WEE CARE PEDIATRICS

JAMES A. BAKERINK, M.D.
CANDACE MOORE, P.A.-C
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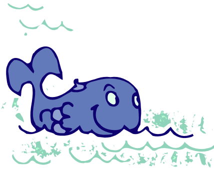

Patient and Parent Information

Please Fill Out Completely!

Child's Name:
Last:___________________________ First:____________________ MI:______________
Other Names this Child has been known by:______________________________________
Sex:___________ Birthdate:____________________ Home Phone #_________________
Alternate Phone #_____________________________
Street Address:_______________________ Apt #____________ City________________
State________________Zip__________________

Mother's Name:
Last:_____________________________ First:______________________________
Home Phone #:_____________________ Alternate Phone #:__________________
Street Address:_____________________ State:___________ Zip:______________
Social Security #:____________________ Birthdate:________________________
Employer:___________________________ Employer's Phone:_________________
Occupation:___________________________________

Father's Name:
Last:_____________________________ First:______________________________
Home Phone #:_____________________ Alternate Phone #:__________________
Street Address:_____________________ State:___________ Zip:______________
Social Security #:____________________ Birthdate:________________________
Employer:___________________________ Employer's Phone:_________________
Occupation:___________________________________

Emergency Contact: (Not Living With You) ___________________________
Phone #________________________ Relationship________________________

How were you referred to Wee Care Pediatrics?_____ Physician?______ Friend?_______ Family?________ Previous Patient at another office?__________ Insurance? _________ Yellow Pages?____________

If this is a newborn, which hospital was the baby born?___________________________
Which pediatrician saw you in the hospital?_____________________________________

I authorize the providers of Wee Care Pediatrics to provide medical care for my child as necessary. I am financially responsible for any amount not covered by my insurance. I also authorize Wee Care Pediatrics to release to my insurance plan information concerning the health care provided. The information will be used for the purpose of evaluating and administrating claims for benefits. Information released for any other purpose will require my signature for release.

Signature___________________________________ Date__________________________

____

Initial History Questionnaire

FORM COMPLETED BY _______________ DATE COMPLETED _______________

Name _______________

ID NUMBER _______________

BIRTH DATE _______________ AGE _______________ M F

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names and ages and where they live. _______________

If mother and father are not living together or if child does not live with parents, what is the child's custody status? _______________

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home? _______________

Birth History

Birth weight _______________

Was the baby born at term? __________ Early? __________ Late? __________

If early, how many weeks' gestation? _______________

Did mother have any illness or problem with her pregnancy?
☐ Yes ☐ No Explain _______________

During pregnancy, did mother
Smoke ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No
Use drugs or medications ☐ Yes ☐ No
What __________ When __________

Was the delivery ☐ Vaginal? ☐ Cesarean?

If cesarean, why? _______________

Did your baby have any problems right after birth?
☐ Yes ☐ No Explain _______________

Was initial feeding ☐ Breast? ☐ Bottle?

Did your baby go home with mother from the hospital?
☐ Yes ☐ No Explain _______________

General

Do you consider your child to be in good health? ☐ Yes ☐ No Explain _______________

Does your child have any serious illness or medical condition? ☐ Yes ☐ No Explain _______________

Has your child had serious injuries or accidents? ☐ Yes ☐ No Explain _______________

Has your child had any surgery? ☐ Yes ☐ No Explain _______________

Has your child ever been hospitalized? ☐ Yes ☐ No Explain _______________

Is your child allergic to any medicines or drugs? ☐ Yes ☐ No Explain _______________

Development

Are you concerned about your child's physical development? ☐ Yes ☐ No Explain _______________

Are you concerned about your child's mental or emotional development? ☐ Yes ☐ No Explain _______________

Are you concerned about your child's attention span? ☐ Yes ☐ No Explain _______________

If your child is in school:

How is his/her behavior in school? _______________

Has he/she failed or repeated a grade in school? _______________

How is he/she doing in academic subjects? _______________

Is he/she in special or resource classes? _______________

Family History

Have any family members had the following:

