popcorn, hotdogs, hard candy?
- ☐ ☐ 1 year: Drinks regular milk no less than 16 ounces/day?
- ☐ ☐ 9–12 months: Feeds self, joins family meal and snack times?
- ☐ ☐ 12–24 months: Eats variety of foods: small portions, i.e., 1–2 Tbsp., ½ c juice, ½ slice of bread.

Child: 2 to 8 years

Yes / No

- ☐ ☐ Eats recommended variety and amounts of foods daily for age from the food guide pyramid?

Limit Fats and Sweets; Milk (Calcium) 2–3 servings; Protein (Iron) 2–3 servings; Vegetables 3–5 servings; Fruits 2–4 servings; Breads, Grains, and Cereals 6–11 servings

Mealtime/Others:

Yes / No

- ☐ ☐ Set meal and snack times?
- ☐ ☐ Brush teeth by himself at 5 years?
- ☐ ☐ Good food supply?
- ☐ ☐ Takes vitamins, iron, or fluoride?
- ☐ ☐ Growing normally according to his/her growth patterns?
- ☐ ☐ Does child play with or eat dirt, plaster, clay, and paint chips?
- ☐ ☐ Any food intolerances or allergies? ________
- ☐ ☐ Referral for identified nutrition problem? Where? ________

Activity:

- ☐ ☐ Actively plays everyday, i.e., running, biking, sports, 1 hour/day?
- ☐ ☐ TV viewing: 2 hours or less/day?

Acknowledgement of Notice of Privacy Practices

By signing this form you acknowledge you were advised of the Notice of Privacy Practices for Long Beach Pediatric Clinic. Our Notice of Privacy Practices provides information about how we may use and disclose your protected information. We encourage you to read it in full. Our Notice of Privacy Practices is subject to change. The Notice of Privacy in our office. You may request a copy of the Notice of Privacy.

____________________________________ __________________

Signature of Patient /Patient Representative Date

____ ____________________

Name of Patient/ Patient Representative (please print) Relationship to Patient

Pediatric Health History

Date of Visit: ____________ *Date of Birth* ____________
Child's Name: ____________ *M / F*
Your Name: ____________
Relationship to Child: ____________

Reason for visit? ____________
Date of last physical exam: ____________
Does child have a primary care physician/other health care providers? Please list.
____

Vital Information:

Child's Birth date ____________ ☐ Boy ☐ Girl
Birthplace: City/State ____________
☐ Home ☐Hospital / Birth Center ____________
Mother's Name ____________ *Birth date:* ____________
Occupation ____________ Ht ______ Wt ______
Father's Name ____________ *Birth date:* ____________
Occupation ____________ Ht ______ Wt ______
Names of living brothers and sisters *Birth dates*

____
____
____
____

Was child adopted? ☐ Yes ☐ No At what age? ____________
If adopted, country of origin ____________
Religious Preference ____________

Pregnancy History

Number of pregnancies before this one: ____________
How long was this pregnancy? ____________ weeks
How many months pregnant when prenatal care was begun? ____________
Were there any of the following illnesses or problems?
☐ Rubella (measles) ☐ Accident / Injury ☐ Bleeding
☐ High blood pressure ☐ Swelling ☐ Sugar in urine
☐ Excessive weight gain ☐ Other infections
Explain: ____________
Medicines or supplements used during pregnancy:
____
____
Smoking while pregnant: ☐ None ☐ Moderate ☐ Heavy
Alcohol while pregnant: ☐ None ☐ <1 per week ☐ >1 per week

Birth Information

How long was labor? ____________ Was labor induced? ____________
At delivery (check all that apply):
☐ Breech (feet or bottom first) ☐ Cesarean section ☐ VBAC
☐ Breathed and cried immediately ☐ Resuscitated ☐ In oxygen
Did baby require:
☐ special nursery ☐ blood transfusion ☐ antibiotics ☐ lights
Did baby have:
☐ breathing problems ☐ yellow jaundice ☐ Other ____________
At birth:
Weight ____________ Length: ____________ Apgar score ____________
Discharge weight ____________ Length of hospital stay: ____________
Did baby receive Vit K Hep B vaccine newborn screening tests
Describe any problems with birth or first days of life ____________:
____

Family Background

Ethnic origin/Race: Mother: ____________ Father: ____________
☐ Married ☐ Living together ☐ Separated ☐ Divorced ☐ Single
Child lives with:
☐ Both parents ☐ Mother ☐ Father ☐ Guardian
Other members of household: ____________
Age of home or apartment: ____________ Any pets? ____________
Has any parent, brother, or sister died? ______ Who? ____________
Cause of death ____________ Age ____________

