PEDIATRIC INTAKE FORM

Patient's Name _____ Today's Date _____
Date of Birth _____ Age _____ Sex _____ S.S. # _____
Mother's Name _____ Father's Name _____
Home Address _____
City _____ State ____ Phone (Home) _____ (Work) _____
How did you hear about the clinic? _____
Name and Address of Dr.'s office/hospital/clinic where your child's health records are kept
_____
Reason for referral or presenting problem(s) _____
_____
_____
_____

MEDICATIONS

	Now	Past		Now	Past
Aspirin	____	____	Antibiotics	____	____
Tylenol	____	____	Anti-histamine	____	____
Decongestant	____	____	Other	____	____
Ibuprofen	____	____	List meds _____		

Allergies to meds _____ _____

MEDICAL HISTORY

Childhood Illnesses:

___ Chicken Pox ___ Scarlet Fever ___ Tonsillitis, no. ____
___ Measles ___ Pneumonia ___ Ear Infections, no. ___
___ Mumps ___ Frequent colds ___ Other (please list)
___ Rubella ___ Rheumatic Fever

Has your child ever had any of the following tests?

	When	Where	Results
EKG			
EEG			
Psychological Eval.			
Hearing			
Speech/language			

IMMUNIZATIONS

___ Measles ___ Polio ___ MMR ___ Smallpox ___ Diphtheria
___ Mumps ___ DPT ___ Tetanus ___ Influenza ___ Other (list)

FAMILY HISTORY

___ Heart disease ___ Diabetes ___ Birth defects ___ Hypertension
___ Arthritis ___ Tuberculosis ___ Cancer ___ Allergies
___ Mental illness

Previous pregnancies by natural mother, miscarriages or complications?
Mother's age at child's birth? _____
Mother's health during pregnancy?

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

BIRTH HISTORY

Term: ___ Full ___ Premature ___ Late Weight at birth _____ lbs _____ oz
Length of labor _____ hours Complications? _____

Has your child ever had any of the following problems?

___ Jaundice
___ Colic
___ Blue baby
___ Diarrhea
___ Fever
___ Seizures
___ Birth defects
___ Cerebral palsy
___ Birth injuries
___ Rashes
___ Allergies
___ Other (explain)

_____

Child's sleep pattern (first year) _____
Food intolerance (if any) _____
Feeding: Breast fed? ___ How long? _____ Formula: Milk Soy Other _____
Age began solid foods _____
Age began: Sitting _____ Crawling _____ Walking _____ First words _____

SYMPTOMS (Mark 2 for current and 1 for past)

___ Hives
___ Eczema
___ Bleeding of gums
___ Nose bleeds
___ Acne
___ High fevers
___ Chronic rash
___ Hearing loss
___ Diarrhea
___ Sore throat
___ Frequent 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 pain
___ 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:

_____
_____
_____

Name:_____ Date of Birth _____

Who can we share your medical information with?

I authorize the release of my information from the Colville Naturopathic Clinic P.S. including diagnosis, records, appointments, and billing information to the **following family and friends**:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

[ ] Information is not to be released to anyone.

This release of information will remain in effect until terminated by me in writing.

Contact Information/Messages

I authorize the Colville Naturopathic Clinic P.S. to contact me via the following methods.

For appointment reminders please: [ ] Text [ ] Call #_____

Preferred method of contact for other information: _____

home _____ work _____

cell _____ Text to cell [ ] Yes [ ] No

email _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to call you back

If my contact information should change at any time, I understand that it is my responsibility to notify the Colville Naturopathic Clinic P.S. of such changes in order to continue communication.

Patient/Guardian: _____ Date: _____

Who can we share your medical information with?

I authorize the release of my information from the Colville Naturopathic Clinic P.S. including diagnosis, records, appointment dates and times; examination rendered to me and claims information. This information may be released to (family/friends):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

[ ] Information is not to be released to anyone.

This release of information will remain in effect until terminated by me in writing.

Contact Information/Messages

I authorize the Colville Naturopathic Clinic P.S. to contact me via the following methods.

For appointment reminders please: [ ] Text [ ] Leave Message [ ] Ask for me to call back

[ ] home _____ [ ] work _____

[ ] cell _____ Text to cell [ ] Yes [ ] No

[ ] email _____

Preferred method of contact for all other information: _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to call you back

If my contact information should change at any time, I understand that it is my responsibility to notify the Colville Naturopathic Clinic P.S. of such changes in order to continue communication.

Patient/Guardian: _____ Date: _____

Colville Naturopathic Clinic P.S.

Randy Sandaine, N.D. & Beck Nickel, N.D.

NEW PATIENT INFORMATION FORM Date_____

Patient's Last Name _____ First_____ Middle_____

Age_____ Date of Birth _____ Social Security #_____

Mailing Address_____

City_____ State _____Zip Code_____ Marital Status _____

Email Address_____

Home Phone_____ Business Phone_____ Cell Phone _____

Occupation _____Employer's Name_____

Employer Address _____

Spouse(or parent)_____ Telephone #_____

How did you hear about our clinic: ☐ Radio ☐ Newspaper ☐ Referred by: _____

FINANCIAL RESPONSIBILITY

☐ **Check here if same as above**

Last Name_____First_____Middle_____

Date of Birth_____ Social Security #_____

Address_____

City_____ State_____ Zip Code_____

Relationship to patient_____ Home Phone_____ Work Phone_____

Employer's Name _____ Address_____

INSURANCE INFORMATION

Subscriber Name_____ Relationship to Patient_____

Subscriber Date of Birth _____ Does this plan have an HSA or HRA? _____

Name of Insurance_____ Policy ID#_____

Name of Employer Providing Insurance_____

Insurance Phone #_____ Referring Doctor_____

In case of emergency please notify _____ Relationship_____ Phone_____

I consent to treatment necessary for the care of the above named patient. I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable. I allow fax transmittal of my medical records, if necessary. I acknowledge full financial responsibility for services rendered by Colville Naturopathic Clinic P.S.. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges. I further authorize and request that insurance payments be made directly to Colville Naturopathic Clinic P.S. should they elect to receive such payment.

