RejuveNature Medical
7787 W. Deer Valley Rd. Ste 299
Peoria, AZ 85382
www.RejuveNatureMedical.com
(623) 487-0002

Pediatric Intake Form **Date** _____

Name: _____
DOB: ___/___/___ Grade: _____

Address: _____ Phone: _____
_____ Work: _____
_____ Email: _____

Mother's Name and Occupation: _____

Father's Name and Occupation: _____

Emergency Contact and Phone #: _____

Legal Guardians and Phone #:_____

Parents are (circle): Married Separated Divorced Living Together
Other _____

Siblings? Names _____

Reason for Office Visit: _____

Regular Pediatrician Name and Address: _____
_____
_____

Child's Blood type (include RH factor) _____

Child's Height _____ Weight _____

Past Medical History

List All Surgeries & Hospitalizations, including date of occurrence:

1. _____ 3. _____
2. _____ 4. _____

List All Medications and Supplements/Homeopathics the child is currently taking:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

List All Past Medications the child has taken and how often:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

List All Known Allergies:

_____

_____

Indicate **Y (yes)** if the child gets the problem regularly, **N (no)** if the child never had the problem; and **P (past)** if the child had the problem in the past, but not recently. Please circle the correct one for your child.

Ear Infections: Y N P How often: _____
Colds: Y N P How often: _____
Strep Throat: Y N P How often: _____
Diarrhea/Constipation: Y N P How often: _____
How many times has the child taken antibiotics: _____Steroids: _____
Hearing Tests Normal: Y N Not Tested
Speech Impediments: Y N Past
Vision Tests Normal: Y N Not Tested
Learning Impediments: Y N Past

Does your child receive dental care? _____ Where and how often?

_____

How often are the bowl movements? _____stool description_____
How often does your child urinate? _____ color _____
Does your child have nightmares? _____ how often? _____
Any particular fears? _____
Does your child have emotional disturbances, learning difficulties or low attention span?

_____

_____

When your child is angry, how do they express it? _____

_____

When did your child start walking? _____ talking? _____
Is your child messy or neat? _____

Does your child show any of the following? (circle)

Bed wetting Thumb sucking Nail biting Nose picking Other _____

How is your child's relationship to other siblings? _____

How does your child do in school? _____

Does your child get along well with other children? _____

Family History

Allergies:	Y	N	P	Obesity:	Y	N	P
Tuberculosis:	Y	N	P	Mental Illness:	Y	N	P
Diabetes mellitus:	Y	N	P	Asthma:	Y	N	P
Cancer:	Y	N	P	Cardio. Disease:	Y	N	P

Mother's Pregnancy History

Age at conception: _____			Other children?	Y N	#_____
Smoking:	Y	N	Coffee:	Y	N
Nausea/Vomiting:	Y	N	Emotional Stress:	Y	N
Preeclampsia:	Y	N	Gestational Diabetes:	Y	N
Alcohol:	Y	N	Recreational Drugs:	Y	N
Prescription Drugs:	Y	N			

Length of Labor: _____ Vaginal Birth C-Section VBAC (circle one)

Traumatic Birth: Y N If Yes, please explain: _____

_____

What were the Apgar scores for your child _____

Health History of Child

Weight at Birth: _____ Health of baby at birth: _____

Child Breastfed: Y N How long? _____ When put on formula _____

Type of formula? _____ When was child put on solid food: _____

When did the child walk: _____ Talk: _____

When did the child develop teeth: _____

Jaundice as a baby:	Y	N	Colic:	Y	N
Cradle Cap:	Y	N	Anemia:	Y	N
Eczema/Psoriasis:	Y	N	Asthma/Wheezing:	Y	N
Diarrhea:	Y	N	Warts:	Y	N
Constipation:	Y	N	Nightmares:	Y	N
Finicky Eating:	Y	N	Bed-wetting:	Y	N
Poor Teeth:	Y	N	Tantrums:	Y	N
Chronic Sniffles:	Y	N	Disobedient:	Y	N
Bad Foot Odor:	Y	N	Fears/Phobia:	Y	N

Very Sweaty Baby	Y	N	Diaper Rash:	Y	N
Hyperactivity:	Y	N	Early Puberty:	Y	N
Growing Pains:	Y	N	Stomach Aches:	Y	N

Any Particular household stressors child has witnessed or gone through:

1. _____ 3. _____
2. _____ 4. _____

Toxin Exposure

Has the child ever lived near a:

Refinery Polluted area Home with leaded paint

Has the child ever lived in a house that had:

New carpeting Paint Cabinets Other refurbishing

Does the child seem particularly sensitive to:

Perfumes Gasoline Other vapors

Do you spray in your home:

Pesticides Herbicides Other chemicals

Does your child eat artificially colored or flavored foods? _____

_____

Does your child eat lunch meats/hot dogs preserved with nitrates? _____

_____

Typical Day's Diet

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Drinks: Water: _____ Soda: _____

Dairy: _____ Soy: _____

Other: _____

How often do you and your child eat out? What restaurants do you frequent?