Condition	Yes	No	Who	Comments
Deafness	☐ Yes	☐ No	Who ________	Comments ________
Nasal allergies	☐ Yes	☐ No	Who ________	Comments ________
Asthma	☐ Yes	☐ No	Who ________	Comments ________
Tuberculosis	☐ Yes	☐ No	Who ________	Comments ________
Heart disease (before 50 years old)	☐ Yes	☐ No	Who ________	Comments ________
High blood pressure (before 50 years old)	☐ Yes	☐ No	Who ________	Comments ________
High cholesterol	☐ Yes	☐ No	Who ________	Comments ________
Anemia	☐ Yes	☐ No	Who ________	Comments ________
Bleeding disorder	☐ Yes	☐ No	Who ________	Comments ________
Liver disease	☐ Yes	☐ No	Who ________	Comments ________
Kidney disease	☐ Yes	☐ No	Who ________	Comments ________
Diabetes (before 50 years old)	☐ Yes	☐ No	Who ________	Comments ________
Bed-wetting (after 10 years old)	☐ Yes	☐ No	Who ________	Comments ________
Epilepsy or convulsions	☐ Yes	☐ No	Who ________	Comments ________
Alcohol abuse	☐ Yes	☐ No	Who ________	Comments ________
Drug abuse	☐ Yes	☐ No	Who ________	Comments ________
Mental illness	☐ Yes	☐ No	Who ________	Comments ________
Mental retardation	☐ Yes	☐ No	Who ________	Comments ________
Immune problems, HIV, or AIDS	☐ Yes	☐ No	Who ________	Comments ________

Additional family history ____

____

____

Past History

Does your child have, or has he/she ever had:

Condition	Yes	No	
Chickenpox	☐ Yes	☐ No	When ________
Frequent ear infections	☐ Yes	☐ No	Explain ________
Problems with ears or hearing	☐ Yes	☐ No	Explain ________
Nasal allergies	☐ Yes	☐ No	Explain ________
Problems with eyes or vision	☐ Yes	☐ No	Explain ________
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	Explain ________
Any heart problem or heart murmur	☐ Yes	☐ No	Explain ________
Anemia or bleeding problem	☐ Yes	☐ No	Explain ________
Blood transfusion	☐ Yes	☐ No	Explain ________
Frequent abdominal pain	☐ Yes	☐ No	Explain ________
Constipation requiring doctor visits	☐ Yes	☐ No	Explain ________
Bladder or kidney infection	☐ Yes	☐ No	Explain ________
Bed-wetting (after 5 years old)	☐ Yes	☐ No	Explain ________
(For girls) Has she started her menstrual periods?	☐ Yes	☐ No	When ________
(For girls) Are there problems with her periods?	☐ Yes	☐ No	Explain ________
Any chronic or recurrent skin problem (acne, eczema, etc)	☐ Yes	☐ No	Explain ________
Frequent headaches	☐ Yes	☐ No	Explain ________
Convulsions or other neurologic problem	☐ Yes	☐ No	Explain ________
Diabetes	☐ Yes	☐ No	Explain ________
Thyroid or other endocrine problem	☐ Yes	☐ No	Explain ________
Any other significant problem	☐ Yes	☐ No	Explain ________
Use of alcohol or drugs	☐ Yes	☐ No	Explain ________

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

HE0328

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9-52/Rep0804

WEE CARE PEDIATRICS
4785 S. Durango Dr. Ste. 101
Las Vegas, NV 89147
702-889-8444
702-889-8454

Request for Medical Records

RECORDS ARE BEING REQUESTED FROM:

____
Name of Doctor/Facility

______________________________ ________________
Street Address **Phone**

______________________________ ________________
City, State and Zip **Fax**

TO BE SENT TO:

Wee Care Pediatrics
4785 S. Durango Dr. Ste. 101
Las Vegas, NV 89147
702-889-8444
702-889-8454

Please forward copies of medical records including all reports and correspondence on the patients named below to Wee Care Pediatrics at the above address.

Patient Name	**Date of Birth**
______________________________	____________
______________________________	____________
______________________________	____________

Thank you.

______________________________ ______________
Signature of Parent or Guardian **Date**

WEE CARE PEDIATRICS

5105 E. Sahara Ave. #134
Las Vegas, NV 89142
702-431-0121
702-431-1006

Request for Medical Records

RECORDS ARE BEING REQUESTED FROM:

____
Name of Doctor/Facility

______________________________ ____________________
Street Address **Phone**

______________________________ ____________________
City, State and Zip **Fax**

TO BE SENT TO:

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Patient Name	Date of Birth

Thank you.

