Skagit Family Health Clinic
916 South 3rd Street
Mt. Vernon, WA 98273-4324
Voice: (360) 336-5658
Fax: (360) 336-5655
www.skagitfamilyhealth.com

PEDIATRIC MEDICAL HISTORY INFORMATION

Last Name:_____________________________________ First Name:_____________________________________ MI:_____

Date of Birth:_______________________ Today's Date:_______________________

HEALTH COMPLAINT/REASON FOR TODAY'S VISIT

Birth History	
Date	Health Condition

MEDICAL HISTORY - List chronic, serious or significant health conditions with date of onset/diagnosis	
Date	Health Condition

SURGICAL HISTORY - List surgeries and dates	
Date	Surgery

MEDICATIONS/SUPPLEMENTS – List current prescription medications, over the counter medications and supplements			
Name	Strength (e.g. 10 mg tablets)	How is it taken (e.g. 10 mg 2x a day)	Daily or as needed

Please complete other side. Thank you.

Additional Medical History

ALLERGIES - List all medication allergies and reactions	
Name of Medication	Brief description of your reaction (e.g. rash)

FAMILY MEDICAL HISTORY - List serious health conditions			
Relation	Health Conditions and/or Cause of Death	Age if Living	Age at Death
GRANPARENTS			
FATHER			
MOTHER			
BROTHERS			
SISTERS			

SOCIAL HISTORY	
Schooling: *Public* *Private* *Homeschooled*	Grade:
Exercise (*circle*): *Active* *1/wkly* *1-3/wkly* *4+/wkly* *Sedentary* *Other:*	
Diet: *Foods that are avoided:*	
See dentist routinely?	

IMMUNIZATIONS HISTORY – List shots, date given and booster number if known (e.g. DTaP 1/2/11, #3)

ADDITIONAL MEDICAL INFORMATION – Please use the space below to list any other important information

If you need additional space to complete information use a separate piece of paper, attach to this form and check this box. ☐
Thank you.

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Baby and Pediatric Demographics Date: __________

Last Name: ______________________________ First Name: ________________________ MI: _________

Preferred Name (if applicable): ________________ Date of Birth: ________________ Sex: _________

Social Security #: ___________________________

Preferred Pharmacy (please select one): _________________________ City: ____________________

Race (check one): ____White ____American Indian/Alaska Native ____Asian

____Black/African American ___Nat Hawaiian/Pacific Is ____Other _____Declined

Ethnicity (check one): ____ Hispanic/Latino _____Not Hispanic or Latino ______Declined

Primary Language (check): ____English ____Other:_______________ Religion: _________________

***Mother's Name:* ____________________________________ *DOB:* ________________**

***Father's Name:* _____________________________________ *DOB:* ________________**

***Child lives with:* □ *both parents* □ *mother* □ *father* □ *other* ______________________**

***Who will be the guarantor for this account?* _______________________ *Date of Birth:* ______________**

***Address (if different from patient)* ___________________________________ *Phone:* ________________**

Mailing Address____

City: ___________________________________ State: __________ Zip code: ____________________

Street Address: ____ Apartment #: _________

City: ___________________________________ State: __________ Zip code: ____________________

Home Phone: ____________________ Cell Phone: _________________ Work Phone: ________________

Email (required for patient portal): ___________________________________

Preferred Communications: ____Cell phone ____Home phone ____Work phone ____Mail ____Email ___ ____Text

Emergency Contact: ______________________________ Contact's Phone #: _____________________

Relation to patient: ______________________

See Other Side

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Primary care provider (PCP)? Dr.________________________________ Phone #:____________________

How did you hear about our clinic? ___________________________________

Primary Insurance Company: ____

ID Number: _____________________________________ Group/Policy Number: ____________________

Name of policy holder: ______________________ **If policy holder is the same, check here:** □

Policy holder's DOB: ______________________ Policy holder's SSN: _____________________________

Relationship to policy holder: □ spouse □ child □ other _________________________

Secondary Insurance Company: ____

ID Number: _______________________________ Group/Policy Number: ___________________________

Name of policy holder: ______________________________ DOB: ____________ SSN: _____________

Relationship to policy holder: □ spouse □ child □ other ______________________

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FINANCIAL POLICY

Thank you for choosing one of the healthcare providers at Skagit Family Health Clinic (SFHC). We will do our best to provide you with the highest quality medical services. We feel that it is very important that our patients have a clear understanding of our expectations regarding billing and payment. Please read and sign the following Financial Policy prior to your visit, and please ask if you have questions.

