Canadian Valley Pediatrics

PATIENT INFORMATION

PATIENT FULL NAME: _____ **MALE** ☐ **FEMALE** ☐

BIRTHDATE: _____ **PERFERRED NAME:** _____ _____

ADDRESS: _____

_____ EMAIL: _____

PRIMARY PHONE: _____ **SECONDARY** PHONE: _____

EMERGENCY CONTACT

In case of emergency, please provide information for the nearest relative or designated contact person NOT at the patient's address:

NAME: _____ PHONE: _____

RELATIONSHIP TO PATIENT:

FINACIALLY RESPONSIBLE PERSON

This is the information for the person that carries the primary insurance. They will receive billing statements.

NAME: _____ CELL: _____

BIRTHDATE: _____ EMAIL: _____

ADDRESS: _____

_____ OCCUPATION: _____

INSURANCE INFORMATION

PRIMARY INSURANCE

INSURANCE: _____ EFFECTIVE: _____

ID #: _____ GROUP #: _____ COPAY: _____

SECONDARY INSURANCE:

INSURANCE: _____ EFFECTIVE: _____

ID #: _____ GROUP #: _____ COPAY: _____

PLEASE SIGN AND DATE BELOW:

SIGN: _____ DATE: _____

RELATIONSHIP TO PATIENT: _____

DR DINA BOWEN CANADIAN VALLEY PEDIATRICS*1601 HEALTH CENTER PKWY, BUILDING 900 YUKON OK 73099* (405)577-6700* FAX (405) 265-4135*

Canadian Valley Pediatrics

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

UPDATED 2023

PATIENTS NAME: _____ BIRTHDAY: _____

I understand and agree that all co-pays and outstanding balances are due at the time of my appointment. I may be charged $25 for any calls after business hours that are considered non-emergent in nature, this does include medication refills and dosage amounts. If your child has a true medical emergency and needs immediate treatment, call 9-1-1 or go the nearest emergency room. Dr Bowen and staff reserve the right to terminate patient care at any point. The Practice is authorized to disclose my child's medical information and remind me of appointments on my answering machine, text, voicemail or email. Please note: any appointment reminder given to the patient by the Practice is a courtesy. It is the patient's responsibility to be aware and keep all appointments. There may be a $25 charge for any missed appointment, if a 24 hour notice is not given. If you are late for your appointment time, you will be seen after the patients who were on time.

I understand and agree that I will be held responsible for all charges incurred for services rendered. Regardless of my insurance status, I am ultimately responsible for the balance on my account. I authorize direct payment to be made to the office of Dr. Dina Bowen, M.D. (The Practice) for any rendered services. Please note: Your insurance plan is a contract between you and your insurance company. Our office provides medical service and file claims on your behalf. We do our best to provide any information available to us from your insurance company. However, it remains the policy holder's responsibility to know their insurance policy and specific coverage. You will be responsible for an amount that your insurance does not cover, you should familiarize yourself and anyone listed below, that has permission to bring your child to the doctor, with the insurance policy and coverage.

I hereby authorize the office of Dr Dina Bowen, M.D. to release any information concerning my child's health care, advice, treatment or services provided. This information is to be used in administering medical claims and/or discussing treatment options with insurers and/or other medical providers outside of the Practice, when necessary, so that these providers may treat my child, seek payment for services rendered and for the purpose of their health care operations (e.g. quality assurance).

The following family members/ friends have my permission to accompany my child to his/her medical appointment on my behalf: (please print and list people over the age of 18 along with their relationship to the patient).

_____

_____

_____

I have reviewed the Notice of Privacy Practice. I understand I may receive a printed copy of this information upon verbal or written request now or in the future. To the best of my knowledge all information provided is correct. If I have changes in my health status, medication changes, address changes, phone numbers or insurance changes, I shall inform the Practice without fail.

By signing below, I acknowledge that I have read, understand and agree to the statements mentioned above.

SIGN: _____

RELATIONSHIP TO PATIENT: _____ DATE: _____

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NAME:_____ BIRTHDATE: _____ CITY OF BIRTH: _____

HOSPITAL OF BIRTH: _____ OBSTETRICIAN: _____

PREGNANCY: (MOM)

ANY ILLNESSES? _____ ANY MEDICINES? _____

DID YOU SMOKE? _____USE ALCOHOL? _____ USE RECREATIONAL DRUGS? _____

WAS BABY EARLY OR LATE? _____ C-SECTION? _____ ANESTHESIA? _____

ANY OTHER PROBLEMS: _____

PERINATAL:

BIRTHWEIGHT _____ DID BABY CRY RIGHT AWAY? _____ APGARS_____

REQUIRE OXYGEN? _____ IV? _____ WAS BABY JAUNDICED (YELLOW)? _____

DAYS IN HOSPITAL _____ IF BREAST FED, HOW LONG? _____ IF BOTTLE FED, WHAT FORMULA? _____

SINCE BIRTH, LIST ANY OF THE FOLLOWING THAT APPLY, INCLUDING DATES:

ILLNESSES _____

_____

HOSPITALIZATIONS _____

SURGERIES_____

ALLERGIES OR REACTIONS TO MEDICATIONS _____

MEDICINES NOW TAKING _____

SCHOOL:

CURRENT GRADE _____ SPECIAL EDUCATION? _____ NAME OF SCHOOL _____

USUAL GRADES: A-B B-C C-D D-F ANY PROBLEMS? _____

LIST THOSE WHO CURRENTLY LIVE IN THE HOME, THEIR DATE OF BIRTH, AND HEALTH STATUS:

1._____ DOB:_____ Health:_____

2._____ DOB:_____ Health:_____

3._____ DOB:_____ Health:_____

4._____ DOB:_____ Health:_____

5._____ DOB:_____ Health:_____

OTHER:

DOES YOUR CHILD GO TO A SITTER? _____ DAYCARE? _____ PRESCHOOL? _____

IF YES, WHERE? _____

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FAMILY HISTORY

**** FAMILY INCLUDES ONLY PARENTS, SIBLINGS AND GRANDPARENTS OF CHILD***

NAME_____ **AGE**_____ **BIRTHDAY** _____

MEDICAL CONDITIONS	HAS CHILD HAD?		*CHILD'S FAMILY?		WHO?
NERVE OR MUSCLE DISORDERS	YES	NO	YES	NO	
BROKEN BONES/ BONE DISEASE	YES	NO	YES	NO	
BIRTH DEFECTS	YES	NO	YES	NO	
FREQUENT EAR INFECTIONS	YES	NO	YES	NO	
CYSTIC FIBROSIS	YES	NO	YES	NO	
MUMPS, MEASLES, CHICKEN POX	YES	NO	YES	NO	
WHEEZING/ ASTHMA	YES	NO	YES	NO	
PNEUMONIA/ CROUP	YES	NO	YES	NO	
EYE PROBLEMS/ POOR VISION	YES	NO	YES	NO	
DENTAL PROBLEMS	YES	NO	YES	NO	
HEARING PROBLEMS	YES	NO	YES	NO	
HAY FEVER/ ALLERGIES	YES	NO	YES	NO	
ECZEMA/ SKIN PROBLEMS	YES	NO	YES	NO	
ANEMIA/ BLOOD PROBLEMS/ EASY BLEEDING	YES	NO	YES	NO	
ARTHRITIS	YES	NO	YES	NO	
ULCERS/ STOMACH PROBLEMS	YES	NO	YES	NO	
BLOOD TRANSFUSIONS	YES	NO	YES	NO	
DIARRHEA/ CONSTIPATION	YES	NO	YES	NO	
HEART ATTACK BEFORE AGED 55 YEARS	YES	NO	YES	NO	
LEARNING DISORDERS/ SCHOOL PROBLEM	YES	NO	YES	NO	
MENTAL RETARDATION	YES	NO	YES	NO	
KIDNEY/ BLADDER PROBLEMS/ BEDWETTING	YES	NO	YES	NO	
DIABETES	YES	NO	YES	NO	
SEIZURES/ CONVULSIONS	YES	NO	YES	NO	
HEART DISEASE/ ABNORMAL HEART RHYTHMS AS A CHILD OR TEENAGER	YES	NO	YES	NO	
HIGH BLOOD PRESSURE	YES	NO	YES	NO	
HIGH CHOLESTEROL	YES	NO	YES	NO	
LUNG DISEASE/ TUBERCULOSIS	YES	NO	YES	NO	
SEXUALLY TRANSMITTED DISEASES/ HIV	YES	NO	YES	NO	
MENTAL/ EMOTIONAL DISORDERS	YES	NO	YES	NO	
THYROID DISEASE	YES	NO	YES	NO	
CHILDHOOD CANCER	YES	NO	YES	NO	
MIGRAINES/ HEADACHES	YES	NO	YES	NO	
MONO/ HEPATITIS/ LIVER PROBLEMS	YES	NO	YES	NO	
SMOKE OR USE TOBACCO	YES	NO	YES	NO	
CONSUME ALCOHOLIC BEVERAGES	YES	NO	YES	NO	
USE RECREATIONAL DRUGS	YES	NO	YES	NO	
DEATH OF ANY SIBLING	YES	NO	YES	NO	
SIDS/ APNEA/ SNORING/ SLEEPING ISSUES	YES	NO	YES	NO	
FREQUENT TONSILLITIS/ SINUSITIS	YES	NO	YES	NO	
ADENOID PROBLEMS	YES	NO	YES	NO	
LUPUS/ AUTOIMMUNE DISORDERS	YES	NO	YES	NO	

**** FAMILY INCLUDES ONLY PARENTS, SIBLINGS AND GRANDPARENTS OF CHILD***

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Dr. Dina Bowen 1601 Health Center Pkwy, building 900 Yukon, OK 73099

Email: medicalrecords@shgcvp.com **Phone: (405) 577-6700**

Fax: (405) 265- 4135

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patient Name: _____ **Date of Birth**: _____

Patient Name: _____ **Date of Birth**: _____

Patient Name: _____ **Date of Birth**: _____

Patient Name: _____ **Date of Birth**: _____

I hereby authorize the release of my child's medical records to Canadian Valley Pediatrics from:

DOCTOR: _____

ADDRESS: _____

CITY: _____ **STATE**: _____ **ZIP CODE**: _____

PHONE: _____ **FAX**: _____

PLEASE INCLUDE VACCINE RECORD

For the purpose of: (__) Continuing or transfer care (__) Vaccine record (__) Legal matters

_____Release information concerning the following dates: from _____ to _____

_____Complete medical record

_____Other (specify): _____

I (__) **DO** or (__) **DO NOT** (check one & initial here _____) consent to the release of information relating to psychiatric or psychological testing or treatment, alcohol and/or drug abuse diagnosis/treatment, or HIV (AIDS) testing.
I, the parent/guardian, agree that a photocopy or fax of this authorization may be considered valid, this authorization shall be valid for 100 days from the date of signature, and that this authorization can be revoked in writing at any time prior to the expiration date. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected.

Relationship to Patient (circle one): ***self*** ***mother*** ***father*** ***guardian***

Parent/Guardian Printed Name: _____

Signature: _____ **Date**: _____

PATIENT(S) & D.O.B.:_____

DUE TO THE MASSIVE AMOUNTS OF OUTSTANDING BALANCES, AFTER HOURS CALLS FOR NON EMERGENT ISSUES, AND MISSED APPOINTMENTS THAT COULD BE GIVEN TO TRULY ILL PATIENTS, OUR OFFICE WILL BE IMPLEMENTING A FEW CHANGES.

BEGINNING JANUARY 1ST, 2022:

- ANY PATIENT ACCOUNTS WITH OUTSTANDING BALANCES PAST 120 DAYS WILL BE SENT TO COLLECTIONS. IT IS THE PATIENTS RESPONSIBILITY TO ASK ABOUT BALANCES. OUR OFFICE IS NOT RESPONSIBLE FOR THE PATIENT NOT RECEIVING BILLING STATEMENTS.
- ANY AFTER HOURS CALLS FROM PATIENTS THAT ARE NOT TRUE MEDICAL EMERGENCIES WILL BE BILLED A FEE OF $25 (PER CALL). THIS INCLUDES BUT NOT LIMITED TO: APPOINTMENT REQUESTS, MEDICATION REQUESTS, AND MEDICATION DOSAGES.
- ANY APPOINTMENT IN WHICH THE PATIENT DOESN'T SHOW OR IF A 24 HOUR CANCELLATION CALL ISN'T GIVEN DIRECTLY WITH SOMEONE IN OUR OFFICE, THERE WILL BE A FEE OF $25 BILLED TO THE GUARANTOR OF THE PATIENT(S). WHEN YOU SCHEDULE AN APPOINTMENT AND DO NOT COME FOR THAT VISIT THAT IS TAKING A TIME THAT A TRULY SICK KID COULD BE SEEN. WITH THE CURRENT COVID PANDEMIC APPOINTMENT TIMES ARE ALWAYS NEEDED.

AS A COURTESY FROM OUR OFFICE WE SEND REMINDERS FOR ALL APPOINTMENTS TO THE PATIENTS. THESE REMINDERS ARE SENT VIA TEXT AND EMAIL TO THE INFORMATION PROVIDED BY THE PATIENT. WE ASK IF THERE ARE ANY CHANGES BUT ULTIMATELY THE PATIENT IS RESPONSIBLE FOR PROVIDING THE CORRECT INFORMATION.

DR. BOWEN

SIGN AND DATE: _____

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