I have read and fully understand that above consent for treatment, financial responsibility, release of medical information, and insurance authorization.

Patient/Guardian Signature _____ Date_____

COLVILLE NATUROPATHIC CLINIC P.S.

Family Medicine/Preventative Care

Dr. Randy L. Sandaine N.D. & Beck Nickel N.D.

Phone (509) 684-1104

234 North Oak Fax (509) 684-0242 Colville, WA 99114

Parental Consent

I hereby give my permission that _____ is allowed to be seen and treated by Dr. Randy Sandaine or Dr. Beck Nickel without my presence when brought in by the following family members/friends:

Name:_____ Relation:_____

Name:_____ Relation:_____

Name:_____ Relation:_____

Name:_____ Relation:_____

Name:_____ Relation:_____

Name:_____ Relation:_____

_____ _____

Parent/Guardian Signature Date

NOTICE OF PRIVACY PRACTICES

Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create record of the care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

Our Legal Duty

Law requires us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow terms of the notice that is now in effect.

We Have the Right to:

1. Change our Privacy practices and the terms of this notice at any time, provided the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Changes to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

Use & Disclosure of Your Medical Information

This is how we use and disclose medical information. Note: We will not use or disclose your medical information for any purpose not listed below, with out your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

For Treatment:

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you.

Example: You are in the hospital with a broken leg. You also have diabetes. A number of health care and support staff need to know about your diabetes during your stay:

The doctor treating you for your broken leg needs to know if you have diabetes because it may slow the healing process.

The dietician needs to know your disease to arrange for proper meals.

The pharmacy needs to know about possible medicines that you may be taking as a diabetic.

The information about your diabetes may help in diagnosing, testing and x-ray work.

We may also share medical information about you with other health care providers to assist them in treating you.

For Payment:

We may disclose your medical information for payment purposes.

Example: You are treated in the hospital for a broken leg.

We may need to give your health insurance plan information about surgery you received at our organization so that your health plan will pay us or repay you for any surgery that you paid for.

We may also tell your health plan about a treatment you are going to receive to get approval or to determine if your plan will pay for the treatment.

Health Care Operations:

We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditations, certificates, licenses, and credentials we need to serve you.

Additional Uses:

In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may disclose medical information for the following purposes.

We may disclose this information to members of the clergy or, except or you religious affiliation, to others who contact us and ask for information about you by:

Funeral Director, Coroner, Medical Examiner:

We may share the medical information about a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization to help them carry out their duties.

Specialized Government Functions:

Subject to certain requirements, we may disclose or use health information for military personnel and veterans for national security and intelligence activities, for protective services for the president and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders, Judicial and Administrative Proceedings:

We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances, under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim, or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities:

As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury, or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purpose of reporting adverse events associated with product defects or problems to enable product recalls, repairs, or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also when authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence:

We may disclose medical information to appropriate authorities if we reasonably believe that you re a possible victim of abuse, neglect, or domestic violence, or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety and health of others. We may share your medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Health Oversight Activities:

We may disclose your medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil administrative, or criminal investigations or proceeding, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement:

Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes, on our premises, and crimes in emergencies.

Your Individual Rights

You Have a Right to:

1. Look at or get your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may ask the receptionist for the form needed to request access. There maybe charges for copying and for postage if you want the copies mailed to you. Ask the receptionist about our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other exceptions
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in case of emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be in writing to our Privacy Officer.
5. Request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information that you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any further sharing of that information.
6. If you wish to receive a paper copy of this privacy notice, then you have the right to obtain a paper copy by making a request in writing to our Privacy officer.

Please sign above that you agree to these terms

Questions and Complaints

If you have any questions about this notice, please ask the receptionist for help or ask to speak to our Privacy Officer.

If you think that we may have violated your privacy rights, contact the person named above. You may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with address to file your complaint. We will not retaliate in anyway if you choose to file a complaint.

These privacy practices are in effect and will remain in effect until further notice.

COLVILLE NATUROPATHIC CLINIC P.S.

No Show/Cancellation Policy

I understand that I will be charged and responsible for a $35.00 fee, which will not be covered by my insurance, if I do not show up for my scheduled appointment. We understand that unforeseen circumstances arise and request that you inform our office 24 hours in advance, in order to avoid the $35.00 fee, so that we may better accommodate other patients.

Patient/Guardian Signature _____

Date _____

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DRIVING DIRECTIONS:

Colville Naturopathic Clinic, PS
234 N. Oak
Colville, WA 99114
(509)684-1104 phone

South Bound (coming from Kettle Falls or north): Travel south on Hwy 395. At the roundabout take first exit to continue on Hwy 395/W 5th Ave. Continue on through the first light. The road will curve around Safeway turning into Main St. At the second light just after Safeway take a left onto E 3rd/Hwy20 (Tiger Hwy). You will then take you next right onto North Oak Street. We will be the third building on your left.

North Bound (coming from Chewelah or south): Travel north on Hwy 395. At the roundabout take the second exit to continue on Hwy 395/Main St. Continue on Main St. until you reach the stop light for the intersection of Main & 3rd. Take a Right onto E. 3rd Ave/Hwy 20 (Tiger Hwy). You will then take your next right onto North Oak Street. We will be the third building on your left.