______________________________ ____________________
Signature of Parent or Guardian **Date**

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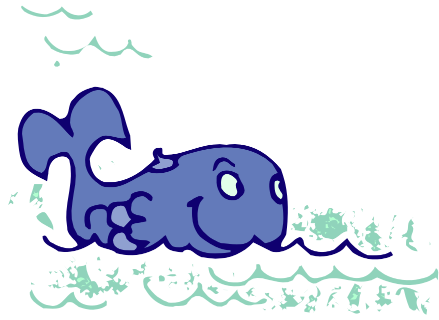

Treatment Authorization

The following people other than the parent are authorized to bring:

____________________________________ to Wee Care Pediatrics
(Name of Child/Children)

For Treatment:

_________________________ _____________________
(Name) (Relationship to child

_________________________ _____________________
(Name) (Relationship to child)

_________________________ _____________________
(Name) (Relationship to child)

Parent or Guardian:
____
(signature)

Date:_____________Witness:_________________________

____
Ofc Initials

Wee Care Pediatrics

James A. Bakerink, M.D.
Candace Moore, P.A.-C
Amie Duford, P.A.-C
Christine Estepa, P.A.-C

Protected Health Information (PHI) Disclosure Record

Patient Name:______________________________ DOB _____/_____/_____

Authorized Methods of Communication (✓ Check all that apply)

☐ Residence Phone	☐ Work Phone	☐ Written Correspondence	☐ Other (Specify)
Number ( )	Number ( )	Number ( )	
☐ Leave call back number Do not leave message	☐ Leave call back number only; do not leave message	☐ Mail/Delivery Service ☐ Fax ( )	
☐ Okay to leave detailed message with person	☐ Okay to leave detailed message with operator	☐ Email @ Residence	
☐ Okay to leave detailed message on answering machine	☐ Okay to leave detailed message on personal voice mail	☐ Email @ Work	

Parent/Guardian Signature_______________________________________ Date___________

Record of Disclosures

Date of Disclosure	Disclosed to Name & Address or Contact Number	Description of PHI Disclosed and Purpose of Disclosure (If a copy of the authorization or request is attached, check the box below.)	Type of Disclosure Enter T, P, or O	Person Disclosing	Method of Disclosure **Enter M, P, F, E, or OT
		☐			
		☐			
		☐			
		☐			
		☐			
		☐			

*T=Treatment, P=Payment, O=Health Care Operations Activities
**M=Mail, P=Telephone, F=Fax, E=E-Mail, OT=Other(and specify mode of deliver)

Wee Care Pediatrics

James Bakerink, M.D.
Maria Santos, M.D.
Candace Moore, P.A.-C
Chris Wlodarczyk, P.A.-C

Payment Policy

Thank you for choosing Wee Care Pediatrics for you child's medical care. The following is an explanation of our payment procedures and office policies.

1. Payment is due at the time of service. We do not bill for deductibles or co-pays. We accept cash, Visa, MasterCard, Discover, and American express. We do not accept personal checks.
2. The parent or guardian who brings the child for their visit is responsible for payment independent of what a divorce decree may say. Reimbursement must be made between the divorced parents-we will not intervene.
3. Appointments must be cancelled within 4 hours of the scheduled time in order to avoid a $25.00 no show fee.
4. Outstanding balances must be paid prior to any future visits, unless emergent.
5. Account balances that exceed 90 days past due are sent to an outside collection agency. You will be responsible for all collection and legal fees that accrue by the outside agency.
6. We do not bill secondary insurance plans. We will gladly bill your primary insurance and provide you with a receipt for your co-pay.
7. Patients utilizing our cash pay program must pay at the time of visit. There may be additional charges for procedures, medications, or lab tests.
8. In order to bill your insurance company, we must have a valid insurance card. If you are unable to obtain a card, we need the Insurance companies name, phone number, and mailing address. We also must have your Identification/member number, and group number. Otherwise we will ask you to pay our cash pay rate for the visit until you can obtain complete insurance company information. You will be reimbursed after Insurance payment.
9. Most importantly, Wee Care Pediatrics wants the best care possible for your child and we understand you may have certain financial difficulties. Please feel free to discuss any financial matters with our billing department.

I have read the above policy and agree to the terms of this agreement.

Signature ______________________________ Date ______________