Pediatric Patient Registration Information

PALOMAR HEALTH Medical Group

HOW DID YOU HEAR ABOUT US? ☐ NEWSPAPER ☐ SOCIAL MEDIA/WEB SEARCH ☐ INSURANCE REFERRAL ☐ FAMILY/FRIEND

PATIENT INFORMATION

NAME (Last, First, M.I.)	SSN	BIRTH DATE	LANGUAGE	PRIMARY DOCTOR	SEX: ☐M ☐F

PHYSICAL ADDRESS	CITY	STATE	ZIP

MOTHER'S MAIDEN NAME	RACE	ETHNICITY

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT NAME	RELATIONSHIP TO PATIENT	EMERGENCY PHONE

PATIENT'S INSURANCE

NAME OF INSURANCE COMPANY	POLICY #

NAME OF POLICY HOLDER	GROUP #

RELATIONSHIP TO PATIENT	PRIMARY COPAY $	COPAY AMT. SPECIALIST $

ADDRESS OF INSURANCE COMPANY	DEDUCTIBLE AMT. SELF	DEDUCTIBLE AMT. FAMILY

EFFECTIVE DATE	EXPIRATION DATE

PARENTS' INFORMATION

MOTHER'S NAME (Last, First, M.I.)	SSN	BIRTH DATE	LANGUAGE	PRIMARY CARE PROVIDER	SEX: ☐M ☐F

BILLING ADDRESS	CITY	STATE	ZIP

STREET ADDRESS (If different than billing)	CITY	STATE	ZIP

HOME PHONE XXX-XXX-XXXX	WORK PHONE XXX-XXX-XXXX	CELL PHONE XXX-XXX-XXXX	EMAIL

PREFERRED CONTACT METHOD (Required) ☐Home ☐Work ☐Cell ☐Email	MARITAL STATUS	MAIDEN NAME	RACE	ETHNICITY

RELATIONSHIP TO PATIENT

FATHER'S NAME (Last, First, M.I.)	SSN	BIRTH DATE	LANGUAGE	PRIMARY CARE PROVIDER	SEX: ☐M ☐F

BILLING ADDRESS	CITY	STATE	ZIP

STREET ADDRESS (If different than billing)	CITY	STATE	ZIP

HOME PHONE XXX-XXX-XXXX	WORK PHONE XXX-XXX-XXXX	CELL PHONE XXX-XXX-XXXX	EMAIL

PREFERRED CONTACT METHOD (Required) ☐Home ☐Work ☐Cell ☐Email	MARITAL STATUS	RACE	ETHNICITY

RELATIONSHIP TO PATIENT

CUSTODIAL INFORMATION

CUSTODIAL PARENT IS
☐Mother ☐Father ☐Other_____

FINANCIAL POLICY: Payment in full or co-payment is expected at the time of service. Services provided that are not a covered benefit of your health plan will be your responsibility.

CONSENT TO TREATMENT/RELEASE OF INFORMATION: I grant Palomar Health Medical Group, to administer medical treatment and perform medical procedures as deemed necessary. I authorize the release of medical information to my insurer, or the insurer's agents to process my payments for service. To the best of my knowledge, all of the information above is true and correct.

ASSIGNMENT OF BENEFITS: I thereby assign all benefits payable by my insurance company to Palomar Health Medical Group.

TREATMENT IF PARENT OR GUARDIAN IS NOT PRESENT: CHILD MUST must have a note from a parent or guardian giving permission for Palomar Health Medical Group to examine child. Please Include in this note the date of visit, any known allergies, the name of the person bringing in the child and his or her relationship to the child, and reason for visit. Forms are available if you'd like to have one for reference. Please ask the Receptionist for details.

