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

PEDIATRIC INTAKE FORM (Birth- 5 years)

Patient's name: _____ Date of first visit: _____

Age: _____ Date of Birth: ____/____/____Gender: female _____ male _____

Mother's name:_____Father's name:_____

Address: _____City: _____ State: ____ Zip: _____

Phone# (home): _____ Parents# (work):_____

Parents e-mail address: _____

How did you hear about Dr. Booren? _____

Name of Dr.'s Office/Hospital/Clinic where your child's health records are kept:

_____

Reason for referral or presenting problems: _____

_____

INSURANCE INFORMATION:

Does your child have 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: _____

MEDICATIONS

	Now	Past		Now	Past
Aspirin	____	____	Antibiotics	____	____
Tylenol	____	____	Anti-histamine	____	____
Decongestant	____	____	Ibuprofin	____	____

Other: _____

Allergies to medicines _____

MEDICAL HISTORY

_____Chicken pox _____Scarlet fever _____Tonsillitis, approx no. : _____

_____Measles _____Pneumonia _____Ear infections, no. : _____

_____Mumps _____Frequent colds _____Rubella

_____Rheumatic fever Other (please list) : _____

Has your child had any of the following tests?

	When	Where	Results
Electroencephalogram			
Psychological evaluation			
Hearing			
Speech/Language			

Injuries/Surgeries/Hospitalizations (please list): _____

_____

IMMUNIZATIONS

_____ Measles _____ Polio_____ MMR _____ Smallpox _____ Diphtheria

_____ Mumps _____ DPT _____ Tetanus _____ Influenza

Others (list): _____

_____

Any adverse reactions? Y N What ?

_____

FAMILY HISTORY

_____ Heart disease	_____ Diabetes	_____ Birth defects
_____ Hypertension	_____ Arthritis	_____ Tuberculosis
_____ Cancer	_____ Allergies	_____ Mental Illness

PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications?

_____

_____

Mother's age at child's birth? _____

Mother's health during pregnancy:

_____ Bleeding _____ Physical or emotional trauma
_____ Nausea _____ Cigarettes, alcohol, drug consumption
_____ Illnesses _____ Medications : _____
_____ Hypertension _____ Thyroid problems _____ Diabetes

BIRTH HISTORY

Term: Full _____ Premature _____ Late _____ Weight at birth: _____

Length of labor: _____ Complications? _____

Did your child have any of the following problems shortly after birth?

_____Birth defects _____Birth injuries _____Blue baby
_____Cerebral palsy _____Seizures _____Jaundice
_____Colic _____Fever _____Rashes

Other (explain) _____

Child's sleep patterns (first year) _____

Food intolerances (if any) _____

Feeding: Breast fed?_____ how long? _____ Formula? _____ milk / soy _____

Age began solids: _____ Which foods? _____

Age began: Sitting _____ Crawling _____ Walking _____ Talking _____

SYMPTOMS (mark **Y** if current, **P** significant past symptom)

_____Hives
_____Eczema
_____Bleeding gums
_____Nose bleeds
_____Acne
_____High fevers
_____Chronic rash
_____Hearing loss
_____Diarrhea
_____Sore throats
_____Headaches
_____Frequent colds
_____Wheezing
_____Cough

_____Burning of urine
_____Frequent urination
_____Heart murmur
_____Vomiting spells
_____Anemia
_____Stomach aches
_____Jaundice
_____Easy bruising
_____Flat feet
_____Constipation
_____Gas
_____Bleeding tendency
_____Joint pains
_____Dizzy spells

_____Bloody urine
_____Cries easily
_____Nervous
_____Sleep problems
_____Night sweats
_____Sensitive to light
_____Body/breath odor
_____Motion/car sickness
_____No appetite
_____Nightmares
_____Canker sores
_____Unusual fears
_____Excessive fatigue
_____Hair loss

DIET

Please describe your child's typical daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To Drink: _____

Thank you. I look forward to helping your child in any way I can.

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)

_____

_____

_____