Patient Name:_____Provider:_____

The Village Doctor at Cherry Hill

Pediatric Medical History

Relationship to Child: _____
Child's Age Today:_____
Who lives at home?_____
_____

Past Medical Problems: Check all that apply

❑ Asthma/Wheezing	❑ Diabetes	❑ Broken Bones	❑ Meningitis	❑ Behavior Probs/ADHD
❑ Chickenpox	❑ Measles	❑ Mumps	❑ Rubella	❑ Genetic Disease
Ever Hospitalized overnight?		Any Surgery?		
Other:				

Medications: All prescription and non-prescription drugs, and supplements that you take regularly

Medication	Dose (milligrams)	Frequency (how often)	How long taking it?

Allergies: list allergic reactions to any medications or foods

Medication/Food	Type of Reaction

Pregnancy and Birth
Is the child adopted?_____ If yes, does he/she know?_____
Problems during pregnancy? _____
Born by normal (Vaginal) birth or c-section? _____ Reason for c-section _____
Born on-time, early, or late (how much?) _____
Complications with or after birth? _____ Left hospital with mom? _____
Birth Weight_____ Length_____

Development: At what age did the child learn to:
Roll over? _____months Sit alone? _____ months Stand alone?_____months
1st word? _____months 1st sentence?_____ months Ride tricycle?_____years
1st menstrual period _____years

Immunizations
Has the child had all immunizations for his/her age?_____If not, reason_____
Which ones missing? _____ Can we give them today? _____

Initials_____

Pediatric Medical History Form, Page 2 Date:

Nutrition

Was the child breastfed?_____ If yes, how long? _____
How much milk per day now? _____ Juice? _____ Pop? _____
Servings of fruit per day? _____ Vegetables?_____
Comments about diet _____

Family History: have any of the child's blood-relatives had

Disease	Who?	Disease	Who?
❑ Cancer (type:_____)		❑ Heart Attack (Age:_____)	
❑ Diabetes (?on insulin Yes or No)		❑ High Blood Pressure	
❑ High Cholesterol		❑ Stroke/mini-stroke	
❑ Asthma/Emphysema		❑ Thyroid Disease	
❑ Alcoholism		❑ Depression/Anxiety	
❑ Other:		❑ Other:	

Father's health status? _____
Mother's health status?_____
Health status of brothers/sisters? _____

Social History:

Are there smokers in the child's home?_____
Are there pets in the child's home? _____
How many hours of TV / video games / computer per day? _____
Does the child always use a car seat / booster / seat belt? _____
Concerns about lead exposure (older home/paint)? _____
Are there smoke detectors in child's home?_____ Last time batteries were changed?_____
Are there any guns that may be accessible to the child at home? _____

School/Daycare

Does the child attend a school or daycare? _____ Grade?_____
Grades?_____ Problems? _____

Concerns:

Please list any concerns that were not covered on this form:_____
_____
_____

Other Healthcare Providers: physicians, chiropractors, etc.

Provider	Specialty	Reason	Still seeing (Y or N)

Initials_____

Pediatric Medical History, Page 3 Date:

Review of Systems

Constitutional
- ❑ Fever/Night sweats
- ❑ Weight loss
- ❑ Fatigue

Eyes
- ❑ Eye pain
- ❑ Redness
- ❑ Discharge
- ❑ Blurry vision
- ❑ Double vision

Ears/Nose/Mouth/Throat
- ❑ Ear pain
- ❑ Discharge
- ❑ Ringing
- ❑ Difficulty hearing
- ❑ Nosebleeds
- ❑ Nasal discharge
- ❑ Sinus pain/pressure
- ❑ Ulcers of the mouth
- ❑ Tooth pain
- ❑ Sore throat
- ❑ Changes in voice
- ❑ Trouble swallowing
- ❑ Lump or mass in neck

Cardiovascular
- ❑ Chest pain/pressure
- ❑ Short of breath with activity
- ❑ Trouble breathing while lying flat
- ❑ Palpitation/irregular heartbeat
- ❑ Fainting
- ❑ Blue spells

Respiratory
- ❑ Cough
- ❑ Coughing up blood
- ❑ Shortness of breath
- ❑ Wheezing

Gastrointestinal
- ❑ Abdominal pain
- ❑ Nausea/vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Blood in stool
- ❑ Change in stool color
- ❑ Soiling