Patient / Guardian Signature _____ Date _____ Relationship to Patient _____

Patient Financial Agreement

PATIENT INFORMATION

Deductible/Co-Insurance: All applicable co-insurance and deductibles are due at the time of service. An estimate will be provided and payment is required before services are rendered. This does not constitute final payment and any additional balance due after the insurance claim is adjudicated will be due upon receipt of a bill. **Initials** _____

Co-Payments: Your insurance company requires us to collect co-payments at the time of service. Due to state and federal laws, co-payments will not be waived. **Initials** ____

Checks: Returned checks may be subject to a $30.00 fee. **Initials** ____

Cash Pay Patients: The amounts you pay for today's scheduled office visit may not be your final payment. Other costs that may be accrued for today's appointment are including, but not limited to, laboratory tests, X-ray tests, any injections, special procedures or additional office visit charges. **Initials** ____

Claims Submission: As a courtesy, Palomar Health Medical Group will bill your insurance. A quote of benefits is not a guarantee of payment. We will submit your claims and assist you until claim is resolved. Payment from your insurance company is expected within 45 days. After 45 days, we will look to you for full payment. You are responsible for all non-covered services according to your insurance company's guidelines. If we receive notification that you are not eligible for coverage or we are not contracted with your insurance, you will be responsible for all charges incurred and payment is due upon receipt of the bill. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request in a timely manner. You are responsible to provide a copy of your most recent insurance cards for all applicable health plans. Accounts that are 90 days past due may be referred to a collection agency. **Initials** ____

Preventative Care Services: Routine exams may be covered by your insurance. When a medical concern is addressed at the time of your visit, preventative benefits will no longer apply. Additional fees may incur including but not limited to co-pays, deductibles and co-insurance. **Initials** ____

Ancillary Services: Laboratory and outpatient radiology procedures will be billed separately by an outside provider. Please contact them directly with any questions regarding your bill. **Initials** ____

Assignment of Benefits: Authorization is hereby granted to release information as may be necessary (in compliance with HIPAA guidelines) to process and complete my insurance claim and payment of medical benefit is to be paid directly to Palomar Health Medical Group for all services rendered. **Initials** ____

Missed Appointments: Please note a $25.00 cancellation fee will apply for missed appointments or failure to cancel within 24 hours prior to your scheduled appointment time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

If at any time you should experience financial hardship and need to make special payment plan arrangements, please contact our billing office.

I have read and understand the above statements. **Initials** ____

I agree to comply with the financial policies of Palomar Health Medical Group and, I understand that I am financially responsible for payment of all medical services or treatment(s) administered with my account.

_____ _____

Patient / Guardian Signature Date

_____ _____

Patient Name (Please print) Date of Birth

Authorization For Third Party To Consent To Treatment of Minor Lacking Capacity To Consent

I am the ☐ Parent
☐ Guardian
☐ Other person having legal custody _____
(describe legal relationship)

of (name of minor)_____, a minor.

I hereby authorize (name of agent) _____, to act as my agent to consent to any X-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment, and hospital care which is recommended by, and to be rendered under the general or special supervision of, any licensed doctor or dentist, whether such diagnosis or treatment is rendered at the doctor's office or at a hospital.

I understand that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority to the above-name agent to give consent to any and all such diagnosis, treatment, or hospital care which a licensed doctor or dentist recommends.

This authorization is given pursuant to the provisions of Family Code Section 6910.

I hereby authorize any hospital providing treatment to the above-name minor pursuant to the provisions of Family Code Section 6910 to surrender physical custody of the minor to the above- named agent upon the completion of treatment. This authorization is given pursuant to Health and Safety Code Section 1283.

This authorization shall remain effective until (month and day) _____, 20 _____, unless sooner revoked in writing delivered to the agent named above.

_____ _____ AM/PM
Date Time

_____
Signature (circle relationship: parent/legal representative/person having legal custody)

_____
Print Name (circle relationship: parent/legal representative/person having legal custody)

_____
Signature (parent)

Medically Relevant Information

Minor's Name: _____

Minor's date of birth: _____

Allergies to drugs or food: _____

Conditions for which is currently being treated: _____

_____

Current medications: _____

_____

Authorization For Third Party To Consent To Treatment of Minor Lacking Capacity To Consent

Restrictions on activity: _____

Primary care physician (name and telephone number): _____

_____

Insurance Company: _____

Mother's name: _____

Mother's address: _____

Mother's telephone numbers: _____ WORK _____ HOME _____ OTHER

Father's name: _____

Father's address: _____

Father's telephone numbers: _____ WORK _____ HOME _____ OTHER

Patient Diversity Form

PATIENT INFORMATION

Dear Palomar Health Medical Group Patient:

The Federal Government requests the following questions be asked of every patient. Please select the preference that fits you the best and return this to the front office person. *** See below for race and ethnicity descriptions*

I identify my race as: (Please check one)

- ☐ I decline to self identify.
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black, African American
- ☐ Native Hawaiian or other Pacific
- ☐ Islander Other Pacific Islander
- ☐ Other Race- _____
- ☐ White

I identify my ethnicity as: (Please check one)

- ☐ I decline to self identify.
- ☐ Central American
- ☐ Cuban
- ☐ Dominican
- ☐ Hispanic or Latino / Spanish
- ☐ Latin / American / Latin, Latino Mexican
- ☐ Not Hispanic / Latino
- ☐ Puerto Rican
- ☐ South American
- ☐ Spaniard

My Language Preference is: (Please check one)

- ☐ English
- ☐ Spanish
- ☐ Tagalog
- ☐ Russian
- ☐ Persian / Farsi
- ☐ Other (Please specify) _____

***Race is defined as a "person's self-identification with one or more social group".*

***Ethnicity is defined as a "person's self-identification based on nationality, language, culture and religion, geography or family's origin."*

DO NOT FILE IN NG

Effective April 14, 2003 Revised September 10, 2013; March 23, 2015; July 29, 2019

Notice of *Privacy* Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this notice, please contact the Palomar Health Medical Group Privacy Office at **1.877.376.3930**. This notice describes Palomar Health Medical Group's practices and that of:

- Any health care professional authorized to enter information into your health record.
- All departments and clinic sites of Palomar Health Medical Group.
- Any member of a volunteer group we allow to help you while you are in our care.
- All employees, staff and other Palomar Health Medical Group personnel.
- Affiliated Physicians

All these entities, sites and locations follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment or health care operations purposes described in this notice.

The providers participating in this notice (referred to as "we") understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive during your visit with us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by any of the Palomar Health Medical Group sites or affiliated entities, whether made by Palomar Health Medical Group personnel or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic. This notice tells you about the ways we may use and disclose your medical information. This notice also describes your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to make sure that medical information that identifies you is kept private (with certain exceptions), to notify you of our legal duties and privacy practices with respect to medical information about you, to notify you if a breach of your medical information occurs, and to follow the terms of the notice of privacy practices currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

DISCLOSURE AT YOUR REQUEST

We may disclose information when requested by you. This disclosure at your request may require a written authorization by you.

Treatment – We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, pharmacists, health care students or other Palomar Health Medical Group personnel and workforce members who are involved in providing for your well-being during your visit with us. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Additionally, the doctor may need to tell the dietitian if you have diabetes so we can arrange for appropriate meals. Different departments within Palomar Health Medical Group also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and X-rays. We also may disclose medical information about you to people outside of Palomar Health Medical Group who may be involved in your medical care after you leave us, such as skilled nursing facilities, home health agencies and physicians or other practitioners, including, without limitation, your primary care provider, so they can provide care or coordinate continuing care.

For Payment – We may use and disclose your medical information so that the treatment and services you receive at our facilities or from us may be billed and payment collected from you, an insurance company, a third party or a collection agency For example, we may need to give information about a medical service you received at a PHMG clinic to your health plan so it will pay us or reimburse you for the medical service. We may also tell your health plan about a proposed treatment to determine whether your plan will cover the treatment. We may also provide basic information about you and your health plan, insurance company or other source of payment to practitioners outside the hospital who are involved in your care, to assist them in obtaining payment for services they provide to you.

For Health Care Operations – We may use and disclose medical information about you for health care and business operations, a variety of activities necessary to run our health care facilities and ensure all of our patients receive quality care. For example, we may use medical information to review the quality and safety of our treatment and services, to evaluate the performance of our staff in caring for you, or for business planning, management and administrative services. We may also use and disclose your medical information to an outside company that performs services for us such as accreditation, legal, computer or auditing services. These outside companies are called business associates and are required by law to keep your medical information confidential. We may also disclose information to doctors, nurses, technicians, medical students and other hospital personnel for review and learning purposes. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

Fundraising Activities – We may use information about you, or disclose such information to a foundation related to Palomar Health Medical Group, to contact you in efforts to raise money for our health care organization and its operations. You have the right to opt out of receiving fundraising communications. If you receive a fundraising communication, it will tell you how to opt out.