CONTRACTED INSURANCE PLANS

SFHC's healthcare providers are contracted with most healthcare insurance plans. SFHC will bill them directly, if services at SFHC are not covered by your healthcare insurance, you are responsible for any balance left after payment and/or denial.

SECONDARY INSURANCE PLANS

If you have secondary insurance, we will courtesy bill the secondary insurance one time only. It will be your responsibility to pay if the secondary insurance denies payment for any reason. We will not bill secondary insurance if the healthcare provider is not contracted with your primary insurance provider (e.g. Medicare). We do not bill tertiary insurance. ***Failure to disclose any or all current insurance coverage will result in you being billed for any charges incurred. SFHC will not sort out any coordination of insurance benefits issues.***

CO-PAYMENTS AND DEDUCTIONS

If your policy has an office visit co-payment, you must agree to pay the co-payment at the time of your visit. Failure to do so will result in an additional $15.00 fee. **Patients are responsible to know the terms of their insurance and whether services are covered.**

PATIENTS WITHOUT INSURANCE

We will require a minimum payment of $50 prior to seeing the provider. The balance is due upon checkout. Just like banks who extend you credit, we require your social security number. If you refuse to provide this form of identification, we will require full payment at the time of service. ***We do offer a discount if full payment is made at the time of service.***

ALTERNATIVE BENEFITS

Naturopathy can be considered an alternative therapy that may or may not be covered by your insurance. It is your responsibility to verify before your scheduled appointment that naturopathic doctors are a covered provider type under your specific insurance policy. Even though our providers may be contracted with your insurance, there are provider specialties and services that can be excluded on insurance plans.

ADDITIONAL CHARGES AND FEES

For any check that is returned for non-sufficient funds, SFHC will charge an additional $30.00 to your account and we will not accept your personal checks in the future. You will be asked to remit the amount of the check plus the service charge in cash or with a credit card payment within 10 days. If your account has not cleared by then, we will refer it for collection action.

All monthly statement balances are due within 30 days of the statement date. Any balances over 30 days will be assessed 1% interest per month.

Patients that "no show" or do not cancel 24 hours prior to their appointment time may be assessed an appointment charge of $25. This charge is your responsibility.

When a child of divorced parents is seen, we will expect payment from whichever parent accompanies that child. We will not bill ex-spouses or the other parent.

I have read and fully understand SFHC's Financial Policy. I hereby authorize SFHC to release all information necessary to secure the payment of insurance benefits, and I authorize the use of this signature on all my insurance submissions.

______________________________	______________________________	______________
Signature of Patient/Guardian	**Printed Name of Patient**	**Date**

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Contact & Privacy at Skagit Family Health Clinic

Patient name: ____________________________________

Contact me

Home Phone: __________________
Ok to leave detailed message: □ Yes □ No

Cell Phone: ___________________
Ok to leave detailed message: □ Yes □ No

Work Phone: ___________________
Ok to leave detailed message: □ Yes □ No

Email Address: _________________
Ok to leave detailed message: □ Yes □ No

Sharing SFHC can share my health info with (i.e. family members):

Name: ___________________ Relation: ______________

Name: ___________________ Relation: ______________

Name: ___________________ Relation: ______________

Name: ___________________ Relation: ______________

*****This form is not a consent to release records to other provider offices*****

Time Limits share records from:

□ Anytime (past/now/future)

□ Dates from _______to _______

For How Long

□ Indefinite

□This date/event: ___________

Topic Limits share records:

□ General records & include
- □ Mental Health
- □ Communicable diseases including HIV/AIDs
- □ Alcohol/Drug abuse treatment

Canceling

I can cancel this permission, in writing, at any time. But I can't retroactively cancel permission.

After Sharing
SFHC protects privacy. But SFHC can't control how my designees share information after SFHC has shared it.

Patient/Guardian's Signature______________________ **Date**_____________