Dr. Chris Booren
Naturopathic Physician
1820 SW Vermont St.
Suite G
Portland, OR. 97219
503-246-3919

PEDIATRIC INTAKE FORM (6-12 years)

PATIENT INFORMATION:

Name: ______________________________ Date: ______________

Age: ____ Date of Birth: _____/_____/_____ Female: □ Male: □

Mother's name: ____________________ Father's name: ______________________

Address: ____

City: ______________________________State: _______ Zip Code: ____________

Phone # (home): (_____)_______________ Parent's # (work): (_____)_______________

Parent's e-mail address: ____

How did you hear about our clinic? _____________________________________

If by referral, please let us know who so we can say thank you: ___________________

INSURANCE INFORMATION:

Health Insurance (Yes/No): ______

If yes, name of insurance company: ______________________________________

Subscriber ID#: _______________________ Group #: _______________________

Please provide us with your insurance card to photocopy.

Parent/Legal Guardian's Signature: ___________________________ Date: _________

HEALTH HISTORY QUESTIONNAIRE

What are your child's most important health problems? List as many as you can in order of importance:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

Does your child have a contagious disease at this time? Y N

If yes, what? ______________________________

PREVIOUS ILLNESSES

Rheumatic fever	Y N	German measles	Y N
Chicken pox	Y N	Measles	Y N
Tonsillitis	Y N	approx. number _____	
Ear infections	Y N	approx. number _____	

Immunizations

Polio	Y N	Pertussis	Y N
Tetanus shot	Y N	Diphtheria	Y N
Measles/Mumps/Rubella	Y N	Influenza	Y N

Any adverse reactions? Y N If yes, what ? ______________________________

Allergies

Is your child hypersensitive or allergic to:

Any drugs? ______________________________

Any foods? ______________________________

Any environmentals? ______________________________

Breast fed? ________ how long? ____________ Formula? _______ milk / soy _________

Has your child had any of the following tests? When Where

Electroencephalogram (EEG)

....

Psychological evaluation

....

Hearing tests

....

Speech/Language tests

....

Hospitalizations/ Surgeries/ Injuries

What hospitalizations, surgeries or injuries has your child had?

____

____

Typical Food Intake

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

To Drink: ____

Please list **any** prescription medications, over the counter medications, vitamins or other supplements your child is taking:

1) ______________________	5) ______________________
2) ______________________	6) ______________________
3) ______________________	7) ______________________
4) ______________________	8) ______________________

REVIEW OF SYSTEMS

Y = a condition now **P** = significant problem in the past **N** = never had

MENTAL/ EMOTIONAL

Mood Swings	Y P N	Anxiety/nervousness	Y P N
Irritability	Y P N	Cries easily	Y P N
Hyperactivity	Y P N	Unusual fears	Y P N
Introvert/extrovert	Y P N	Sleep problems	Y P N
Motion/car sickness	Y P N	Nightmares	Y P N

ENDOCRINE

Heat/cold intolerance	Y P N	Fatigue	Y P N
Excessive thirst	Y P N	Excessive hunger	Y P N
Low blood sugar	Y P N	High blood sugar	Y P N

SKIN

Rashes	Y P N	Eczema, Hives	Y P N
Acne, Boils	Y P N	Itching	Y P N

HEAD

Headaches	Y P N	Head Injury	Y P N
Dizzy spells	Y P N	High fevers	Y P N

EYES

Glasses or contacts	Y P N	Tearing or dryness	Y P N
Eye pain/strain	Y P N		

EARS

Earaches	Y P N	Impaired hearing	Y P N

NOSE AND SINUSES

Frequent colds	Y P N	Nose Bleeds	Y P N
Stuffiness	Y P N	Hayfever	Y P N
Sinus problems	Y P N	Loss of smell	Y P N

MOUTH AND THROAT

Frequent sore throat	Y P N	Canker sores	Y P N
Breath odor	Y P N		

RESPIRATORY

Cough	Y P N	Wheezing	Y P N
Asthma	Y P N	Bronchitis	Y P N

CARDIOVASCULAR

Heart disease	Y P N	Murmurs	Y P N

Y = a condition now **P** = significant problem in the past **N** = never had

URINARY

Frequent urination	Y P N	Bed wetting	Y P N

GASTROINTESTINAL

Belching/passing gas	Y P N	Stomach aches	Y P N
Constipation	Y P N	Diarrhea	Y P N

Bowel Movements How often ________________

MUSCULOSKELETAL

Joint pain/stiffness	Y P N	Muscle spasms/cramps	Y P N
Broken bones	Y P N		

BLOOD/PERIPHERAL VASCULAR

Anemia	Y P N	Easy bleeding/bruising	Y P N

Is there any information about your child's health that you would like to add?

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____

____

____

What expectations do you have for your child from working with our clinic?

____

____

____

____

Welcome! I'm honored to be of service for you and your child!

Chris Booren N.D.
1820 SW Vermont Street Ste. G Portland, OR 97219
(503) 246-3919

Office, Financial and Insurance Policies

We are committed to providing you with the best possible healthcare.

If you have medical insurance that covers Naturopathic services, we will be happy to assist you in submitting your insurance claims. I hereby authorize Dr. Chris Booren to bill my charges through my primary and then, if applicable, secondary insurance plans. I understand that, in some cases, care provided to me by Dr. Booren, although agreed medically indicated by her and I, may not be covered by either plan. In this instance, I agree to pay any balance owed. Please submit your insurance information as soon as possible to our office so that we may determine your coverage. Knowing the details of your coverage ahead of your visit may save time, money and frustration.

Payment is due at time of service.

We request lab work that is medically necessary to determine your health needs. If these are not covered by your insurance it will be your responsibility to pay any lab fees.

Supplements are not covered by insurance companies. We will need you to provide payment for those items at the time you pick them up or when you order them over the phone.

We understand that, on occasion, temporary financial problems may affect timely payment of your account. If such problems do arise we encourage you to contact our office promptly and make arrangements. We will be happy to set up payment arrangements, or answer any questions concerning your insurance reimbursements.
A finance charge of $.50 will be imposed on your account if it has not been paid within 30 days of your appointment unless you have established a payment plan and are current with your monthly payment. An additional $7.00 penalty fee will be added each month if we need to call, rebill or otherwise remind you of your delinquent account. We accept cash, checks, debit, visa, and master card. There is a $37.00 charge for retuned checks.

As a courtesy to other patients requiring services, we request that you provide notice of cancellation 24 hours in advance. Persons missing appointments will be charged a fee of $50.00 unless we are notified.

If you have any questions concerning the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask. We appreciate your patronage and are glad to be of service to you.

I have read the above information and agree that, regardless of my insurance status, I am responsible for the balance of my account. I agree to make payment on my account, as discussed above, and to notify this office should there be any change in my insurance coverage. I also understand that Dr. Booren may order tests which are not covered by my insurance company, and I will be responsible for those fees.

Signature: ______________________________ **Date:** ______________

I authorize the release of any medical or other information necessary to process this claim. I also request payment to be made directly to Dr. Booren.

Signature: ______________________________ **Date:** ______________

NOTICE OF PRIVACY PRACTICES

(MEDICAL)

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, ______________________________, have received a copy of this office's Notice of Privacy Practices.

____
Please Print Name

____
Signature

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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