Marketing and Sale – Most uses and disclosures of medical information for marketing purposes, and disclosures that constitute a sale of medical information, require your authorization.

To Individuals Involved in your Care or Payment for your Care – We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose medical information about you to an organization assisting in a disaster relief effort so your family can be notified about your condition, status and location.

For Research – Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, as long as the medical information does not leave our facilities or offices.

As Required by Law – We will disclose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety – We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Psychotherapy Notes – Most uses and disclosures of psychotherapy notes require your authorization.

Organ and Tissue Donation – We may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans – If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation – We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Activities – We may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report regarding the abuse or neglect of children, elders and dependent adults;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law;
- To notify emergency response employees regarding possible exposure to HIV/AIDS, to the extent necessary to comply with state and federal laws.

Health Oversight Activities – We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure.

These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Lawsuits and Disputes – If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you) or to allow you to obtain an order protecting the information requested.

Law Enforcement – We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at our facility(ies); and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors – We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the hospital to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities – We may release medical information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

Protective Services for the President and Others – We may disclose medical information about you to authorized federal officials so they may conduct investigations or provide protection to the President, other authorized persons or foreign heads of state.

Inmates – If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose medical information about you to the correctional institution or law enforcement official a s a uthorized o r required by law. This disclosure would be necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others; or 3) for the safety and security of the correctional institution.

Special Categories of Information – In some circumstances, your health information may be subject to restrictions that may limit or preclude some uses or disclosures described in this notice. For example, there are special restrictions on the use or disclosure of certain categories of information — e.g., tests for HIV or treatment for mental health conditions or alcohol and drug abuse.

Health Information Exchange (HIE) – We may share your health information electronically with other organizations where you receive health care. Sharing information electronically is a faster way to get your health information to the health care providers treating you. HIE participants are required to meet rules that protect the privacy and security of your health and personal information.

Secure Patient Portal – We have established a web-based system, called a Patient Portal, which allows us to securely communicate and transfer health care information to you. With your consent, you will receive a user ID and password to access the Patient Portal. If your user ID or password to your Patient Portal is obtained by another person, your medical information is subject to improper disclosure. Please notify us immediately if you feel your Patient Portal is being improperly accessed.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION WE MAINTAIN ABOUT YOU

You have rights regarding the medical information we maintain about you. To exercise your rights regarding medical information we maintain about you, you must submit a written request to Palomar Health Medical Group, Privacy Office, 15611 Pomerado Road, Suite 400, Poway, CA 92064.

RIGHT TO INSPECT AND COPY

You have the right to inspect and/or obtain a copy of your medical information, including lab test results. You can ask for an electronic or paper copy of your medical information.

We may deny your request to inspect and obtain a copy in very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

RIGHT TO AMEND

If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for Palomar Health Medical Group. Your request must be made in writing, and you must provide a reason that supports your request. We may deny your request as authorized by law.

Even if we deny your request for amendment, you have the right to submit a statement of disagreement.

RIGHT TO AN ACCOUNTING OF DISCLOSURES

You have the right to request an accounting of disclosures. This is a list of the disclosures we made of medical information about you other than our own uses for treatment, payment and health care operations, and with other exceptions pursuant to law. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list.

RIGHT TO REQUEST RESTRICTIONS

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations; for use in a facility directory; or to family members and others involved in your care. We are not required to agree to your request, except to the extent that you request us to restrict disclosure to a health plan or insurer for payment or health care operations purposes if you, or someone else on your behalf (other than the health plan or insurer), has paid for the item or service out of pocket in full.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

RIGHT TO A PAPER COPY OF THIS NOTICE

You have the right to a paper copy of this notice upon request. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website: **PalomarHealth.org**.

Changes to this Notice – We reserve the right to change this notice at any time, and to make the new notice effective for all medical information we maintain, including medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in all of our departments and clinic sites.

Complaints – If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with us by contacting the Privacy Officer by telephone at **1.877.376.3930** or in writing to Palomar Health Medical Group, Privacy Officer, 15611 Pomerado Road, Suite 400, Poway, CA 92064. You will not be penalized or retaliated against for filing a complaint.

