



PATIENT NAME: _____

DATE: ____ / ____ / ____

Questions for Newborn Visit

Please complete the following questions as they apply to your infant.

NUTRITION

Breastfeeding

Are you breast feeding? yes no

Do you feel that breast feeding is going well? yes no

If no, why?

cracked nipples nipple pain a poor latch a sleepy infant a poor milk supply

Have you seen or spoken to a lactation consultant (other than in the hospital)? yes no

Are you taking medications to increase your milk supply? yes no

Are you interested in information about breast feeding support groups? yes no

Regarding breast feeding, are you?

exclusively breast feeding exclusively pumping breast feeding and pumping breast feeding and supplementing with formula

Does your infant wake up to be fed? yes no

Does your infant feed from one or both sides? yes no

Approximately how long does your infant feed from each breast?

< 15 minutes 15 to 30 minutes 30 to 45 minutes > 45 minutes

Approximately how often does your infant feed?

every 1 to 2 hours every 2 to 3 hours every 3 to 4 hours > every 4 hours

Approximately how many feedings does your infant take in a 24 hour period?

5 to 6 7 to 8 9 to 10 10 to 12 > 12

Are you currently taking your prenatal vitamins? yes no

Formula

Regarding formula, is your infant?

completely formula fed supplemented with formula after breast feeding not formula fed

How many ounces does your infant take per feeding?

½ to 1 oz 1 to 2 oz 2 to 4 oz >4 oz

Approximately how often does your infant feed?

receives formula as a supplement after each breast feeding receives formula randomly as a supplement to breast feeding

every 1 to 2 hours every 2 to 3 hours every 3 to 4 hours > every 4 hours

Approximately how many feedings does your infant take in a 24 hour period?

5 to 6 7 to 8 9 to 10 10 to 12 > 12

Approximately how long does it take to feed your infant?

< 15 minutes 15 to 30 minutes 30 to 45 minutes > 45 minutes

What type of formula do you feed your infant?

Enfamil Lipil Similac Advance Nestle Goodstart Isomil Prosobee Nutramigen
 Enfacare Neosure Other: _____



ELIMINATION

How many wet diapers does your infant have per day?

- 1 to 3 4 to 6 > 6

How frequent does your infant have a bowel movement?

- > 6 per day 3 to 6 per day 1 to 2 per day 1 per day
 every other day every 3 to 4 days > every 4 days

What color are your infant's bowel movements?

- black brown green yellow

What consistency are your infant's bowel movements?

- hard formed but soft pudding-like seedy and liquid-like liquid-like

SLEEP

How long does your infant sleep (consecutively) at night?

- 1 to 2 hours 2 to 3 hours 3 to 4 hours 4 to 6 hours > 6 hours

Is your infant sleeping on his/her back? yes no

Is your infant co-sleeping with you? yes no

Is your infant using a pacifier to fall asleep? yes no

VISION

Do you have any concerns regarding your infant's vision? yes no

If yes, please explain: _____

HEARING

Do you have any concerns regarding your infant's hearing? yes no

If yes, please explain: _____

DEVELOPMENT

Responds to sound by blinking, crying, quieting, changing respirations, or showing a startle response yes no

Responds to your face and voice yes no

Fixates on the human face and follows with eyes yes no

Holds head, neck, trunk, arms, and legs in a flexed position yes no

Moves both arms and legs yes no

Lifts head briefly while lying on stomach yes no

SAFETY

What type of car seat does your infant use?

- a 5 point (rear facing) infant carrier in the back seat of the vehicle other: _____

J.A.N. 27.2010 Signature of Provider _____ Date: _____ / _____ / _____



PATIENT NAME: _____ BIRTHDATE: ____/____/____

PROVIDER: _____ DATE: ____/____/____

Pediatric Health Form

Does your child have any of the following ongoing medical conditions, health challenges or past medical history?

