Mesquite
PEDIATRICS

Patient Past Medical History Questionnaire

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Any allergic reactions to medications? Yes No Which ones? _____

Any reactions to immunizations? Yes No Which ones? _____

Any medications taken regularly? Yes No Which ones? _____

Any complications with birth? Yes No Which ones? _____

Circle any medical problems your child has had:

- Eye Conditions/Corrective Lenses
- Frequent Ear Infections
- Hearing Loss or Other Ear Problem
- Frequent Sore Throat
- Allergies:
  - Nasal or Eye Allergies
  - Foods: _____
  - Other Severe Reactions: _____
- Eczema
- Asthma
- Pneumonia
- Heart Murmur or Congenital Heart Disease
- Anemia or Bleeding Disorder
- Gastroesophageal Reflux (GERD)
- Frequent/recurrent Abdominal Pain
- Constipation
- UTI/Bladder Infection or other Urologic Problem
- ADD/ADHD
- Headaches/Migraines
- Seizures
- Mental Health Problem
  - Specify: _____
- Developmental Delay
- Other Neurologic Disorder
  - Specify: _____
- Orthopedic Problem
  - Specify: _____
- Acne
- Diabetes
- Thyroid or Other Endocrine Problem
  - Specify: _____
- Alcohol or Drug Use

For Girls: Have Periods Started? Yes No If "Yes" At what age? _____

	For What?	When?
Surgeries:	_____	_____
Hospitalizations:	_____	_____
Serious Injuries:	_____	_____

Other medical problems not listed above: _____

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CONSENT TO TREAT, PRIVACY NOTICE ACKNOWLEDGMENT, INSURANCE ASSIGNMENTS, & AUTHORIZATION TO RELEASE INFORMATION

CONSENT TO TREAT: I consent to medical care and treatment as may be deemed necessary or advisable in the judgment of my physician, which may include but are not limited to; laboratory procedures medical or surgical treatment or procedures, local anesthesia, or other services rendered the patient under the general and special instructions of the patient's physician. _____**(Initial)**

PRIVACY NOTICE ACKNOWLEDGEMENT: I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") I have the right to privacy regarding my protected health information. I understand that this information will be used to carry out treatment, payment and health care operations. I hereby acknowledge that I have been presented with a copy of Mesquite Pediatrics' Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information and my individual rights with respect to my protected health information. _____**(Initial)**

INSURANCE ASSIGNMENTS: I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including private insurance and any other health/medical plan, to issue payment check(s) directly to Mesquite Pediatrics for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance. _____**(Initial)**

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Mesquite Pediatrics to: (1) release any information necessary to insurance carriers regarding myself and/or my dependent's illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims during my child's treatment. This order will remain in effect until revoked by me in writing. _____**(Initial)**

Patient Name _____ Date of Birth _____

_____ _____ _____
Responsible Party Signature Print Name Date

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MESQUITE PEDIATRICS FINANCIAL POLICY

We are doing everything possible to hold down the cost of medical care. You can help a great deal by reducing the number of bills we send to you. The following is a summary of our payment policy.

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance, co-payments and deductibles for participating insurance companies. Acceptable forms of payment include cash, personal checks (established patients only), VISA, and MasterCard. Please note that there is a service charge of **$25.00** for returned checks.

Patients with an outstanding balance 60 days or more overdue must make arrangements for payment prior to scheduling appointments. We reserve the right to charge a billing fee after 60 days. Any unpaid balances after 90 days could result in collection action. **If this should occur, you will be charged a 35% collection fee.** We realize that financial difficulty is a reality and we are happy to help our families in need. Financial arrangements are encouraged should you be unable to pay your balance in full. If you need assistance in this area, please contact our practice manager.

INSURANCE: We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and co-payments at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you may be expected to pay the balance in full. You are responsible to be sure all charges are paid whether by you or by your insurance carrier.

REFUNDS: Patient/guarantor credits in amounts less than $20.00 will be retained on account to be credited toward future balances unless a written request for refund is received. Amounts $20.00 and greater will be refunded to the patient/guarantor.

MISSED APPOINTMENTS/LATE CANCELLATIONS: Missed appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are required 24 hours prior to the appointment. We reserve the right to charge the current no show fee as listed on our website for missed or late-canceled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

PRIMARY CARE PHYSICIAN ASSIGNMENT: It is your responsibility to ensure that one of the doctors at Mesquite Pediatrics is assigned as your Primary Care Physician if your insurance policy requires you to choose one. Failure to do so may result in additional out of pocket costs for you.

FINANCIAL AGREEMENT: I have requested medical services from Mesquite Pediatrics on behalf of myself and/or my dependents, and understand that by making this request I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges (copay, coinsurance and/or deductible) incurred in full immediately upon presentation of the appropriate statement.

I understand and agree to follow the payment policies set forth in the Mesquite Pediatrics Financial Policy and have been given the opportunity to ask questions about this policy.

_____ _____

Patient Name Date of Birth

_____ _____ _____

Responsible Party Signature Print Name Date

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Authorization for Release of Medical Information

Patient Name: _____ Date of Birth: _____

Parent/Guardian Full Name: _____

Address: _____

Phone Number: _____

This Authorizes: _____
(previous provider name)

_____
(previous provider address)

_____ _____
(phone number) (fax number)

To Release Information to: Mesquite Pediatrics
5983 E Grant Rd, Suite 105
Tucson, AZ 85712
Phone 520-648-5437 Fax 520-648-5438

PLEASE SEND ALL MEDICAL RECORDS – BIRTH TO PRESENT

We cannot give comprehensive care without complete records so please initial all three categories below:

Please initial next to any of the following categories of records that you would like to have transferred:

___ Mental condition and/or treatment including psychotherapy notes

___ Drug or alcohol abuse and/or treatment

___ HIV, AIDS, or AIDS-related complex condition and/or treatment

I authorize the release of all my medical records including those noted above.
This authorization releases Mesquite Pediatrics and any staff, employees, and agents of any responsibility for information contained in such records released in case of loss or theft from my person, or distress of any type caused to me or other. Mesquite Pediatrics will not be held liable for any misuse or misunderstanding of the information contained herein as a result of this release. I understand that I may revoke this release at any time in writing with the exception of records already released. No authorization will be made more than one year after the date of signature.

_____ _____
Signature of Parent/Guardian, or patient if over 18 Date

If over 30 pages, fax immunizations and mail other records