Complaints – Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, this will stop any further use or disclosure of your medical information for the purposes covered by your written authorization, except if we have already acted in reliance on your permission. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

PALOMAR HEALTH Medical Group

Notice Of Privacy Practices

Patient Label Here

Patient Name: _____

DOB: _____ MRN: _____

Acknowledgement of Receipt

PATIENT INFORMATION

_____ _____
Patient Name (Please Print) Patient Date of Birth

_____ _____
Patient / Guardian Signature Date

_____ _____
Patient Phone XXX-XXX-XXXX Name of Physician

By signing this form, the patient acknowledges receipt of the "Notice of Privacy Practices" of Palomar Health Medical Group. Our "Notice of Privacy Practices" provides information about how we may use and disclose protected health information. We encourage you to read it in full.

I acknowledge receipt of the "Notice of Privacy Practices" of Palomar Health Medical Group.

_____ _____
Patient / Guardian Signature Date

_____
If legal representative, state relationship to patient

☐ I would like to receive a copy of any amended Notice of Privacy Practices via e-mail.

My email address is: _____

Pediatric Health History

PALOMAR HEALTH Medical Group

NAME (LAST, FIRST, M.I.)	DATE OF BIRTH	SEX: ☐M ☐F	TODAY'S DATE
ADDRESS	PHONE		EMAIL

PHARMACY

PHARMACY	ADDRESS	PHONE #
PHARMACY	ADDRESS	PHONE #

MEDICATIONS, OVER THE COUNTER MEDICATIONS & VITAMINS

DRUG NAME, STRENGTH, FREQUENCY	DRUG NAME, STRENGTH, FREQUENCY

PEDS ALLERGIES

NOTE: ALLERGIES ENTERED HERE WILL NOT BE CHECKED AGAINST THE CURRENT MEDICATION LIST. INCLUDES FOOD AND DRUG ALLERGIES AND ADVERSE DRUG REACTIONS.

☐ ACETAMINOPHEN (TYLENOL)	☐ CIPROFLOXACIN (CIPRO)	☐ IMIPRAMINE (TOFRANIL)	☐ PROPRANOLOL (INDERAL)
☐ ALBUTEROL	☐ CLARITHROMYCIN (BIAXIN)	☐ INSULIN	☐ PROPOXYPHENE (DAVON)
☐ AMOXICILLAN	☐ CLONAZEPAM (KLONOPIN)	☐ IODINE OR SHELLFISH	☐ QUINOLONES
☐ AUGMENTIN	☐ CLONIDINE (CATAPRESS)	☐ ISOTRETINOIN (ACCUTANE™)	☐ RISPERIDONE (RISPERIDAL)
☐ AMPHETAMINE SALTS (ADDERALL)	☐ CLOZAPINE (CLOZARIL)	☐ LANSOPRAZOLE (PREVACID)	☐ SULFA
☐ AMPICILLIN	☐ CODEINE	☐ LATEX	☐ TETANUS TOXOID
☐ ASPIRIN	☐ CONTRAST MEDIA (CONRAY)	☐ LEVALBUTEROL HCL (XOPENEX)	☐ TETRACYCLINE
☐ ATOMEXTINE (STRATTERA)	☐ CORTISPORIN (OTIC)	☐ LEVOFLOXACIN (LEVAQUIN)	☐ TMP/SMX (BACTRIM)
☐ AZITHROMYCIN (ZITHROMAX)	☐ DESMOPRESSIN (DDAVP)	☐ LIDOCAINE (XYLOCAINE)	☐ VALPROIC ACID (DEPAKOTE)
☐ BUPROPION HCL (WELLBUTRIN)	☐ DEXTROAMPHETAMINE	☐ MEPERIDINE (DEMEROL)	☐ VANCOMYCIN
☐ BUSPIRONE (BUSPAR)	☐ DIAZEPAM (VALIUM)	☐ METHYLPHENIDATE (RITALIN)	**FOOD / OTHER ALLERGIES**
☐ CARBAMAZEPINE (TEGRETOL)	☐ DICLOXACILLIN (DYNAPEN)	☐ METRONIDAZOLE (FLAGYL)	
☐ CARBAMIDE PEROXIDE (DEBROX)	☐ DIPHENHYDRAMINE (BENADRYL)	☐ MINOCYLCLINE (MINOCIN)	
☐ CEFACLOR (CECLOR)	☐ DOXYCYCLINE (VIBRAMYCIN)	☐ MONTELUKAST (SINGULAIR)	
☐ CEFADROXIL (DURICEF)	☐ ENALAPRIL MALETE (VASOTEC)	☐ MORPHINE	
☐ CEFAZOLIN (ANCEF)	☐ ERYTHRYOMYCIN	☐ NAPROXEN (NAPROSYN)	
☐ CEFDINIR (OMNICEF)	☐ ETODOLAC (LODINE)	☐ NEOMYCIN	
☐ CEFDITOREN (SPECTRACEF)	☐ FAMOTIDINE (PEPCID)	☐ NIACIN (NICOBID)	
☐ CEFEPIME (MAXIPIME)	☐ FLUCONAZOLE (DIFLUCAN)	☐ OFLOXACIN (FLOXIN)	
☐ CEFPROZIL (CEFZIL)	☐ FLUXETINE (PROZAC)	☐ OMEPRAZOLE (PRILOSEC)	
☐ CEFTIZOXIME (CEFIZOX)	☐ FUROSEMIDE (LASIX)	☐ OXYCODONE	
☐ CELECOXIB (CELEBREX)	☐ HALOPERIDOL (HALDOL)	☐ PENICILLIN (PEN-VEE K)	
☐ CEPHALEXIN (KEFLEX)	☐ HEPARIN	☐ PHENYTOIN NA (DILANTIN)	
☐ CIMETIDINE (TAGAMET)	☐ IBUPROFEN (ADVIL, MOTRIN)	☐ POLYMYXIN B	

