DALE AVENUE PEDIATRICS

KRISTIN STAHL M.D. ***LILING LAI M.D.***
GRETCHEN SANDER M.D. ***SARAH O'GRADY M.D.***

Child's name________________SS#______________DOB:_______________Phone#________________

Address_____________________City_______________ State_______________Zip____________________

Father's Name________________SS#_______________DOB:______________Phone#________________

Address_____________________City_______________State_________Zip_________________________

Employer______________________Work #_________________Cell #______________________________

Occupation____

Mother's Name______________SS#________________D.O.B._______ Phone#____________________

Employer______________________Work#_________________Cell #______________________________

Occupation____

Primary Insurance___________________________Subscriber's Name______________________________

Secondary Insurance_________________________Subscriber's Name______________________________

Email: ____

Contact Preference: (circle one) PHONE TEXT EMAIL

Emergency Contact #1______________Phone_____________Relation to Patient_______________________

Emergency Contact #2______________Phone_____________Relation to Patient_______________________

Siblings _____________________ _________________________ ____________________________
__________________________ _________________________ ____________________________

I _________________________________ parent/legal guardian of____________________________________
DOB____________________give my permission for medical treatment to the attending physicians Dale Avenue Pediatrics. This permission will cover anyone bringing the child including babysitter, daycare, grandparent, or if the patient is capable of bringing him/herself. My insurance or I will pay for the cost of the visit.

Parent/Guardian____________________________________Date signed______________________________

Witness (office personnel)__________________________Date Signed__________________________________

HEALTH HISTORY

CHILD'S NAME:____

FIRST **MIDDLE** **LAST**

BIRTHDATE: ______________________ **TODAY DATE:** ______________________

MEDICATION ALLERGIES:______________________ **FOOD ALLERGIES:**______________________

ARE VACCINES UP TO DATE? ______________________

ANY SERIOUS MEDICAL PROBLEMS/ILLNESSES? ______________________

LIST MEDICATIONS CHILD IS CURRENTLY TAKING______________________

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: (CIRCLCE ONE) VAGINAL C-SECTION

IF C-SECTION WHAT WAS THE REASON? ______________________

IF DELIVERY ASSISTED: (CIRCLE ONE) FORCEPS VACUUM SUCTION

COMPLICATIONS WITH BIRTH? (INCLUDING THE NEED FOR 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 MEMBERS OF HOUSHOLD, THEIR AGES AND RELATIONSHIP TO PATIENT: PLEASE TELL EACH HOME IF SEPARATE

HOMES:____

____

WHAT PETS ARE IN THE HOME? ______________________________

DOES ANY MEMBER OF THE HOUSEHOLD SMOKE? ______________________________

ARE THERE GUNS IN THE HOME? ______________________________

PAST MEDICAL HISTORY

HAS YOUR CHILD EVER BEEN HOSPITALIZED OR REQUIRED SURGERY? (EXPLAIN DETAILS)

____

____

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 INFECTIONSE?	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

ANY OTHER MEDICAL PROBLEMS? ____

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 ______________
BLOOD PRESSURE/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 FIROSIS?	YES	NO	UNCERTAIN	WHO ______________
DEPRESSION	YES	NO	UNCERTAIN	WHO______________
ALCOHOLISM?	YES	NO	UNCERTAIN	WHO ______________
LEARNING DISORDER?	YES	NO	UNCERTAIN	WHO ______________
MENTAL ILLNESS?	YES	NO	UNCERTAIN	WHO ______________
SIDS?	YES	NO	UNCERTAIN	WHO ______________
CANCER?	YES	NO	UNCERTAIN	WHO ______________

Dale Avenue Pediatrics

No Call No Show & Late Cancellation Policy

Review carefully Strict Policy

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.** 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 $50.00 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 you family's needs.

Please be advised that if schedule appointment for multiple children and do not keep the appointments, the $50.00 no call no show 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 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 its entirety and agree to abide by it's contents.

______________________ ______________________

(parent's signature) (date)

__________ 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: ________________________

DALE AVENUE PEDIATRICS

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 anyway.

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!

DALE AVENUE PEDIATRICS

Kristin V. Stahl, M.D. Sarah O'Grady, M.D.

Gretchen Sander, M.D. Liling Lai, M.D.

CONSENT AUTHORIZATION

The undersigned hereby authorizes Dale Avenue 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 Dale Avenue 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: 7600 Dale Avenue, Richmond Heights, Mo. 63117 PHONE (314) 833-5437 FAX (314) 833-3627

DALE AVENUE PEDIATRICS

KRISTIN STAHL M.D. **GRETCHEN SANDER M.D.**

LILING LAI M.D. **SARAH O'GRADY M.D.**

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

I, ______________________________hereby give my consent to

(Name of Patient or Authorized Agent)

Dale Avenue Pediatrics. 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 upon request.

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 physician's office.

Signed: ____

Date:____If you are not the patient, please specify your relationship to the patient

____

Dale Avenue Pediatrics

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Gretchen Sander, M.D. Liling Lai, M.D.

Authorization to Release Healthcare Information

Patient's Name: ______________________ D.O.B: _______________

I request and authorize to release healthcare information of the patient named above TO:

Dale Avenue Pediatrics

Address: 7600 Dale Avenue Pediatrics

City: Richmond Heights **State:** Missouri **Zip Code:** 63117

FROM:

DOCTOR/FACILITY NAME: ____________________________________

Address: ____

City: __________________ State: ____________________ZIP:__________

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, nonspecific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, 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: ________________

Office: 7600 Dale Avenue Richmond Heights, MO. 63117 Phone: 314-833-5437 Fax 314-833-3627