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Abdominal pain (frequent affecting quality of life)
<input type="checkbox"/> Allergic rhinitis (an allergic nose)
<input type="checkbox"/> Asperger's disorder
<input type="checkbox"/> Asthma or recurrent bronchial problems
<input type="checkbox"/> Attention deficit hyperactivity disorder (ADHD)
<input type="checkbox"/> Autism/PDD
<input type="checkbox"/> Behavioral problems
<input type="checkbox"/> Birth defects
<input type="checkbox"/> Blood/bleeding disorder (anemia, hemophilia, other)
<input type="checkbox"/> Broken or fractured bone(s)
<input type="checkbox"/> Cancer/leukemia
<input type="checkbox"/> Cerebral palsy
<input type="checkbox"/> Constipation
<input type="checkbox"/> Croup (>2 events/year in a child under 3 and >1/year in a child >3)
<input type="checkbox"/> Cystic fibrosis
<input type="checkbox"/> Dental problems
<input type="checkbox"/> Multiple cavities
<input type="checkbox"/> Chipped tooth/teeth
<input type="checkbox"/> Braces
<input type="checkbox"/> Bridge
<input type="checkbox"/> Plate
<input type="checkbox"/> Other(s)
<input type="checkbox"/> Depression or extreme sadness | <input type="checkbox"/> Developmental delay
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Discipline problems
<input type="checkbox"/> Eczema
<input type="checkbox"/> Emotional problems
<input type="checkbox"/> Epistaxis (nose bleeds >2 events/month)
<input type="checkbox"/> Encopresis (fecal soiling)
<input type="checkbox"/> Enuresis (daytime wetting >4 years old)
<input type="checkbox"/> Enuresis (bed wetting > 5 years old)
<input type="checkbox"/> Fine motor problems
<input type="checkbox"/> Genetic disorder/syndrome
<input type="checkbox"/> Gross (large) motor delay
<input type="checkbox"/> Headaches (frequent affecting quality of life)
<input type="checkbox"/> Hearing problems
<input type="checkbox"/> Resulting in temporary hearing loss
<input type="checkbox"/> Resulting in permanent hearing loss
<input type="checkbox"/> Other(s)
<input type="checkbox"/> Heart infection
<input type="checkbox"/> Heart murmur
<input type="checkbox"/> Heart problem
<input type="checkbox"/> Heart rhythm problem (beating to fast or slow)
<input type="checkbox"/> Heart testing including an EKG, ECHO (ultrasound), Holter monitor, or stress testing) | <input type="checkbox"/> Hernia
<input type="checkbox"/> High blood pressure
<input type="checkbox"/> High cholesterol
<input type="checkbox"/> High lead level (>10) or at risk for lead exposure (positive screening questionnaire)
<input type="checkbox"/> History of abuse
<input type="checkbox"/> History of tobacco/drug/alcohol abuse
<input type="checkbox"/> Immunization reaction
<input type="checkbox"/> Allergic reaction
<input type="checkbox"/> Altered consciousness
<input type="checkbox"/> High fever ≥ 105 degrees
<input type="checkbox"/> Nonstop, high pitched crying for > 3 hours
<input type="checkbox"/> Seizures
<input type="checkbox"/> Other
<input type="checkbox"/> Learning problems
<input type="checkbox"/> No past medical history
<input type="checkbox"/> Nervousness or unusual fears (affecting quality of life)
<input type="checkbox"/> Otitis media (>2 ear infections/ year)
<input type="checkbox"/> Otitis media with effusion (recurrent/persistent water behind one or both ears)
<input type="checkbox"/> Other(s)
<input type="checkbox"/> Pneumonia (recurrent)
<input type="checkbox"/> Prematurity related complications | <input type="checkbox"/> Seizures/convulsions/neurological problems
<input type="checkbox"/> Sickle cell disease or trait
<input type="checkbox"/> Sinusitis (>2/year)
<input type="checkbox"/> Speech/language problems
<input type="checkbox"/> Socialization problems
<input type="checkbox"/> Syncope (passing out)
<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Tonsillitis or throat infections (>3 events/year)
<input type="checkbox"/> Tuberculosis history, a positive skin test (PPD), or a risk for tuberculosis exposure (positive screening questionnaire)
<input type="checkbox"/> Upper respiratory infections/colds (>8/year)
<input type="checkbox"/> Urinary/kidney problems or infections
<input type="checkbox"/> Urticaria (hives)
<input type="checkbox"/> Vision problems
<input type="checkbox"/> Requiring glasses
<input type="checkbox"/> Requiring surgery
<input type="checkbox"/> Resulting in permanent visual loss
<input type="checkbox"/> Concerns including crossed eye(s), drooping lid(s), squinting, or difficulty reading
<input type="checkbox"/> Other(s) |
|--|--|--|--|