Pediatric Health History

PALOMAR HEALTH Medical Group

MEDICAL HISTORY

☐ ABDOMINAL PAIN	ONSET DATE	☐ FRACTURE	ONSET DATE
☐ ACNE	ONSET DATE	☐ GERD	ONSET DATE
☐ ADD	ONSET DATE	☐ HEAD INJURY	ONSET DATE
☐ ADHD	ONSET DATE	☐ HEADACHE, MIGRAINE	ONSET DATE
☐ ALLERGIC RHINITIS	ONSET DATE	☐ HEADACHES	ONSET DATE
☐ ALLERGIES	ONSET DATE	☐ HEARING PROBLEMS	ONSET DATE
☐ ANEMIA	ONSET DATE	☐ HEART MURMUR	ONSET DATE
☐ ASTHMA	ONSET DATE	☐ MICROGNATHIA	ONSET DATE
☐ BIRTH TRAUMA	ONSET DATE	☐ MICROTIA	ONSET DATE
☐ BLEEDING DISORDER	ONSET DATE	☐ QTITIS MEDIA, RECURRENT	ONSET DATE
☐ BRONCHIOLITIS	ONSET DATE	☐ PNEUMONIA	ONSET DATE
☐ BRONCHITIS	ONSET DATE	☐ PREMATURITY	ONSET DATE
☐ CHICKENPOX	ONSET DATE	☐ PYELONEPHRITIS	ONSET DATE
☐ CONCUSSION	ONSET DATE	☐ SEIZURE DISORDER	ONSET DATE
☐ CONGENITAL HEART DISEASE	ONSET DATE	☐ SEIZURES, FEBRILE	ONSET DATE
☐ CONSTIPATION	ONSET DATE	☐ URINARY TRACT INFECTION	ONSET DATE
☐ DIABETES	ONSET DATE	☐ VESICOURETERAL REFLUX	ONSET DATE
☐ ECZEMA	ONSET DATE		

☐ OTHER	ONSET DATE	☐ OTHER	ONSET DATE
☐ OTHER	ONSET DATE	☐ OTHER	ONSET DATE
☐ OTHER	ONSET DATE	☐ OTHER	ONSET DATE

SURGICAL HISTORY

☐ ADENOIDECTOMY	DATE	☐ HERNIA REPAIR, UMBILICAL	DATE
☐ APPENDECTOMY	DATE	☐ LYMPH NODE BIOPSY/EXCISION	DATE
☐ BLOOD TRANSFUSION	DATE	☐ TONSILLECTOMY	DATE
☐ DENTAL SURGERY	DATE	☐ UMBILICAL HERNIA REPAIR	DATE
☐ HERNIA REPAIR, INGUINAL	DATE		

