Pediatric Health History Questionnaire:

Child's name________________________________ Date of birth________________________________

Mother's name:______________________________ Father's name:______________________________

Telephone:__________________________________ Telephone:__________________________________

Address____

Pregnancy and Birth History	
Mother's age at birth:	Father's age at birth:
Did mother have any of the following during pregnancy?	
☐ Fever or rash	☐ Tobacco use (how much)
☐ Group B strep	☐ Alcohol use (how much)
☐ Sugar in urine / diabetes	☐ Street drug use (what type)
☐ High blood pressure	☐ Medication use (prescription or over-the-counter - list below)
☐ Anemia	
☐ Infections (if yes what type and how were they treated)	

Newborn History		
Birth Weight:	Birth length:	Head Circumference:
Born on time? ☐ Early	☐ Late	How much:
Type of delivery ☐ Vaginal	☐ C-section (why):	
How old was baby when she/he left the hospital?		
During the first week of life did your child have any of the following		
☐ Feeding trouble	☐ Seizures	☐ Fever
☐ Excess vomiting	☐ Breathing trouble	☐ Receive antibiotics
☐ Jaundice (yellow skin)	☐ Need of oxygen	☐ Diarrhea
☐ Cyanosis (blueness)	☐ Blood transfusion	☐ In intensive care unit

Family History				
Relationship	Name	Living Y/N	Age	Major Medical Problems and/or Cause of Death
Father				
Mother				
Siblings				
If more than 3 siblings continue on back				

Have any of the child's relatives had the following conditions

Condition	Relative	Condition	Relative
☐ Diabetes		☐ Kidney problems	
☐ Cancer		☐ Heart disease	
☐ Seizures		☐ Stroke	
☐ Allergies/asthma		☐ Anemia	
☐ Bleeding problems		☐ HIV	
☐ High blood pressure		☐ Skin problems	
☐ Lung disease		☐ Chemical dependency	

☐ Mental illness			☐ Other:	
Are there any religious or cultural factors that you would like us to take into account when planning your child's healthcare?				

Past Medical History		
Where has child gone for check-ups previously:		
Date of last medical checkup:		
Date of last dental check-up:		
Is your child up-to-date on immunizations? Please supply immunization records.		
Does any of the following apply to your child:		
☐ Chicken pox	☐ Wears glasses	☐ Asthma
☐ Measles	☐ Heart murmur	☐ Allergies
☐ Mumps	☐ Kidney or bladder infection	☐ Broken bones
☐ Frequent ear infections (>4 year)	☐ Bed wetting (>5 years old)	☐ Head injury
☐ Frequent throat infections (>4 year)	☐ Diabetes	☐ Seizures
Has your child ever been hospitalized or had surgery? If yes, list age and reason:		
Has your child ever been on medication regularly that is not on their current medication list? If yes, list medication(s) and reason:		
Do you have any concerns about your child's development? If yes, please describe:		

Childs Social Characteristics	
School Grade/Preschool:	City Water: Yes / No
Hours of TV/Electronics Each Day:	Pets:
Special Diet:	Sports:
Weekly Hours of Outdoor Activity:	Hobbies:
Membership in External Organizations:	
Other:	

At Risk Behaviors	
Tobacco use (how much) Yes / No	Sexually Active Yes / No
Alcohol use (how much) Yes / No	Do you use protection during sex Yes / No
Street drug use (what type) Yes / No	Do you make yourself sick by eating too much Yes / No
Exposure to Second Hand Smoke: Yes / No	Do you worry about your weight Yes / No
Guns in Home: Yes / No	Is food one of your biggest conerns Yes / No
Wears Sunscreen: Yes / No	Other:
Wears Seatbelt/Car Seat/Booster: Yes / No	

Allergies		
Please list any allergies to medications or foods and environmental allergies		

Medications	
Please list any medications that your child takes including over the counter medications, herbs, vitamins and supplements. Include dose and frequency (if more room is needed continue on back)	

It is very important that your child take the medication(s) your health care professional has given you. Please check any of the below

Are you unable to fill your child's prescription(s) because of the cost ☐ Yes ☐ No

Are you unable to fill your child's prescriptions because of lack of transportation ☐ Yes ☐ No

Have you ever applied for any pharmacy assistance ☐ Yes ☐ No

Specialty Providers	
In order that we can best coordinate your child's care, please list any medical providers the child sees outside of this practice and list the year that they last saw them (if more room is needed continue on back)	