Genitourinary
- ❑ Pain with urination
- ❑ Bed wetting
- ❑ Blood in urine

Females
- ❑ Irregular or absent periods
  Start of last period_____
- ❑ Vaginal discharge
- ❑ Abnormal Pap Smears
  Date of last Pap_____
- ❑ Age when periods began_____

Musculoskeletal
- ❑ Joint pain
- ❑ Morning stiffness
- ❑ Joint swelling
- ❑ Back pain

Skin/Breast
- ❑ Rash
- ❑ Itching
- ❑ Lump under skin
- ❑ New or changing mole
- ❑ Lump in breast
- ❑ Skin or nipple changes
- ❑ Breast pain

Endocrine
- ❑ Always hot
- ❑ Always cold
- ❑ Excessive urination
- ❑ Excessive thirst

Hematologic/Lymphatic
- ❑ Lymph nodes/swollen glands
- ❑ Easy bruising or bleeding

Allergic/Immunologic
- ❑ Seasonal allergies/hayfever
- ❑ Frequent infection

Neurological
- ❑ Headache
- ❑ Weakness
- ❑ Dizziness/unsteadiness
- ❑ Seizures
- ❑ Fainting/loss of conciousness
- ❑ Numbness/tingling
- ❑ Memory problems/confusion

Psychiatric
- ❑ Depression
- ❑ Anxiety
- ❑ Difficulty with sleep
- ❑ Difficulty concentrating
- ❑ Hyperactivity
- ❑ Excessive anger

Parent_____ Date:_____
Provider:_____ Date:_____

The Village Doctor at Cherry Hill

PATIENT INFORMATION UPDATE

Name (First, Middle, Last):_____

Preferred Name:_____Maiden Name:_____

Date of Birth:_____Sex:_____

Address:_____

City, State, Zip:_____

Cell Phone:_____

Home Phone:_____

Work Phone:_____

Preferred Method of Contact: Cell Home Work (circle one)

Email Address:_____

Would you like access to our patient portal?____Yes_____No_(circle one)_____

Parent/Guardian Name (if minor):_____

Emergency Contact Name:_____

Emergency Contact Relationship:_____

Emergency Contact Phone:_____

Pharmacy Name:_____

Pharmacy Phone or City and Crossroads:_____

Health Insurance:_____

Policy Holder Name: (if other than self)_____

Policy Holder Date of Birth:_____

Cherry Hill Village Family Medicine

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information (verbally, electronically or via paper) about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information), or alternative means of communication to ensure privacy.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law or national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (Such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office. The Privacy Officer can be contacted by simply contacting the office and asking to speak to the Office Manager who serves as the Privacy Officer.

Cherry Hill Village Family Medicine

PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

_____

Print Patient's Name Date

I,_____, acknowledge that I
(Signature of Patient or Parent or Legal Guardian)

Have either received a copy of this office's NOTICE OF PRIVACY PRACTICES or that this office's NOTICE OF PRIVACY PRACTICES was made available to me to receive.

I,_____, consent to the use and disclosure of
(Signature of Patient or Parent or Legal Guardian)

My personal health information by your office for Treatment, Billing / Payment and Health care Operations as outlined in the NOTICE OF PRIVACY PRACTICES.

Please identify below any individuals that we may release medical information to:

_____ _____
Name Relationship

_____ _____
Name Relationship

Please identify below any individuals that we are strictly prohibited from releasing medical information to:

_____ _____
Name Relationship

_____ _____
Name Relationship

I authorize Cherry Hill Family Medicine to send health care reminders by post-card

Yes ☐ No ☐

If attempt is made to reach you by phone, are we authorized to leave a voicemail message?

Yes ☐ No ☐

Preferred Phone # _____

The Village Doctor at Cherry Hill

GENERAL CONSENT FOR TREATMENT

Patient Name:_____ Date of Birth:_____

1. **CONSENT:** I request and authorize inpatient, emergency, and/or outpatient care as my physician, and his/her designees and assistants may deem necessary or advisable. This includes, but is not limited to, routine diagnostic, radiology, and laboratory procedures, administration of routine drugs and other therapeutics, and routine medical, nursing, and hospital care.