☐ OTHER	DATE	☐ OTHER	DATE
☐ OTHER	DATE	☐ OTHER	DATE
☐ OTHER	DATE	☐ OTHER	DATE

Pediatric Health History

PALOMAR HEALTH Medical Group

FAMILY HISTORY ☐ None

RELATIONSHIP	☐ ALIVE AND WELL
FAMILY MEMBER NAME	☐ DECEASED
☐ ADD / ADHD ONSET AGE	☐ CAUSE OF DEATH
☐ ALLERGIES ONSET AGE	☐ CAUSE OF DEATH
☐ ASTHMA ONSET AGE	☐ CAUSE OF DEATH
☐ BIRTH DEFECTS ONSET AGE	☐ CAUSE OF DEATH
☐ CANCER ONSET AGE	☐ CAUSE OF DEATH
☐ CARDIOVASCULAR DISEASE ONSET AGE	☐ CAUSE OF DEATH
☐ CORONARY ARTERY DISEASE ONSET AGE	☐ CAUSE OF DEATH
☐ DEAFNESS ONSET AGE	☐ CAUSE OF DEATH
☐ DEPRESSION ONSET AGE	☐ CAUSE OF DEATH
☐ DEVELOPMENTAL DELAY ONSET AGE	☐ CAUSE OF DEATH
☐ DEVELOPMENTAL DISLOCATION OF HIP ONSET AGE	☐ CAUSE OF DEATH
☐ DIABETES ONSET AGE	☐ CAUSE OF DEATH
☐ ECZEMA ONSET AGE	☐ CAUSE OF DEATH
☐ ELEVATED LIPIDS ONSET AGE	☐ CAUSE OF DEATH
☐ GENETIC DISEASE ONSET AGE	☐ CAUSE OF DEATH
☐ HEMOGLOBINOPATHY ONSET AGE	☐ CAUSE OF DEATH
☐ HYPERTENSION ONSET AGE	☐ CAUSE OF DEATH
☐ LEARNING DISABILITY ONSET AGE	☐ CAUSE OF DEATH
☐ MENTAL RETARDNESS ONSET AGE	☐ CAUSE OF DEATH
☐ MIGRANES ONSET AGE	☐ CAUSE OF DEATH
☐ OBESITY ONSET AGE	☐ CAUSE OF DEATH
☐ RENAL DISEASE ONSET AGE	☐ CAUSE OF DEATH
☐ SEIZURE DISORDER ONSET AGE	☐ CAUSE OF DEATH
☐ STRABISMUS ONSET AGE	☐ CAUSE OF DEATH
☐ SUDDEN INFANT DEATH SYNDROME ONSET AGE	☐ CAUSE OF DEATH
☐ THYROID DISEASE ONSET AGE	☐ CAUSE OF DEATH
☐ OTHER ONSET AGE	☐ CAUSE OF DEATH

FAMILY HISTORY – Continued

RELATIONSHIP	☐ ALIVE AND WELL
FAMILY MEMBER NAME	☐ DECEASED
☐ ADD / ADHD ONSET AGE	☐ CAUSE OF DEATH
☐ ALLERGIES ONSET AGE	☐ CAUSE OF DEATH
☐ ASTHMA ONSET AGE	☐ CAUSE OF DEATH
☐ BIRTH DEFECTS ONSET AGE	☐ CAUSE OF DEATH
☐ CANCER ONSET AGE	☐ CAUSE OF DEATH
☐ CARDIOVASCULAR DISEASE ONSET AGE	☐ CAUSE OF DEATH
☐ CORONARY ARTERY DISEASE ONSET AGE	☐ CAUSE OF DEATH
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☐ SUDDEN INFANT DEATH SYNDROME ONSET AGE	☐ CAUSE OF DEATH
☐ THYROID DISEASE ONSET AGE	☐ CAUSE OF DEATH
☐ OTHER ONSET AGE	☐ CAUSE OF DEATH

