DATE:(*FECHA*) _____ please print *letra de molde por favor*

REGISTRATION INFORMATION SHEET

YOUR NAME (*NOMBRE SUYO*) _____ RELATIONSHIP TO THIS CHILD _____
PERSON FILLING OUT THE FORM (*PERSONA LLENANDO LA FORMA*) PARENTESCO CON ESTE NIÑO(A)

PATIENT'S NAME _____
NOMBRE DEL PACIENTE LAST (*APELLIDO*) FIRST (*NOMBRE DE PILA*) MIDDLE (*SEGUNDO*)

MAILING ADDRESS _____
DIRECCIÓN POSTAL NUMBER (*NUMERO*) STREET (*CALLE*) CITY (*CIUDAD*) ZIP (*ZONA*)

HOME ADDRESS _____
DIRECCIÓN DEL HOGAR NUMBER (*NUMERO*) STREET (*CALLE*) CITY (*CIUDAD*) ZIP (*ZONA*)
IF DIFFERENT FROM ABOVE (*SI DIFERENTE DE ARRIBA*)

CHILD'S DATE OF BIRTH _____ AGE _____
FECHA DE NACIMIENTO DEL NIÑO(A) MO (*MES*) DAY (*DIA*) YEAR (*AÑO*) *EDAD*

CHILD'S SOCIAL SECURITY # _____ CHILD'S HOME PHONE # _____
 # DE SEGURO SOCIAL DEL NIÑO(A) *# DE TELEFONE DEL NIÑO(A)*

CHILD LIVES IN THE HOME OF : MOTHER FATHER GRANDPARENT FOSTER CARE GUARDIAN RELATIVE
EL NIÑO(A) VIVE EN LA CASA DE: MADRE *PADRE* *ABUELO* *FOSTER CARE* *TUTOR* *PARIENTE*

MOTHER'S NAME _____ SOCIAL SECURITY # _____
NOMBRE DE LA MADRE LAST (*APELLIDO*) FIRST (*NOMBRE DE PILA*) *# DE SEGURO SOCIAL*

DATE OF BIRTH _____ DRIVERS LICENCE _____
FECHA DE NACIMIENTO MO (*MES*) DAY (*DIA*) YEAR (*AÑO*) *LICENCIA DE MANEJAR* STATE (*ESTADO*)

OCCUPATION _____ EMPLOYER _____ EMPLOYER'S PHONE # _____
OCUPACIÓN *PATRÓN* *# DE TELEFONO DEL PATRÓN*

FATHER'S NAME _____ SOCIAL SECURITY # _____
NOMBRE DEL PADRE LAST (*APELLIDO*) FIRST (*NOMBRE DE PILA*) *# DE SEGURO SOCIAL*

DATE OF BIRTH _____ DRIVERS LICENCE _____
FECHA DE NACIMIENTO MO (*MES*) DAY (*DIA*) YEAR (*AÑO*) *LICENCIA DE MANEJAR* STATE (*ESTADO*)

OCCUPATION _____ EMPLOYER _____ EMPLOYER'S PHONE # _____
OCUPACIÓN *PATRÓN* *# DE TELEFONO DEL PATRÓN*

GUARDIAN'S NAME _____ RELATIONSHIP _____
NOMBRE DEL TUTOR *PARENTESCO*

DATE OF BIRTH _____ DRIVERS LICENCE _____
FECHA DE NACIMIENTO MO (*MES*) DAY (*DIA*) YEAR (*AÑO*) *LICENCIA DE MANEJAR* STATE (*ESTADO*)

SOCIAL SECURITY # _____ AGENCY NAME & PHONE # _____
 # DE SEGURO SOCIAL

IN CASE OF EMERGENCY ***ENCASO DE EMERGENCIA***

NAME: TELEPHONE # RELATIONSHIP
NOMBRE: _____ *# DE TELEFONO* _____ *PARENTESCO* _____
PERSON WHO DOES NOT LIVE IN THE HOME (*ALGUIEN QUE NO VIVE EN EL HOGAR*)

HOW DO YOU USUALLY PAY FOR YOUR VISITS: CASH MEDI-CAL INSURANCE
COMO PAGA LA VISITA USUALMENTE : CONTADO MEDI-CAL ASEGURANZA _____
CIRCLE ONE PLEASE *FAVOR DE CIRCULAR UNO*

PLEASE LIST THE OTHER PEOPLE LIVING IN THE HOUSE FAVOR DE HACER UNA LISTA DE LOS QUE VIVEN EN EL HOGAR

NAME (NOMBRE) DATE OF BIRTH (FECHA DE NACIMIENTO) RELATIONSHIP TO THIS CHILD (PARENTESCO CON ESTE NIÑO(A)

_____
_____
_____
_____
_____

if you need more space please turn the page over si requiere mas espacio voltea la pagina por favor

Dr. Timothy D. Watson

CHILD HEALTH HISTORY

HISTORY OF PREGNANCY WITH THIS CHILD:

During which month of pregnancy did you first see the doctor?_____month
How long was your pregnancy?_____months

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

Did you have any illnesses or problems? (Including sexually transmitted or other communicable diseases)	YES	NO	Did you use any non-prescribed drugs? (tobacco, alcohol, "street drugs", over-the-counter or home remedies)	YES	NO
Did you take any medications prescribed by your doctor?	YES	NO	Did the baby go home with you from the hospital?	YES	NO
Did you have a difficult/abnormal delivery/C-section?	YES	NO	Was more than one baby born?	YES	NO
Did the baby have any problems during the 1st week of life?	YES	NO	Did baby receive any shots for Hepatitis B?	YES	NO

CHILD'S HISTORY: ☐MALE ☐FEMALE Is this child adopted? ☐YES ☐NO Birth Weight: _____pounds _____ounces Length:_____inches

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/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 transfusions	YES	NO	Problems with development or school performance	YES	NO
Stomachaches	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	YES	NO	(GIRLS) Has she started her periods?	YES	NO
Constipation	YES	NO	(GIRLS) Are there problems with her periods?	YES	NO

FAMILY HISTORY: Does mother (M), father (F), brother (B), sister (S), aunt (A), uncle (U), or grandparent (GP)have:

			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 problems		YES	NO	Ear disorder	

PARENT INFORMATION:

	Mother:	Father:
Age:		
Height:		
Occupation:		

HOUSEHOLD INFORMATION: Number of people in home:_____
Are both parents living in the home? ☐Yes ☐No
Does anyone in the home smoke, or use drugs or alcohol? ☐Yes ☐No
Language spoken in the home:_____
Do you live in a: ☐House ☐Apartment ☐Mobile Home ☐Shelter ☐Homeless

Patient Identification:

Signature:_____ **Date:**_____
Relationship to Child:_____
Reviewer's Signature:_____ **Date:**_____

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information *(PHI)*. The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number

☐ Other _____

_____

_____ _____
Patient Signature Date

_____ _____
Print Name Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for *PHI* to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of *PHI* disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type key: T=Treatment Records: P=Payment Information; O=Healthcare Operations
(3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other

MISSION PEDIATRIC MEDICAL GROUP, INC

PRIVACY NOTICE ACKNOWLEDGEMENT

I understand that as part of my healthcare, Mission Pediatric Medical Group originates and maintains health records describing my child's health history, examination, symptoms, diagnoses, test results, treatment and any plans for future treatment. I understand that this information serves as:

1. A basis for planning my child's healthcare and treatment.
2. A means of communication among other health professionals who contribute to my child's care.
3. A source of information for applying my child's diagnosis and treatment information to my bill.
4. A means by which third party payers (insurance companies) can verify that services billed were actually rendered.
5. A tool for routine healthcare operations.

I understand and have been provided with a notice of privacy practices which provide a more complete description of information and disclosures. I understand that I have a right to review the notice before signing it. I understand that this organization has the right to change their notice and practices and that prior to implementation will mail a copy of the revised notice to the address that I have provided. I understand that I have the right to restrict as to how my information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this organization is not required to agree to the restrictions requested.

I acknowledge receipt of Mission Pediatric Medical Group, Inc.'s privacy practices.

Printed Name of Patient: _____

Printed Name of Parent: _____

Signature of Parent: _____

Date: _____

AUTHORIZATION TO TREAT A MINOR

I, the parent, or legal guardian, acting on behalf of _____
Minor's Name

_____, hereby authorize physical examinations, diagnostic tests (including
Date of Birth

blood, urine and skin tests), and non-surgical outpatient medical treatment of the conditions diagnosed for the above minor to be performed by physicians, physician supervised assistants, and/ or nurse practitioners and staff at Timothy D. Watson M.D. / Wanda Abreu M.D. / Faize Mustafa Infante, M.D. \ 215 W. Fourth Street, Perris CA 92570 / 6926 Brockton Ave. Ste. #6, Riverside, CA 92506

_____ _____
Signature of Parent/Guardian Date

AUTORIZACIÓN PARA DAR TRATMIENTO A UN MENOR DE EDAD

Yo, padre de, o con la tutela legal de _____
Nombre del menor

_____ por medio de ésta autorizo examenes fisicos, pruebas diagnósticas (incluyendo
Fecha de nacimiento

pruebas de sangre, de la orina, y de la piel), y tratamiento no-quirúrgico para el tratamiento medico externo de las condiciones diagnosticadas en el menor nombrado arriba conducidos por medicos, asistentes supervisados por medicos, y/ o enfermeras practicantes y personal de Timothy D. Watson M.D. / Wanda Abreu M.D. / Faize Mustafa Infante, M.D. \
215 W. Fourth Street, Perris CA 92570
6926 Brockton Ave. Ste. #6, Riverside, CA 92506

_____ _____
Firma del Padre/Tutor Legal Fecha

Revised Date
2/28/11

County of Riverside Health Services Agency
Department of Public Health

CHILDHOOD LEAD POISONING EVALUATION QUESTIONNAIRE

The following questions are to be answered by the parents/guardians of CHDP eligible children under 72 months of age at EACH periodic health assessment.