PATIENT NAME: _____

BIRTH HISTORY

Length of pregnancy: Less than 37 weeks (# _____) Over 37 weeks

Type of delivery: Vaginal, normal Vaginal, breech Planned C-section Emergency C-section

Were there any problems with pregnancy, labor or delivery? yes no **Explain:** _____

Did your child have any problems at birth? yes no **Explain:** _____

Did your child have jaundice? yes no

If yes, did your child require any treatment? no Bilirubin Lights Exchange Transfusion

Was your child's discharge from hospital delayed for any reason? yes no **Explain:** _____

Breastfed: no yes If yes, how long? < 3 months 3-6 months 6-12 months > 12 months currently breast feeding

Has your child ever had a **serious injury, burn, or illness**? yes no **Explain:** _____

Has your child ever spent the night in a **hospital**? yes no **Explain:** _____

Has your child ever had **surgery**? yes no **Explain:** _____

MEDICATIONS

Is your child currently taking any prescription or non prescription (over the counter) **medications** or pills? yes no

List medications below. If necessary, use the back of this form to list additional medications. (Please ✓ those medications that need to be given and/or available at school).

MEDICATION	DOSE	FREQUENCY	INDICATIONS
<input type="checkbox"/> _____			
<input type="checkbox"/> _____			
<input type="checkbox"/> _____			

ALLERGY HISTORY

Does your child have any known allergies? yes no

If yes, please list the allergen(s). Then place the number(s) for the type of reaction and the letter(s) for the treatment response required after the name of each allergen.

Allergen	Reaction	Current or past treatment required
Food: Dairy _____	1. Rash	A. None
Eggs _____	2. Hives	B. Epinephrine Auto-injector
Peanuts _____	3. Eczema	C. Benadryl
Shellfish _____	4. Nasal congestion	D. 911 call
Soy _____	5. Eye swelling	E. Emergency room visit
Tree Nuts _____	6. Hoarse voice	F. Hospitalization
Wheat _____	7. Mouth/tongue swelling	G. Other
Other _____	8. Wheezing	
Insects: _____	9. Passed out	
Latex: _____	10. Vomiting/diarrhea	
Medications: _____	11. Other(s)	
Other(s): _____		



PATIENT NAME: _____

GENERAL FAMILY HISTORY

- | | | |
|---|--|--|
| <input type="checkbox"/> NO FAMILY HISTORY | <input type="checkbox"/> Developmental delay | <input type="checkbox"/> Marfan syndrome |
| <input type="checkbox"/> Acne (scarring) | <input type="checkbox"/> Diabetes, not on insulin | <input type="checkbox"/> Metabolic disease |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Diabetes, on insulin | <input type="checkbox"/> Muscle disease (muscular dystrophy) |
| <input type="checkbox"/> Allergies (Food, Environmental, Animals, Insects, Latex) | <input type="checkbox"/> Dislocated joint(s) | <input type="checkbox"/> Myasthenia gravis |
| <input type="checkbox"/> Alpha 1 antitrypsin deficiency | <input type="checkbox"/> Eczema | <input type="checkbox"/> Neurofibromatosis |
| <input type="checkbox"/> Arrhythmia (supraventricular tachycardia, prolonged QT syndrome, WPW syndrome) | <input type="checkbox"/> Eye problems (amblyopia, cataracts, glaucoma, lazy eye, refractive errors, retinal disease) | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Family member having a heart attack before age 50 | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Fragile X syndrome | <input type="checkbox"/> Polycystic kidney disease |
| <input type="checkbox"/> Bleeding disorder (Hemophilia, Von Willebrand disease, platelet abnormality) | <input type="checkbox"/> Growth hormone deficiency | <input type="checkbox"/> Polycystic ovarian syndrome |
| <input type="checkbox"/> Blood disorder (G6PD deficiency, Hereditary Spherocytosis, Thalassemia) | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Pulmonary embolism |
| <input type="checkbox"/> Cancer (breast, ovary, other) | <input type="checkbox"/> Headaches (tension, migraine) | <input type="checkbox"/> Retinoblastoma |
| <input type="checkbox"/> Cardiomyopathy | <input type="checkbox"/> Hearing disorder | <input type="checkbox"/> Ricketts |
| <input type="checkbox"/> Celiac disease | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Cholelithiasis (gall stones) | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Seizures/convulsions |
| <input type="checkbox"/> Colitis or other intestinal problems (Crohn's disease or ulcerative colitis) | <input type="checkbox"/> Hip dysplasia | <input type="checkbox"/> Sickle cell disease/trait |
| <input type="checkbox"/> Congenital anomaly/birth defects | <input type="checkbox"/> Hydrocephalus | <input type="checkbox"/> SIDS |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Immune disorder (common variable, IgA deficiency, IgG subclass deficiency) | <input type="checkbox"/> Skin disorders (psoriasis) |
| <input type="checkbox"/> Death of a family member before age 50 for no apparent reason | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Stomach problems (gastritis, gastroesophageal reflux, ulcers) |
| <input type="checkbox"/> Death of a family member before age 50 of a heart attack | <input type="checkbox"/> Kidney disease (glomerulonephritis, renal failure) | <input type="checkbox"/> Thyroid disorders (Graves' disease, hypothyroidism) |
| | <input type="checkbox"/> Lactose deficiency | <input type="checkbox"/> Tuberos sclerosis |
| | <input type="checkbox"/> Liver disease (hepatitis, cirrhosis, Wilson disease) | <input type="checkbox"/> Urinary tract abnormalities |