Health Literacy Questionnaire	
Many times in healthcare staff and providers use words that are unfamiliar to the general population. Please rate the following questions on a scale of 1 to 10; 1 being strongly disagree and 10 being strongly agree	
I feel that I have a thorough understanding of the instructions that my doctors and nurses give me about my health	1 2 3 4 5 6 7 8 9 10
I feel that I remember the instructions given to me at my doctor's office when I get home	1 2 3 4 5 6 7 8 9 10
I feel that I have a strong understanding of medical language	1 2 3 4 5 6 7 8 9 10

Parent Signature:______________________________ Date:____________________

Financial Policy

Your insurance contract is an agreement between you, your insurance company and in any instance, your employer. The financial side of medical practices has become increasingly complex over the past few years with the advent of managed care and the many different types of insurance plans now available. We try our best to be familiar with the regulations and restrictions of each company, though you, the patient, are ultimately responsible for understanding the details of your own health care coverage. The following are the guidelines we use to regulate the financial side of our practice. Please make yourself familiar with these and let us know if you have any questions.

1. All charges are due at the time of service unless other arrangements have been made in advance.
2. Medicaid Co-Pays will be collected at the time of service in accordance with Carolina Access Policy which states "failure to make co-pays will result in dismissal"
3. Patients with third party insurance plans which require their own co-pay at sign in. Failure to do may result in the patient not being seen by the provider unless it is a genuine medical emergency. We will gladly bill your insurance company for the remainder of the charges associated with your visit. Please be aware that there may be an additional balance even after your insurance payment due to your deductible and/or any non-covered services. If so, our Billing Supervisor will notify you, and the additional charges will need to be paid within 30 days of receipt of your bill.
4. We are not contractually required to file claims for Medicare Secondary plans; however, we will file them once as a courtesy. Should the company not respond within 45 days of our filing, then the charges will be sent to you directly and you will be responsible for them as with any other charges.
5. While we always see patients for emergency care, routine care will only be given to patients whose accounts are current or have made financial arrangements with us maintaining the conditions thereof.

I have read and understand that financial policy of LifeWay Health. My signature below acknowledges that any questions I may have regarding the policy have been fully explained and answered.

Patient Name: ______________________________ Signature: ______________________________

Date: ________________________________

Designated Individuals' Authorization

(HIPAA Compliance)

In order to protect your patient confidentiality, we need to know if there is a phone number (with voicemail) for you where we can leave the results of your laboratory tests or other sensitive information. Please indicate the information below, and we will keep this in your file until you instruct us in writing to remove it.

I give LifeWay Health employees permission to leave confidential health care information for me at the following phone numbers(s):

______________________________________ (if none, please note)

______________________________________ (if none, please note)

______________________________________ (If none, please note)

I understand these numbers will be used until I notify LifeWay Health in writing if they should no longer be used.

I authorize the following people to receive information regarding my medical status (including access to my medical records) and financial records ongoing.

Name ____________________ Relationship ____________________ Phone ____________________

Name ____________________ Relationship ____________________ Phone ____________________

Name ____________________ Relationship ____________________ Phone ____________________

Name ____________________ Relationship ____________________ Phone ____________________

Name ____________________ Relationship ____________________ Phone ____________________

Signature: ____ **Date:** __________________

Appointment Cancellation Policy

Here at LifeWay Health, we are committed to providing quality health care for each patient and we respect your time and make every effort to keep you from waiting. As a result, your appointment time is reserved for exclusively you. Please read and sign our updated policy regarding patient responsibilities.

How To Cancel or Reschedule Your Appointment

We ask that you contact our office **at least 24 hours** in advance to cancel or reschedule your appointment. Appointments are in high demand and your early cancellation will give another patient the opportunity to receive care.

No Show Policy

A "no show" appointment occurs when a patient misses and appointment entirely.

If you "no show" an appointment, we may ask you to place a credit card on file to reschedule another appointment. Continuing to no show appointments may results in a fee up to $50.00 and/or possible dismissal from the practice.

Late Arrival Policy

If you arrive 15 minutes after the start of your appointment, we may have to reschedule your appointment.

I have read and understand the cancellation and payment policy and agree to abide by its guidelines.

Signature: ______________________________ Date: ______________________