2. **MINORS:** A patient under 18 years of age must have authorization for treatment signed by a parent or legal guardian. Minors with decision-making capacity have the right to participate in discussions regarding their care, and to answers to their questions about their condition and treatment.
   Exceptions: Minors do not require consent from their parent/guardian in the following instances:
   a. Minor is married
   b. Minor is in the Armed Forces of the United States
   c. Minor is emancipated by court order
   d. Minor who has/is receiving prenatal or pregnancy related care, substance abuse or psychiatric treatment, or treatment for HIV or sexually transmitted diseases
   e. A minor may consent to the release of their own child(ren)'s records

3. **NO GUARANTEES:** I am aware that the practice of medicine and surgery is not an exact science. I acknowledge that no guarantees or promises have been made to me as to the results of the care and treatment which I have authorized. I understand I have a responsibility to cooperate in my care.

4. **PATIENT RESPONSIBILITIES:** I understand and agree that it is my responsibility to:

- Schedule follow-up appointments and tests ordered by my physician
- Provide a minimum of 24-hour notice of cancellation or to reschedule an appointment if needed
- Call the office if I am unable to keep an appointment for any reason
- Pay all charges not covered by my insurance company including:
  - Deductibles
  - Co-pays
  - Non-covered services
- Pay all charges for services rendered despite any disputes or disagreements between myself and my insurance company.

5. **PAYMENT:** I assign and authorize payment, for any and all services rendered, directly to Cherry Hill Village Family Medicine from my insurance company or third party payor including, but not limited to Medicare, Medicaid, commercial health insurance, automobile no-fault insurance and worker's disability compensation insurance.

6. **RELEASE OF INFORMATION:** I understand that the confidentiality of all medical records will be protected to the full extent of the law. I authorize Cherry Hill Village Family Medicine to release all

information from my medical record, including information about Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), and Hepatitis (if any), and substance abuse treatment information protected by 42 CFR Part 2 (if any):

1) Providers to which I am referred and will receive treatment for the purpose of continuity of care

2) Payors, organizations or insurance companies which are responsible, in whole or in part, or obtaining insurance benefits for me, for billing and/or paying my hospital and/or physicians bill, and for filing appeals of denial of benefits, so that the hospital and physician may be paid for the services provided to me, and

3) Independent auditors or review agencies retained by any third party payors and insurer to analyze the changes for services rendered to me

This authorization shall be effective only so long as is necessary to accomplish the purpose for which it is given. This authorization may be revoked at any time, except to the extent that it has been relied upon.

I understand that Cherry Hill Village Family Medicine may perform a test for HIV or Hepatitis upon me without my written consent, as permitted by State Law, if a health care worker or emergency first responder sustains an exposure to my blood or body fluids. The results of any test will be treated confidentially.

7. **VALUABLES:** I understand that Cherry Hill Village Family Medicine is not responsible for clothing, eyeglasses, dentures, jewelry, money, or other personal articles kept in my possession. I release Cherry Hill Village Family Medicine from responsibility for all personal articles which I have with me during the time I am a patient at the physician office or medical facility.

8. **TEACHING INSTITUTION:** I have been informed that Cherry Hill Village Family Medicine participates with teaching institutions and that my medical, surgical, nursing, and routine health care may be observed and provide for my supervised health care provider students. I authorize such clinical students to observe and provide this care. I also understand that my treatment and medical records may be viewed by approved students and staff for teaching, study and research purposes and the confidentiality of my identity shall be protected. I may request that a clinical student not be involved in my care.

I have read both pages of this consent form or it has been read to me and I am satisfied that I understand its contents. My questions have been answered to my satisfaction.

_____

Signature of Patient/Legal Guardian/Patient Advocate/Parent/Next of Kin (circle one) Date

_____

Printed Name of Patient/Legal Guardian/Patient Advocate/Parent/Next of Kin

The Village Doctor at Cherry Hill

PATIENT DEMOGRAPHIC QUESTIONNAIRE

Name:_____ Date of Birth:_____

Cherry Hill Village Family Medicine is dedicated to providing you with high quality health care that meets your needs. We are asking for your race and ethnicity because this can affect your risk of developing certain diseases, such as high blood pressure, diabetes, and heart disease. It is also important that we know your preferred spoken language to make sure that you and your health care team communicated clearly.

We will keep this information privately in your medical record. This information will assist us in continuing to provide you with the best possible care.

Thank you for filling in the information below.

