HEARTLAND pediatrics

Kristin V. Stahl, M.D. **Gretchen Sander, M.D.** **Liling Lai, M.D.**

Patient's Name:_____ DOB:___/___/_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone: (___)____-_____ Cell: (___)____-_____

Age:_____ Sex: M or F SSN: ___-___-_____

School/Daycare:_____ Phone: (___)____-_____

Siblings:_____

Mother:_____ DOB:___/___/____ SSN:___-___-_____

Address if Different:_____

Cell Phone: (___)____-_____ Work: (___)____-_____

Employer:_____ Occupation:_____

Father:_____ DOB:___/___/____ SSN:___-___-____

Address if Different:_____

Cell Phone: (___)____-_____ Work: (___)____-_____

Employer:_____ Occupation:_____

In Case of Emergency:_____

Phone: (___)____-_____ Relationship:_____

HEALTH HISTORY

NAME: _____
FIRST MIDDLE LAST

BIRTHDATE: _____ TODAY'S DATE: _____

CURRENT MEDICATIONS: _____

ALLERGIES TO MEDICATION? _____ FOODS? _____

PRENATAL HISTORY:

LENGTH OF PREGNANCY: _____ COMPLICATIONS: _____

DURING PREGNANCY DID THE MOTHER DO ANY OF THE FOLLOWING?

_____SMOKE CIGARETTES? IF YES, HOW MUCH? _____

_____DRINK ALCOHOL? IF YES, HOW MUCH? _____

_____USE STREET DRUGS? IF YES, WHICH DRUGS? _____

_____TAKE MEDICATIONS? IF YES, WHICH MEDS? _____

BIRTH HISTORY:

BIRTH WEIGHT: _____ BIRTH PLACE: _____

TYPE OF DELIVERY: (CIRCLE ONE) VAGINAL C-SECTION

IF C-SECTION WHAT WAS THE REASON? _____

WAS THE DELIVERY ASSISTED BY: (CIRCLE ONE) FORCEPS VACUMM SUCTION

COMPLICATIONS WITH BIRTH? (INCLUDE NEED OXYGEN, SPECIAL NURSERY PLACEMENT, DELAYED DISCHARGE FROM NURSERY)

_____

_____

_____

INFANT WAS (CIRCLE ONE) BREAST FED BOTTLE FED BOTH

ANY PROBLEM IMMEDIATELY POST-PARTUM? (INCLUDE JAUNDICE, FEVER, FEEDING PROBLEMS ETC.)

_____

_____

_____

SOCIAL HISTORY

WHO LIVES IN THE PATIENTS HOME? PLEASE LIST ALL MEMEBERS OF HOUSEHOLD, THEIR AGES, AND RELATIONSHIP TO PATIENT:

_____

_____

_____

DO YOU HAVE ANY PETS IN THE HOME? _____

DOES ANY MEMBER OF THE HOUSEHOLD SMOKE? _____

ARE THERE FIREARMS IN THE HOME? _____

PAST MEDICAL HISTORY

Has your child ever been hospitalized? (Please list reason for hospitalization and date):

_____

Has your child ever required surgery? (Please list reason for surgery and date):

_____

Has your child ever had any of the following?

Chicken Pox?	Yes	No	Uncertain
Frequent ear infections?	Yes	No	Uncertain
Frequent strep throat?	Yes	No	Uncertain
Asthma?	Yes	No	Uncertain
Heart defect or murmur?	Yes	No	Uncertain
Pneumonia or frequent bronchitis?	Yes	No	Uncertain
Bladder or kidney infections?	Yes	No	Uncertain
Seizures?	Yes	No	Uncertain
Sickle Cell?	Yes	No	Uncertain
Cancer?	Yes	No	Uncertain
Meningitis?	Yes	No	Uncertain
Eye problems?	Yes	No	Uncertain
Hearing problems?	Yes	No	Uncertain
Serious accident?	Yes	No	Uncertain
Head Injury?	Yes	No	Uncertain
Broken Bones?	Yes	No	Uncertain

Family History:

Has any immediate family member (mom, dad, grandparent, brother or sister only) had any of the following?

Diabetes?	Yes	No	Uncertain	Who_____
Heart problems?	Yes	No	Uncertain	Who_____
High blood pressure or stroke?	Yes	No	Uncertain	Who_____
Asthma?	Yes	No	Uncertain	Who_____
Birth defects?	Yes	No	Uncertain	Who_____
Anemia?	Yes	No	Uncertain	Who_____
Sickle cell trait or disease?	Yes	No	Uncertain	Who_____
Tuberculosis?	Yes	No	Uncertain	Who_____
Cystic fibrosis?	Yes	No	Uncertain	Who_____
Depression or alcoholism?	Yes	No	Uncertain	Who_____
Learning disorder?	Yes	No	Uncertain	Who_____
Kidney problems?	Yes	No	Uncertain	Who_____
Liver problems?	Yes	No	Uncertain	Who_____
Mental illness?	Yes	No	Uncertain	Who_____
Sudden infant death syndrome?	Yes	No	Uncertain	Who_____
Cancer?	Yes	No	Uncertain	Who_____

Any other serious medical problems: _____

HEARTLAND
pediatrics

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CONSENT AUTHORIZATION

The undersigned hereby authorizes Heartland Pediatrics to examine and provide medical care and release any medical information necessary to process my insurance claim for services rendered. I authorize my insurance benefits to be paid directly. I also fully understand that I am directly responsible for all medical bills and if necessary, reasonable attorney fees as well as 35% that will be added to my account balance as a result of being sent to a collection agency as a result of professional fees due to Heartland Pediatrics for medical services rendered to me or my dependent, as well as any cancellation fees, and or no show fees.