_____

Habits

What are the main interests of your child? _____

_____

Does your child exercise? How often and what kind of exercise? _____

_____

How many hours of sleep does your child average? _____ Are they sleeping soundly?_____ Do they experience any of the following while sleeping? (circle)

Frequent nightmares Night terrors Sleep walking Bed Wetting Night sweats

Regular naps Wake up alert Wake up drowsy

RejuveNature
Medical

CONSENT TO TREAT YOUR CHILD

Thank you for choosing *RejuveNature Medical*. We realize that you have choices in the healthcare of you and your family, and we are dedicated to providing the best care possible for our patients.

Please read and sign the following:

I consent to the use and/or disclosure of my protected health information by *RejuveNature Medical* for purposes of diagnosing or providing treatment to me or obtaining payment for my health care bills. I consent to treatment and understand that my physician is a licensed Naturopathic Physician. I understand and agree that diagnosis or treatment of my child by Dr. Peachy may be conditioned upon my consent as evidence by my signature on this document.

Name of Parent/Guardian: _____ Date: __/__/__

Signature of Parent/Guardian: _____

PAYMENTS WILL BE BY:

CASH _____ CHECK _____ VISA _____ MASTERCARD _____

At time of payment, you will be given a copy of your superbill from our office. This will show diagnosis, services and charges. You can submit this form for reimbursement directly to your insurance company. Please let our front office know if you plan to submit your bill for insurance reimbursement. This will enable us to give you the appropriate information.

I understand and agree that health and accident insurance policies are an arrangement between an insurance company and me. I hereby authorize the undersigned physician to furnish medical information to my insurance carriers concerning this illness or accident. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible.

I also understand that if I suspend or terminate my care and treatment any fees for professional service rendered me will be immediately due and payable. Further more, any charges, fees or court costs incurred as a result of collection efforts will be added to my account balance.

Releases may be requested prior to specific procedures being performed (i.e. minor surgery, etc.)

_____ _____

Patient Signature Date

_____

Parent/Guardian Signature

REJUVENATURE MEDICAL

18555 N. 79TH Ave., Suite E-105 Glendale, AZ 85308
(623) 487-0002

I, _____, give permission to RejuveNature Medical to release any of my child's test results or medical information to anyone listed below:

1.

2.

3.

4.

5.

_____ _____

Parent/Guardian Signature Date

RejuveNature Medical
Rescheduled / Cancelled Appointments
After-hour / Emergency Appointments
NSF Check Fees
Insurance Reimbursement

PLEASE BE AWARE:

Appointments:

The patient is ALWAYS responsible to call **24 hours prior to the scheduled appointment time** to reschedule or cancel. Failure to do so will result in a $ 45.00 charge to the patient for the missed appointment.

If you need to reach a doctor after regular business hours, there will be a $75 fee for the urgent phone call**.** If you have an emergency, please call 911.

NSF Checks:

NSF checks that are returned to us will automatically mean a charge to the patient account of $25. The patient will be responsible to replace the amount of the check in addition to the $25 Non-Sufficient Funds amount.

Payment for services:

An insurance policy is a contract between you and your insurance company. The patient is ALWAYS responsible for payment of all charges incurred regardless of any insurance or other third party payment arrangements.

- Payment will be collected at the time of service.
- Any lab kits purchased are non-refundable after 30 days.
- Most insurance companies do not cover Alternative Medical procedures. This includes but is not limited to Acupuncture, Hydrotherapy, Vitamin injections, and Intravenous Nutrition.

The natural medicines that are prescribed by the center's physicians may be purchased here or at a store of your choice.

I certify that I have read and understand the above policies. I guarantee payment of all charges incurred as a patient of RejuveNature Medical.

_____

Signed:
Parent or Guardian (if minor):

_____

Date:

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of RejuveNature Medical's Notice of Privacy Practices. (Attached)

____ ___________________________

Patient or legally authorized individuals signature   Date

____ ___________________________

Printed Name   Relationship (parent, legal guardian, personal representative, etc.)

Revisions (if any):

____

____

____

____

- -

For office use only

- -

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because (please specify):

____

____

____

NOTICE OF PRIVACY PRACTICES

To our patients: This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information.

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.

2. Lawsuits and similar proceedings in response to a court or administrative order.

3. If required to do so by law enforcement official.

4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat

5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

6. To federal officials for intelligence and national security activities authorized by law.

7. To correctional institutions or law enforcement officials, if you are an inmate or under the custody of a law enforcement official.

8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not

including psychotherapy notes. You must submit your request in writing to RejuveNature Medical 7787 W. Deer Valley Road, Suite 299 Peoria, AZ 85382. Note: *We must respond to this request within 30 days.*

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to, RejuveNature Medical 7787 W. Deer Valley Road, Suite 299 Peoria, AZ 85382. You must provide us with a reason that supports your request for amendment.

Note: *We must respond within 60 days. The Privacy Officer or the patient's physician will usually do this. If the physician believes the information is complete and accurate, the physician can refuse to make any changes.*

5. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact the front desk receptionist.

6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Office Manager at RejuveNature Medical, 7787 W. Deer Valley Road, Suite 299 Peoria, AZ 85382. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact the Office Manager at RejuveNature Medical.