

Patient Name _____

Seen By: _____



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

<input type="checkbox"/> Asthma/Wheezing	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Broken Bones	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Behavior Probs/ADHD
<input type="checkbox"/> Chickenpox	<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps	<input type="checkbox"/> Rubella	<input type="checkbox"/> 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 _____

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

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 consciousness
- Numbness/tingling
- Memory problems/confusion

Psychiatric

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

Parent _____
Provider: _____

Date: _____
Date: _____



The Village Doctor at Cherry Hill

PATIENT INFORMATION UPDATE

Name: _____ **Date of Birth:** _____

Address: _____

City, State, Zip: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

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

Email Address: _____

Parent/Guardian Name (if minor): _____

Emergency Contact Name: _____

Emergency Contact Relationship: _____

Emergency Contact Phone: _____

Pharmacy Name: _____

Pharmacy Phone: _____

Health Insurance: _____

Policy Holder: (if other than self) _____

Policy Holder Date Of Birth: _____



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 Native Hawaiian or Pacific Islander
 Black or African American Other (please specify) _____
 American Indian or Alaska Native I prefer not to answer
 Asian

2. Ethnicity—please mark which best describes you

- Hispanic or Latino
 Not Hispanic or Lantino
 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

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 GUARENTEES:** 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 hours' 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 payer 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) Payers, 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 payers 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

Signature of Witness Date



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: _____



The Village Doctor at Cherry Hill

NOTICE OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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

We are committed to protecting the privacy of your personal and health information. All of our employees are required to comply with our confidentiality policies.

We may use or disclose your protected health information for purposes of treatment, payment, or practice operations only with your written consent. For example, we may contact another physician to coordinate your care, submit a claim to an insurer, or look at your file to perform internal quality monitoring. We must obtain your written authorization for any other use or disclosure. You may revoke your consent or authorization at any time in writing. This will not apply to information used or disclosed while the consent or authorization was in effect.

We will provide access to your information, without your consent or authorization, when required to do so by law or regulation. Access may be granted to public health and law enforcement authorities, health care oversight agencies, government benefits programs, employers (in the case of work-related illness or injury), courts and administrative tribunals.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services. You may want a friend or family member to discuss care with a physician, or staff member, take messages, and pick up prescriptions or other medically related communication.

Please indicate if there is a friend or family member to whom **we are allowed** to release medical information:

Name: _____ Phone: _____

You may also identify a friend or family member to whom **we are restricted** specifically from releasing medical information.

Please indicate if you want medical information restricted from:

Name: _____ Phone: _____

You have the right to: access and amend your information, request an accounting of any disclosures, request restrictions on use and disclosure of your information, request a copy of this Notice, or receive confidential communications. If you request restrictions on the use and disclosure of your information, we are not required to grant your request. You may exercise your rights by contacting the individual identified at the conclusion of this Notice.

We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of the most current notice in effect. We reserve the right to change the terms of our notice and to make the new notice provisions effective for all protected health information that we maintain. We will provide you with a revised notice by mail.

If you believe that your privacy rights have been violated, you may complain to us or to the Secretary of the U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint.

For more information about this notice, please contact us at 734-879-1068.

This notice is effective: January 1, 2011

The undersigned acknowledges that he/she has received a copy of this notice of privacy practices.

Print Name

Patient/Guardian Signature

Date

Revised 1/12/2012



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 authoriae 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. I understand a \$10 fee will be added if I do not pay my co-pay at the time of service.

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, as 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 hours notice or "No Show" patients are charted 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

Signature of Witness

Date