PATIENT NAME: _____

ENVIRONMENTAL HISTORY

Lives in: House Townhouse Apartment Mobile Home
 Other _____ Less than 10 years old

Basement: Finished and Dry Finished and Damp Unfinished and Dry Unfinished and Damp

Heating: Forced hot air Hot water radiator Space heater Wood burning stove
 Fireplace Electric baseboard heat

Cooling: Central air conditioning Room air conditioning none

Air filtration unit: Portable air filter Central air filter none

Humidifier: Humidifier on central system Portable humidifier none

Child's bedroom:

Flooring: Carpet Hardwood

Pillow: Feather Foam Polyfill Age of pillow: _____

Mattress: Regular Waterbed Age of mattress: _____

Stuffed animals in bedroom: Yes Less than 3

Window coverings: curtains Venetian blinds

Smokers in the home:

Mother Father Siblings Other relatives

Total number of smokers in the home: _____

Pets:

Cats: Yes Indoors Outdoors

Dogs: Yes Indoors Outdoors

Birds: Yes Indoors Outdoors Type _____

J.A.N. 27.2010 Signature of Provider _____ Date: _____ / _____ / _____



Thank you for choosing Fox Valley Women & Children's Health Partners as your health care provider. We are committed to your treatment being successful and to a long-term relationship with you.

Please understand that payment of your bill is considered a part of your treatment.

The following is a statement of our Financial Policy, please review and initial each section.

_____ **Things to bring with you to EACH appointment:**

- Health Insurance Card
- Drivers License
- Method of Payment

_____ **Appointments:**

- **You MUST arrive for your appointment 15 minutes early or you will be asked to reschedule.**
- Please inform the receptionist of any demographical changes (e.g. phone number, address, email, etc) or financial changes (e.g. insurance information, etc). Failure to notify us immediately of changes in demographical or financial information may result in denial of your medical claim(s) by your insurance provider, thus increasing your financial responsibility for any services provided by our practice.
- It is your responsibility to verify that the physician you are seeing is currently participating with your insurance plan and that you have obtained all necessary referrals **BEFORE** your scheduled appointment. Failure to confirm this may result in your responsibility for any and all charges.
- **24 hours notice is required to cancel and/or reschedule all appointments. Failure to do so will result in a cancellation fee charged to the patient.**

_____ **Minor Patients:**

- The parent(s) or guardian(s) accompanying a minor are both responsible for providing current insurance information for the minor; as well as, payment of any copay or balance due.
- Parent(s) or guardian(s) must have an Authorization for Medical Treatment form signed each time a minor arrives unaccompanied for an appointment.

_____ **Medicare / Medicaid Patients:**

- Medicare requires that we provide patients with a written notification (Advance Beneficiary Notice) whenever it is likely that you will be responsible for a bill.
- **Medicaid/ IDPA Patients MUST bring a current insurance card each visit.** Failure to present a current insurance card at check-in will result in rescheduling of the appointment.

_____ **Lab / Hospital Charges:**

- Any service(s) provided by a lab or hospital is a contract between you and that lab or hospital. Any dispute with lab or hospital charges should be directed to and resolved by the lab or hospital; dispute resolution is not the responsibility of our practice.

_____ **Insurance:**

- It is the patient's responsibility to understand their insurance coverage.
- Your insurance coverage and benefits are a contract between you and your insurance company; therefore, all disputes must be handled between you and your insurance.