OB GYN HISTORY

LAST PERIOD:	☐ LIGHT BLEEDING	FLOW DURATION:	☐ REGULAR CYCLES	LAST PAP SMEAR:
PADS USED IN 24HR:	☐ HEAVY BLEEDING	AGE OF FIRST PERIOD:	☐ IRREGULAR CYCLES	☐ PAST ABNORMAL PAP
☐ TAMPON USE	PREGNANCIES (GRAVID)	DELIVERIES (PARA):		☐ MENOPAUSE

Pediatric Health History

PALOMAR HEALTH Medical Group

PREGNANCY / BIRTH HISTORY – For Children Under 1 Year Of Age

☐ DETAILED DOCUMENT	LAST DETAILED DOC DATE
☐ REVIEWED	COMMENTS
☐ HISTORY UNOBTAINABLE	

PREGNANCY / BIRTH HISTORY – Antenatal

MATERIAL AGE	EDC	MARITAL STATUS	LIVES WITH FOB ☐ NO ☐ YES
GRAVIDA	PARA	AB	LIVING

PRENATAL CARE GIVEN ☐ NO ☐ YES

MATERNAL BLOOD TYPE ☐ RH POSITIVE ☐ RH NEGATIVE

ULTRASOUND RESULTS ☐ NORMAL ☐ ABNORMAL

GROUP B STREP SCREEN ☐ NEGATIVE ☐ POSITIVE

ANTENATAL LABS ☐ NO ☐ YES

MATERNAL ILLNESS / COMPLICATIONS ☐ NO ☐ YES

MATERNAL INFECTIONS ☐ NO ☐ YES

LIVES WITH FOB ☐ NO ☐ YES

MEDICATIONS DURING PREGNANCY

CONFIDENTIAL INFORMATION

PREGNANCY / BIRTH HISTORY – Hospital Course

VITAMIN K INJECTION ☐ NO ☐ YES

HEP B VACCINE ☐ NO ☐ YES

HEARING TEST ☐ PASS ☐ FAIL

INFANT BLOOD TYPE ☐ RH POSITIVE ☐ RH NEGATIVE COOMBS _____

JAUNDICE ☐ NO ☐ YES

PHOTOTHERAPY ☐ NO ☐ YES

SEPSIS EVALUATION ☐ NO ☐ YES

FETAL DISTRESS ☐ NO ☐ YES

OXYGEN REQUIRED ☐ NO ☐ YES

STAYED IN NICU ☐ NO ☐ YES

STAYED IN NURSERY
DAYS REASON

BIRTH DEFECTS ☐ NO ☐ YES

STATE SCREENING DONE ☐ NO ☐ YES

MEDICATION GIVEN ☐ NO ☐ YES

CIRCUMCISED ☐ NO ☐ YES

☐ TURNER SYNDROME ☐ DOWN SYNDROME

PREGNANCY / BIRTH HISTORY – Labor & Delivery

TYPE OF DELIVERY	☐ SGA ☐ AGA ☐ LGA ☐ SROM ☐ AROM HOURS
	APGAR SCORE 1 MIN 5 MIN 10 MIN
TIME OF BIRTH _____HOUR _____MIN ☐ AM ☐ PM	MECONIUM ☐ NO ☐ YES
TIME OF BIRTH / HOURS OF LABOR	MATERNAL FEVER ☐ NO ☐ YES
GESTATION AGE AT BIRTH ☐ RH POSITIVE ☐ RH NEGATIVE	RESUSCITATION ☐ NO ☐ YES
BIRTH WEIGHT _____LBS _____OZ / LENGTH _____CM _____IN	HEAD CIRCUM _____CM _____IN

PREGNANCY / BIRTH HISTORY – Discharge

FEEDING HISTORY ☐ BREAST ☐ BOTTLE ☐ BOTH

FORMULA TYPE

DISCHARGE DATE	TIME HOUR _____ MIN _____ ☐ AM ☐ PM
DISCHARGE TIME	DISCHARGE WEIGHT _____LBS _____OZ

SOCIAL SERVICE REFERRAL ☐ NO ☐ YES

ADOPTION ☐ NO ☐ YES