_____ _____

SIGNATURE OF PARENT/GUARDIAN DATE

Office: 101 United Drive, Suite 110, Collinsville, Illinois 62234, (618) 451-6685 FAX (618) 451-7292

FIR

HEARTLAND PEDIATRICS
DR KRISTIN STAHL
DR. GRETCHEN SANDER
DR. LILING LAI

101 UNITED DRIVE SUITE 110
COLLINSVILLE, IL 62234
(618) 855-9041

Model Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices Form

I, _____, hereby give my consent to Heartland Pediatrics.
(Name of Patient or Authorized Agent)

to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of

_____.
(Patient's Name)

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available in the documents folder in each waiting area.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the
physician's office.

Signed: _____
Date: _____
If you are not the patient, please specify your relationship to the patient
_____.

H

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I _____ DOB _____,
(Name of Parent or Legal Guardian of Patient or Patient over age 18 or Patient over 12 having STD testing)
give Heartland Pediatrics permission to speak to the people listed below, about any and all medical care pertaining to
_____ DOB _____.
(Patient's Name) (Patients birthdate)

Named Individuals:

_____

_____

_____

_____

_____

_____

_____
Signature

_____
Date

_____
Witness

HEARTLAND pediatrics

Edwardsville phone: 618.655.0832
Edwardsville fax: 618.655.0488
Granite City phone: 618.451.6685
Granite City fax: 618.451.7292

In order to better serve you and provide you with the best care possible, we need to update our records with the following information. This information is confidential and will not be used in any way to discriminate or bias the care provided to your child in any way.

Name: _____

D.O.B.: _____

Race:

___ Black/ African American
___ White/ Caucasian
___ Native American/ Alaskan Native
___ Native Hawaiian/ Pacific Islander
___ Asian
___ More than one RACE
___ Unknown

Ethnicity:

___ Hispanic
___ Non Hispanic

Primary language: _____

As always.... Thanks for choosing us for your medical needs !

X

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EFFECTIVE 06/16/2015

No Call No Show & Late Cancellation Policy

*** Review carefully as our policy has changed ****

Heartland Pediatrics values all of our patients and their needs. We attempt to provide care to all of our patients in a timely manner. We ask that our patients be respectful and courteous to fellow patients and their medical needs, as well as our doctors and medical team. We advise that you not schedule your doctor visit for a time that conflicts with other appointments. **If you find that you are unable to keep your scheduled appointment, we require a 24 hour notice of cancellation, otherwise a $50 charge will be added to your account per child scheduled.** This allows our office to offer your appointment time to another patient in need of care.

No Call No Shows are NOT tolerated. There will be a $50 fee added to your account for every missed appointment(s), and we will collect this fee in full before your child will be scheduled for any future appointments. In the event that you call to cancel your child's appointment after the appointment time has passed, it will be counted as no call no show and this fee will still apply. If you no call no show more than 3 times, your child(ren) will be released from our practice, and we will ask you to find another medical home for your family's needs.

Please be advised that if schedule appointment for multiple children and do not keep the appointments, the $50 no call no show /cancellation fee will be charged for EACH child that was scheduled.

In an effort to provide timely and accessible medical care to all our patients, it has become necessary for us to implement these stringent practices so that appointments are available when they are needed. We appreciate your advance consideration in this matter, and, as always, we look forward to serving your family in the future.

My child's name or names are: _____

I, _____, have read this policy in it entirety and agree to abide by
(print parent's name)
its contents.

_____ _____
(parent signature) (date)

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_____ Yes, I wish to receive e-mails

_____ No, I do not wish to receive e-mails

Please Fill Out The Information Below If <u>You Wish</u> To Receive E-mails

Patients Name:_____

Parent Name:_____

Parents E-mail:_____

Child's Name:_____

Parent/Legal Guardian
Signature:_____

Date:_____

Z

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ D.O.B. _____

I request and authorize to release healthcare information of the patient named above FROM / TO (circle one):

NAME: ~~Heartland Pediatrics~~

ADDRESS: 101 United Dr. Suite 110
~~Collinsville, IL 62234~~

CITY: _____ STATE: _____ ZIP CODE: _____

DOCTOR'S INFORMATION

DOCTOR / FACILITY NAME: _____

PHONE: _____ FAX: _____

This request and authorization applies to all healthcare information, including shot records, unless otherwise noted. For other requests, please specify.

Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, warn, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

By signing this release, I agree to the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone. I also authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient/Parent Signature: _____ Date: _____

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