_____ **Payment in full is due at the time services are rendered:**

- Co-pays and all non-covered services are the insured/patient's financial responsibility and are due during the check-in process. Failure to produce payment may result in your appointment being rescheduled.
- Past due balance's are required to be paid prior to any further services provided by our office unless other arrangements have been made with our Patient Financial Services Department. Failure to pay any past due balances will result in restricted services for you and your family.

_____ **Payment Plans:**

- In certain cases, our practice will consider establishing a structured payment plan. Each case is reviewed individually to determine eligibility and establishment of a structured payment plan and is at the sole discretion of the practice.
- Please contact our Patient Financial Services team to have your case considered for a structured payment plan.

_____ **Collections and Outstanding Balances:**

- Delinquent accounts may be placed with a collection agency and may be subject to legal action. In the event that your unpaid balance is turned over to a collection agency for recovery or legal action is warranted, collection and attorney fees; as well as, court costs will be added to your balance.
- Returned checks will incur a \$25.00 service fee.

_____ **Disability, FMLA, School, Camp and Sports forms**

- Completion of Disability or FMLA forms will incur a fee of \$25.00 for EACH completed form.
- Completing a School, Camp, or Sports form separate from an office visit will incur a fee of \$25.00 per form.

_____ **Medical Records (paper copy or electronic copy)**

- If a paper copy is requested, the following fees will be incurred: a \$24.81 handling fee, plus a per page fee as follows: \$0.93 for pages 1-25, \$0.62 for pages 26-50 then \$0.31 per page for each page over 50. These fees are the responsibility of the patient. Within 10 business days of payment receipt, a paper copy will be provided.
- If an electronic copy is requested, the following fees will be incurred: a \$24.81 handling fee, plus a per page charge of 50% of the per page charge for paper copy. Within 3 business days of payment receipt, a CD Rom will be provided.

Our Patient Financial Services office is open Monday–Thursday 8am to 5pm & Friday 8am to 4pm

As a courtesy to our patients, we accept Visa, MasterCard, Discover, and American Express



Please sign below to confirm that you have read and understand the Financial Policy that has been provided to you by Fox Valley Women & Children's Health Partners.

Signature _____

Date _____



Pediatrics Patient Information

Patients Name: | DOB: | Gender: M / F | SS #:

Race: | Ethnicity: Hispanic / Non Hispanic | Primary Language:

Patients Name: | DOB: | Gender: M / F | SS #:

Race: | Ethnicity: Hispanic / Non Hispanic | Primary Language:

Patients Name: | DOB: | Gender: M / F | SS #:

Race: | Ethnicity: Hispanic / Non Hispanic | Primary Language:

Patients Name: | DOB: | Gender: M / F | SS #:

Race: | Ethnicity: Hispanic / Non Hispanic | Primary Language:

Home address: | City: | State:

Zip code: | Home Phone: | Pharmacy Name: | Location:

Parent/Legal Guardian Information

Mother's Name: | Work# | Cell Phone#

SS#: | DOB: | Drivers License #:

Father's Name: | Work# | Cell Phone#:

SS#: | DOB: | Drivers License #:

Emergency Contact Name: | Phone Number:

Primary Health Insurance

Insurance Company Name:

Identification Number: | Group:

Policy Holder Name: | Relationship to patient:

Policy Holder DOB: | Social Security #:

Policy Holders Employer:

Parental Consent

I give my permission for my child to receive medical care as needed at the offices of Fox Valley Women & Children's Health Partners. Below is a list of guardian's or care takers that have my permission to accompany my child for care. They have the authority to participate in deciding care plans for my child in my absence.

Name: | Relationship to patient:

Name: | Relationship to patient:

Name: | Relationship to patient:

Signature of Patient/Parent or Legal Guardian: | Date:

HIPAA

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Fox Valley Women & Children's Health Partners Notice of Privacy Practices.

Signature of Patient/Parent or Legal Guardian: | Date:

Release and Consent

I hereby authorize the physician's of Fox Valley Women & Children's Health Partners and staff under their direction to release all medical information including test results, regarding my collection and medical treatment to my **primary care physician and/or insurance company**. I understand that I am financially responsible for all medical charges, whether paid or not paid by insurance, and I hereby authorize the use of this signature on all insurance submission.

Signature of Patient/Parent or Legal Guardian: | Date: