Welcome to Stanley H. Schwartz, MD INC.!

Thank you for choosing Stanley H. Schwartz, MD INC as your child's primary healthcare provider. We are pleased that you trust us with your child's health needs.

Please complete the following forms to help us best serve you. The more specific you are in your responses allows us to understand your health needs better. If you have questions about any of the items on the form, please ask one of our team members to assist you.

PATIENT INFORMATION			
PATIENT'S NAME (Last, First, Middle)			TODAY'S DATE
DATE OF BIRTH	SEX ☐MALE ☐FEMALE		SOCIAL SECURITY NUMBER
HOME ADDRESS			APT #/COMPLEX #
CITY	STATE	ZIP	PHONE NUMBER
NAME OF SCHOOL/DAYCARE			SCHOOL PHONE NUMBER
SCHOOL STREET ADDRESS			
CITY		STATE	ZIP

PARENT INFORMATION			
MOTHER'S NAME		DRIVER'S LICENSE #	DATE OF BIRTH
MARITAL STATUS	SOCIAL SECURITY NUMBER		OCCUPATION
EMPLOYER NAME			LENGTH OF EMPLOYMENT
BUSINESS STREET ADDRESS			PHONE
CITY		STATE	ZIP
HOME ADDRESS(IF DIFFERENT THAN PATIENT'S)			APT #/COMPLEX #
CITY		STATE	ZIP
TELEPHONE	CELL		FAX
FATHER'S NAME		DRIVER'S LICENSE #	DATE OF BIRTH
MARITAL STATUS	SOCIAL SECURITY NUMBER		OCCUPATION
EMPLOYER NAME			LENGTH OF EMPLOYMENT
BUSINESS STREET ADDRESS			PHONE
CITY		STATE	ZIP
HOME ADDRESS(IF DIFFERENT THAN PATIENT'S)			APT #/COMPLEX #
CITY		STATE	ZIP
TELEPHONE	CELL		FAX

PATIENT'S NAME (Last, First Middle)	DATE OF BIRTH	TODAY'S DATE

GUARDIAN INFORMATION

LEGAL GUARDIAN: ☐ PARENTS ☐ MOTHER ONLY ☐ FATHER ONLY ☐ FOSTER PARENT ☐ OTHER:

NAME OF LEGAL GUARDIAN (IF DIFFERENT THAN ABOVE)	HOME	CELL

HOME ADDRESS		
CITY	STATE	ZIP

INSURED PERSON/SUBSCRIBER

NAME OF PRIMARY SUBSCRIBER	TELEPHONE
STREET ADDRESS	CITY / STATE/ ZIP
RELATIONSHIP TO THE PATIENT	DATE OF BIRTH

INSURANCE INFORMATION

PRIMARY INSURANCE NAME		SECONDARY INSURANCE	
ID NO.	GRP. NO.	ID NO.	GRP. NO.
STREET ADDRESS		STREET ADDRESS	
CITY / STATE/ ZIP	TELEPHONE	CITY / STATE/ ZIP	TELEPHONE

EMERGENCY NOTIFICATION

(List the Closest Relative NOT living with the Patient)

NAME		RELATIONSHIP TO THE PATIENT
WORK PHONE	CELL PHONE	HOME PHONE
STREET ADDRESS		APT #/COMPLEX #
CITY	STATE	ZIP

THE FOLLOWING IS REQUIRED TO MAINTAIN COMPLIANCE WITH FEDERAL REGULATIONS

PREFERRED LANGUAGE	**PATIENT'S RACE**		**ETHNICITY**
☐ English	☐ Asian	☐ Native Hawaiian/Pacific Islander	☐ Hispanic or Latino
☐ Spanish	☐ White	☐ Black /African American	☐ Not Hispanic or Latino
☐ Other:	☐ Decline to State	☐ Native American/Alaskan Native	☐ Decline ☐ Unknown
		☐ Unknown	

PREFERRED PHARMACY

Local Pharmacy Name	Street/Intersection	City	Phone Number (If Known)

PATIENT'S NAME (Last, First Middle)	DATE OF BIRTH	TODAY'S DATE

ASSIGNMENT OF BENEFITS

Please, remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies may pay fixed allowances for certain procedures and others pay a percentage of the charges. **IT IS YOUR RESPOSIBILITY TO PAY ANY DEDUCTIBLE AMOUNT, CO-INSURANCE, CO-PAYMENT , OR ANY BALANCE NOT PAID BY THE INSURANCE. IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGES FOR OFFICE VISIT BE PAID AT THE CONCLUSION OF THE VISIT.**

If this account is assigned to an attorney for collection and/or suit the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.
To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's records. I hereby, assign all medical and /or surgical benefits to which I am entitled including Medical/ Medicaid; private insurance and other health plans to Stanley H. Schwartz, MD, Inc.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am responsible for all the charges whether not paid by my said insurance. I hereby, authorize said assignee to release to my insurance all information necessary to secure payment of medical services.

Initials

CONSENT FOR THERAPEUTIC AND DIAGNOSTIC TREATMENTS OF MINORS

I, We,_____/_____
(Please, Print your Names)

the parents(s) of _____ a minor do consent to
(Please, Print Name of Child or Minor)
and authorize Stanley H. Schwartz, MD to administer all diagnostic and therapeutic treatments that may be considered advisable or necessary in his judgment at the office of the above address or hospital.

Initials

PROVIDER'S DISCLOSURE TO PATIENT OR PARENT/GUARDIAN ON IMMUNIZATION RECORD SHARING

This health care provider will share some immunization and other health-related information on your child with the California Immunization Registry Program administered by the San Bernardino County Department of Public Health and the Riverside County Public Health Department unless you refuse to allow the sharing. This information will only be used to help give your child immunization or to let you know when immunizations are due. This information can only be used to provide or facilitate provision of third-party payment for immunization and to provide statistical immunization information without patient identification. This information may also be shared with the California Department of Health Services unless you refuse such sharing.

The California Immunization Registry Program will share this information with other doctors, clinics, or hospitals to whom you take your children to medical care and when they request for it. The Riverside County Department of Public Health, San Bernardino County Department of Public Health and any health care providers are required by law to keep this information confidential.

The only information we will share Is the following:

- Your child's name, date of birth and the place of birth
- Your child's current address and telephone number
- Your child's gender
- Your name and current address and telephone number
- Dates and types of immunizations your child has received
- Manufacture and lot number for each immunization received
- Any serious reaction your child had to the immunizations
- Other non-medical information to help make sure that this is your child's record

California Immunization Registry Program may also share the same information without your address or phone number with schools, other public health and welfare agencies, health care plans and other persons or entities when disclosure of the information is specifically authorized by law. These persons and entities can use this information for public health and insurance purposes.

You have the following rights:

- To refuse to let us share this information with California Immunization Registry Program now and at any time.
- To refuse to get reminders when immunizations are due.

PATIENT'S NAME (Last, First Middle)	DATE OF BIRTH	TODAY'S DATE

- To inspect your child's immunization record in the California Immunization Registry Program and report any errors.
- To request the names and addresses of anyone with whom this information has been shared.

If you wish to exercise these rights, including refusing to have the information shared, please inform us. You have the right to contact:

If you are a Riverside County resident and a San Bernardino County resident:

Riverside County Community Health Agency
Immunization Registry Program
P.O. Box 7600
Riverside CA 92513 — 9959

Initials

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I, _____, Patient (or representative for patient) of Stanley H. Schwarz, MD,, Inc. (herein known as 'Provider'), have been given a copy of the Notice of Privacy Practices (NOPP). I understand Provider may amend the NOPP at any time, and that I may obtain a copy of the revised NOPP by request. I understand that the HIPAA law grants Provider authorization to use and disclose my medical records for treatment/care and payment operations, as outlined in the NOPP.

☐ Privacy Policy refused by patient/guardian. Reason:_____

Initials

COMMUNICATION AUTHORIZATION

Provider may contact me regarding my diagnosis, results, treatment and care, or payment through mail or the following means:

	(Include Area Codes for all #s)	OK to leave message?
Home Phone:	_____	☐ Yes ☐ No
Work Phone:	_____	☐ Yes ☐ No
Cell Phone:	_____	☐ Yes ☐ No
Email:	_____	

I understand that the above means of communication are NOT considered private/secure methods of communication

I understand that I may authorize Provider to share medical/billing information about my care to relatives, caretaker, close friends, etc., and shall list them below:

Name(s)	Relationship(s)	Phone #(s)
_____	_____	_____
_____	_____	_____

Communication authorization shall expire under the following circumstances:

1. Upon written request for records release for reason of transfer of care.
2. Upon written request by patient or legally responsible person.
3. In the case of a minor reaching the age of 18.

Initials

CONSENT FOR SERVICES BY PHYSICIAN ASSISTANT OR NURSE PRACTITIONER

The patient and/or responsible relative or person acknowledges that he/she has been informed that a Physician Assistant or Nurse Practitioner may provide services under the direction and supervision of a Physician.

The undersign consents to authorize said Physician Assistant or Nurse Practitioner to administer and perform any and all medical examinations, treatments, diagnostic procedures and immunization against diseases which may now or during the course of the patients care be deemed advisable by the supervising physician.

Initials

PATIENT'S NAME (Last, First Middle)	DATE OF BIRTH	TODAY'S DATE

FINANCIAL POLICY

Thank you for choosing us as your Health care provider!

The following is our Financial Policy. It is our goal and objective that you receive optimal and continuity of care to maintain your health and well being. Therefore, please do not hesitate to ask questions to any of our office staff and our health care providers.

We ask all of our patients to read and sign our Financial Policy and complete a Patient Information Form prior to seeing the doctor. All or the required signatures must be affixed in all forms requiring signatures or initial before treatment can be rendered. Affixing your signature gives our staff and health care providers consent to treat and provide health services to you us our patient.

We accept cash, checks and credit card transactions as a form of payment for services rendered. As a courtesy to you, we will assist in the processing of your insurance claim for reimbursement. However, you must understand that:

Your insurance policy is a contract between you and your health insurance company. We are not a party to that contract. OUR RELATIONSHIP IS WITH YOU AND NOT WITH YOUR HEALTH INSURANCE.
All charges incurred are your responsibility whether your health insurance pays or not. Not all services are a covered benefit in some health plans. Fees for these services along with unpaid deductibles and co-payments are due at the time of service.
If the insurance company does not pay your balance in full within 30 days, we ask that you contact them to help speed up things up.
If the insurance company does not pay in full within 45 days, we ask that you pay the balance due with cash, check, money order or credit card. Returned checks and balances older than 45 days may be subject to additional collection fees and interest charges.

We understand that temporary financial problems may affect timely payment of your balance. Please, call our office as soon as possible when there are financial or demographic changes.

Again, thank you for choosing us as your health care provider. We appreciate your trust in us and the opportunity to serve you with your health issues.

I, _____, have read and understood the above Financial Policy

(Please Print Your Name here)

of Stanley H. Schwartz, MD, INC.

_____ _____

SIGNATURE OF PATIENT/ PARENT/ GUARDIAN **RELATIONSHIP TO PATIENT(PARENT/WIFE/GUARDIAN,…ETC.)**

_____

DATE SIGNED

PATIENT'S NAME (Last, First Middle)	DATE OF BIRTH	TODAY'S DATE

FOR OFFICE USE ONLY:
Was copy of immunization record given? ☐ YES ☐ NO/PROMISED TO BRING TO NEXT APPOINTMENT

CHILD HEALTH HISTORY

HISTORY OF PREGNANCY WITH THIS CHILD

During which month of pregnancy did the mother first see the doctor?
_____ month

GESTATION	DELIVERY
☐ FULL TERM ☐ PREMATURE *by* _____ *months*	☐ NORMAL/VAGINAL ☐ CESAREAN SECTION

If the baby was born at home, were blood tests for newborn screening done?
☐ YES ☐ NO

Did the mother have any illness or problems?(Including sexually transmitted or other communicable disease)	**YES**	**NO**	Did the mother use any non-prescribed drugs?(Tobacco, alcohol, *street drugs*, over-the-counter or home remedies)	**YES**	**NO**
Did the mother take any medications prescribed by your doctor?	**YES**	**NO**	Did the baby go home with the mother from the hospital?	**YES**	**NO**
Did the baby have any problems during the first week of life?	**YES**	**NO**	Was more than one baby born?	**YES**	**NO**
			Did the baby receive any shots for Hepatitis B?	**YES**	**NO**

CHILD'S HISTORY

☐ MALE ☐ FEMALE	IS THIS CHILD ADOPTED ☐ YES ☐ NO

NAME OF HOSPITAL CHILD BORN AT

ADDRESS

CITY	STATE	ZIP

BIRTH WEIGHT (lbs, ozs)	LENGTH (inches)

FEEDING ☐ BREAST FEEDING ☐ BOTTLEFEEDING	FORMULA NAME (if applicable)

AGE WEANED BREASTFEEDING	AGE WEANED BOTTLE FEEDING
AGE TOILET TRAINED	THUMBSUCKING?

Is the child currently enrolled in WIC? ☐ YES ☐ NO

IMMUNIZATION INFORMATION

Is the immunization/vaccination current for patient's age? ☐ YES ☐ NO

Please give a copy of the immunization card to be filed in current patient's chart _____(initials)

ILLNESS HISTORY

HAS YOUR CHILD EVER HAD?

Measles, Chickenpox, Mumps, Rubella	**YES**	**NO**	Vomiting after eating, refusal to eat	**YES**	**NO**
Tuberculosis or positive TB test	**YES**	**NO**	Muscle Joint or bone problems	**YES**	**NO**
Tonsillitis, Sore Throat	**YES**	**NO**	Skin Problems	**YES**	**NO**
Problems with eyes or vision	**YES**	**NO**	Headaches or dizziness	**YES**	**NO**
Problems with ears or hearing	**YES**	**NO**	Convulsions, seizures, epilepsy	**YES**	**NO**
Difficulty breathing or snoring at night	**YES**	**NO**	Diabetes	**YES**	**NO**
Heart Problems	**YES**	**NO**	Thyroid problems	**YES**	**NO**
Asthma, bronchitis, or pneumonia	**YES**	**NO**	Allergies	**YES**	**NO**
Anemia, bleeding problems, blood transfusion	**YES**	**NO**	Problems with development or school performance	**YES**	**NO**
Stomach aches	**YES**	**NO**	Serious illness or accident	**YES**	**NO**
Diarrhea, Soiling self with stool	**YES**	**NO**	Surgery or hospitalization	**YES**	**NO**
Bladder or kidney Problems, wetting self or bed wetting	**YES**	**NO**	(GIRLS) Has she started her menstrual periods?	**YES**	**NO**
Constipation	**YES**	**NO**	(GIRLS) Are there problems with her menstrual periods?	**YES**	**NO**

PATIENT'S NAME (Last, First Middle)	DATE OF BIRTH	TODAY'S DATE

RECURRENT/CHRONIC ILLNESS HISTORY

ALLERGIES (*Include food, drugs, and materials)*

SYMPTOMS OF ALLERGIES *(Include rashes, stomach problems, and respiratory)*

RECURRENT/CHRONIC ILLNESS *(Please check if occurs 4 times or more each year)*

☐ ASTHMA ☐ ALLERGY/ SKIN ☐ ALLERGY RUNNY NOSE
☐ ABDOMINAL PAIN ☐ CONSTIPATION ☐ DIARRHEA
☐ DIABETES ☐ EAR INFECTION ☐ URINARY INFECTION
☐ VOMITTING ☐ SORE THROAT ☐ RASH
☐ OTHER _____

HOSPITALIZED IN THE LAST 5 YEARS? ☐ YES ☐ NO

IF YES, WHAT WAS THE DIAGNOSIS OF CONDITION WHEN HOSPITALIZED?

PAST SURGERY/SURGERIES *(Include the year)*

FAMILY HISTORY

NUMBER OF SIBLINGS IN THE FAMILY

_____ BROTHERS _____ SISTERS

PATIENT IS NUMBER _____ FROM THE ELDEST CHILD

PATIENT LIVES WITH
☐ PARENTS ☐ FOSTER ☐ OTHER _____

PARENT INFORMATION			**HOUSEHOLD INFORMATION**	Number of people in the home: _____
	MOTHER	**FATHER**	Are both parents living in the home? ☐ YES ☐ NO	
AGE			Does anyone at the home smoke, use drugs, or alcohol? ☐ YES ☐ NO	
HEIGHT			What language is spoken at home? ☐ English ☐ Spanish ☐ Other	
OCCUPATION			Do you live in a ☐ House ☐ Apartment ☐ Mobile Home ☐ Shelter ☐ Homeless	

HEALTH HISTORY: Does mother **(M)**, father **(F)**, brother **(B)**, sister **(S)**, uncle **(U)**, or grandparents **(GP)** have the following?:

			Which Family Member?				Which Family Member?
YES	**NO**	Diabetes		**YES**	**NO**	High Blood pressure	
YES	**NO**	Epilepsy or convulsions		**YES**	**NO**	Bleeding Disorder	
YES	**NO**	Mental Retardation		**YES**	**NO**	Tuberculosis	
YES	**NO**	Heart Disease		**YES**	**NO**	Allergy	
YES	**NO**	Cancer		**YES**	**NO**	Lung or Breathing Problems	
YES	**NO**	Kidney or Urinary Disease		**YES**	**NO**	Eye Disorder	
YES	**NO**	Bone or Joint Problem		**YES**	**NO**	Ear Disorder	