Please check the box of your child's blood relatives who have ever had any of the following conditions; circle examples in parentheses or write in name of disease, if known:	Father	Mother	Father's side	Mother's side	Siblings
Headaches (migraine, cluster, tension)					
Eye Disease (blindness, tumor, glaucoma)					
Ear Disease (deafness, infections, defects)					
Allergies (eczema, hay fever, sinus, hives)					
Lung Disease (asthma, cystic fibrosis, bronchitis)					
Tuberculosis					
High Blood Pressure					
High Cholesterol					
Heart Attack (age ________)					
Heart Disease					
Anemia (Sickle Cell, Mediterranean, other)					
Bleeding Disorders (hemophilia)					
Stomach or Duodenal Ulcers					
Liver or Gallbladder Disease (hepatitis)					
Intestinal Disease (colitis, polyps)					
Kidney Disease (nephritis, cysts, stones)					
Diabetes					
Thyroid Problems (goiter, nodules, hyper-, hypo-)					
Bone or Joint Disease (arthritis, osteoporosis)					
Muscle Weakness or Dystrophy					
Seizure Disorder (epilepsy)					
Neurologic Disorder					
Learning Disability					
Mental Retardation (Down Syndrome, other)					
Mental Illness (depression, anxiety, other)					
Alcoholism or Drug Abuse					
Birth Defects (cleft lip, other deformity)					
Obesity					
Cancer: Breast, Cervix, Uterine, or Ovarian					
Lung, Thyroid, Pancreas, or Kidney					
Bladder, Prostate, or Testicular					
Colon, Stomach, or Oral Cavity					
Leukemia, Myeloma, or Lymphoma					
Skin, Brain, or Bone					
Other ____________					

Pediatric TB Risk Assessment Questionnaire[1]

A TB screening tool for healthcare providers only

The following questions are designed to determine whether a tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA) is indicated for your pediatric patient. According to recent CDC guidelines, a TST is preferred for a child less than 5 years of age. If a child is 5 years of age or older and is foreign-born, then an IGRA is preferred.[2]

Name of Child: ______________________________

Child's Date of Birth: ____________________ Date of Risk Assessment: ____________________

Questions to be asked of parent/guardian (adolescents can be asked directly)
1. Was your child born in a high-risk country?* Yes ☐ No ☐
2. Has your child traveled to a high-risk country* for more than 1 week? Yes ☐ No ☐
3. Has a family member or contact had tuberculosis disease? Yes ☐ No ☐
4. Has a family member had a positive TST or IGRA result? Yes ☐ No ☐

* High-risk country: Any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe

<u>If there is a "Yes" response to any of the questions above, then TST or IGRA testing should be performed.</u>

Note: If the child being screened was previously tested, had a documented negative TST or IGRA result, and has not acquired any new risk factors since the last assessment, then he/she does not need to be re-tested.

[1] Adapted from the Children's Medical Services, Child Health and Disability Prevention Program Risk Assessment Questionnaire Distributed in August 1, 2011 Provider Information Notice No. 11-04 Revised.

[2] Centers for Disease Control and Prevention (CDC). Updated guidelines for using Interferon Gamma Release Assays to detect *Mycobacterium tuberculosis* infection – United States, 2010. *MMWR Morb Mortal Wkly Rep.* June 25, 2010, Vol. 59, No. RR-5.

Updated 10.15.2012

VACCINES for CHILDREN CALIFORNIA VFC

Patient Eligibility Screening Record for Vaccines for Children Program

Patient Information

Patient Name Last	First	MI	Date

Date of Birth	Parent/Guardian (if applicable) Last	First	MI

Provider Name

☐ **The patient named above qualifies for immunization through the VFC Program because he/she or his/her parent/guardian states the child is 18 years of age or younger and:**

Choose only one of the following.

(Note: If a child meets two or more of the eligibility qualifications, choose the first one that applies.)

- ☐ is Medi-Cal or Child Health and Disability Prevention (CHDP) eligible; or
- ☐ Is uninsured (does not have private health insurance); or
- ☐ Is an American Indian or Alaskan Native.
- ☐ Health insurance does not cover vaccines (only at federally qualified and rural health centers).

☐ **The patient named above does not qualify for immunization through the VFC Program because he/she has health insurance that pays for vaccines.**

Eligibility Status Verification

Screening Date	VFC Eligible				Not VFC Eligible
	Medi-Cal or CHDP Eligible	Uninsured	America Indian/ Alaskan Native	[Under-Insured (health insurance does not cover vaccine(s)]	Insured (Patient has health insurance)

Notes

1. This form documents the eligibility status of the patient named above.
2. The health care provider must keep this record for the VFC-eligible child for no less than three (3) years and make it available to state or federal officials for inspectionupon request.
3. This record may be completed by the patient (if he or she is an emancipated minor or 18 years of age), his or her parent or guardian or by the health care provider.
4. VFC eligibility screening and documentation of eligibility status must take place with each immunization visit to ensure eligibility status has not changed.
5. Parent-provided responses do not need to be verified.

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