1. **Race—please mark which best describes you**
   - □ White or Caucasian
   - □ Black or African American
   - □ American Indian or Alaska Native
   - □Asian
   - □ Native Hawaiian or Pacific Islander
   - □ Other (please specify)_____
   - □ I prefer not to answer

2. **Ethnicity—please mark which best describes you**
   - □ Hispanic or Latino
   - □ Not Hispanic or Latino
   - □ I prefer not to answer

3. **Please tell us your preferred spoken language:_____**
   - □ I prefer not to answer

4. **Interpreter Service: would a language interpreter be helpful to you during your visit?**
   - □ Yes
   - □ No

The Village Doctor at Cherry Hill

PATIENT FINANCIAL RESPONSIBILIY

Thank you for choosing Cherry Hill Village Family Medicine as your health care provider. We are committed to your successful treatment. Please understand that payment of your bill is considered a part of your treatment and also helps to reduce the cost of health care. The following is a statement of our Patient Financial Responsibility Policy, which we require you to read and sign prior to seeing the physician. Please let us know if you have any questions or concerns regarding this policy.

For your convenience, we accept cash, check, Visa, MasterCard, American Express, and Discover.

I understand that I am financially responsible for treatment provided to me or my legal dependent by Cherry Hill Village Family Medicine.

I understand my insurance policy is a contract solely between me and my insurance company. I understand that, as a courtesy, my physician will submit a claim to my insurance plan. I authorize my insurance plan to make payments for covered services directly to my physician.

I understand that I am responsible to pay at the time of service for co-pays, deductibles, non-covered services, or services provided by a physician who is not my primary care provider.

If my physician does not participate with my insurance company, or if my insurance company has not paid the claim within 45 days, I understand the balance remains my responsibility and I must pursue reimbursement directly from my insurance company. If there is a balance on my account, a statement of my charges and payments will be sent to my mailing address.

I authorize Cherry Hill Village Family Medicine to communicate with my health insurance company, in accordance with their Privacy Policy, regarding my policy coverage. I further authorize Cherry Hill Village Family Medicine to release information required by my insurance company to make payment for services rendered.

I understand a payment plan may be set up if I have financial difficulties. Charges over 90 days past due without a payment plan, may be sent to a collection agency and may result in being discharged from the practice.

I understand that there is a $10 late fee for amounts over 60 days. I understand that there is a $20 fee for returned personal checks.

I understand that appointment cancellations with less than 24-hour notice or “No Show” patients are charged a service fee of $25. I understand that I am responsible for this fee. I understand it cannot be billed to my insurance plan.

I have read this Patient Financial Policy and understand my responsibilities.

_____ _____

Signature of Patient or Legal Guardian/Guarantor Date

_____

Printed Name of Patient or Legal Guardian/Guarantor

Revised 8/13/2020

The Village Doctor at Cherry Hill

PERMISSION TO ACCOMPANY AND TREAT A MINOR

PERMISSION TO ACOMPANY

I, _____ give permission to _____
(name of parent/legal guardian) (name of accompanying adult)

to accompany my child _____ and authorize treatment for my child. This includes bringing the child into the office of Cherry Hill Village Family Medicine, providing a history of present illness, disclosure of protected health information, witnessing any physical exam completed by the provider, and responsibility for relaying any diagnosis, treatment plan, or prescription(s) to the parent or legal guardian mentioned above. I agree to be available by phone and to be financially responsible for all co-pays and co-insurance.

This authorization is effective on:_____ and expires_____
(today's date) (expiration date)

_____Signature of Parent/Legal Guardian

PERMISSION TO TREAT

I, _____ give permission to _____
(name of parent/legal guardian) (name of child aged 16-18 years)

to attend his/her doctor's appointment alone without my presence and authorize treatment for my child. This includes providing a history of present illness, disclosure of protected health information, witnessing any physical exam completed by the provider, and responsibility for relaying any diagnosis, treatment plan, or prescription(s) to the parent or legal guardian mentioned above. I agree to be available by phone and to be financially responsible for all co-pays and co-insurance.

This authorization is effective on:_____ and expires_____
(today's date) (expiration date)

_____Signature of Parent/Legal Guardian

Child's Name:_____

Date of Birth:_____ Home Phone:_____

Parent Cell Phone:_____ Parent Work Phone:_____