QUESTIONS	DATE									
1. Does your child live in, or regularly visit a building or house built before 1960, with chipping paint or with recent or ongoing remodeling? (Day care center, preschool, home of baby sitter, relative or friend)	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
2. Does your child live with someone whose job or hobby involves exposure to lead? (Painting, welding, soldering, automobile battery manufacturing, battery recycling, automotive repair or pottery)	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
3. Do you use home remedies or cosmetics that contain lead? (Azarcon, Greta, Albayalde, Pay-loo-ah, Alkohl, or Kohl)	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
4. Does your child live near an active lead melting or battery recycling plant or other industry likely to release lead?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
5. Does your child have a parent, brother, sister, housemate or playmate who is being treated or followed up for lead poisoning?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
6. Does your child eat or chew on non-food items, such as dirt or paint chips?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
7. Do you use imported or homemade dishes or containers to serve, prepare, or store food or drinks? (Clay pots, lead soldered pots, ceramic ware, leaded glass)	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Information Reviewed: (Provider Initials)										

Patient Name_____ **DOB:** _____

Childhood Tuberculosis Evaluation Questionnaire
Cuestionario Evaluatorio Infantil Sobre Tuberculosis

The following questions are to be answered by the parents/guardians of CHDP eligible patients at *EACH* periodic health assessment.

Name of Child_____ **Medical Record #** _____

DOB: _____ **Age:**_____

1. Has your child ever had a positive tuberculosis (TB) skin test? If so, what date?
¿Ha recibido su niño/a un resultado positivo del examen de tuberculosis?

   YES / *Si* ☐ Date_____ *(Fecha)* NO ☐

2. Has a family member or anyone the child sees regularly had a history of confirmed or suspected TB?
¿Hay alguin en su hogar o que visita a su niño/a frecuentemente que pueda haber tenido tuberculosis?

   YES / *Si* ☐ NO ☐

3. Was your child born in or travel to high TB prevalence countries? (Asia, Africa, Latin America)
¿Nació su niño/a fuera de los Estados Unidos o visita lugares donde hay tuberculosis? (Africa, Asia, o Latino America)

   YES / *Si* ☐ NO ☐

4. Do you have any family members or frequent visitors who are from Africa, Asia, or Latin America?
¿Tiene usted familiares provenientes de Africa, Asia, o Latino America viviendo en su hogar?

   YES / *Si* ☐ NO ☐

5. Does your child or any person living in the household have HIV infection or other problems with their immune system?
¿Hay alguien en el hogar de su niño/a con la infección de VIH o con problemas con su sistema immuno?

   YES / *Si* ☐ NO ☐

6. Does the child live in and out of home placements (such as foster care or residential facilities)?
¿El niño ha sido asignado a diferentes hogares (como hogares de crianza)?

   YES / *Si* ☐ NO ☐

7. Does your child live with any adults who have been in prison in the last 5 years?
¿Ha vivido su su niño/a con alguien que estuvo en la carcel en los últimos 5 años?

   YES / *Si* ☐ NO ☐

8. Does your child live with, or is frequently exposed to individuals who are homeless, migrant farm workers, users of street drugs, or residents in nursing homes?
¿Ha vivido su su niño/a con personas sin hogar, ha sido expuesto frecuentemente a trabajadores del campo, personas que usan drogas ilegales o que residen en casas de convalecencia?

   YES / *Si* ☐ NO ☐

Reviewed by_____ **Date**_____

What Does Your Child Eat?

Circle the foods your child ***eats*** every day or at least 3 times per week:

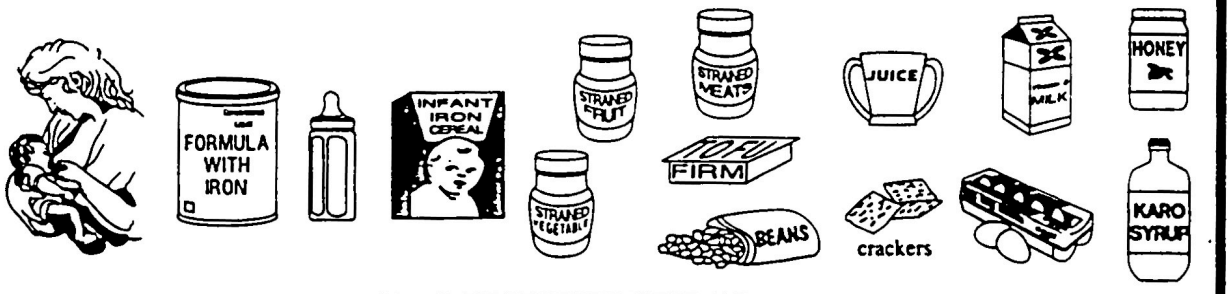
Write everything your baby or child ate and drank yesterday:

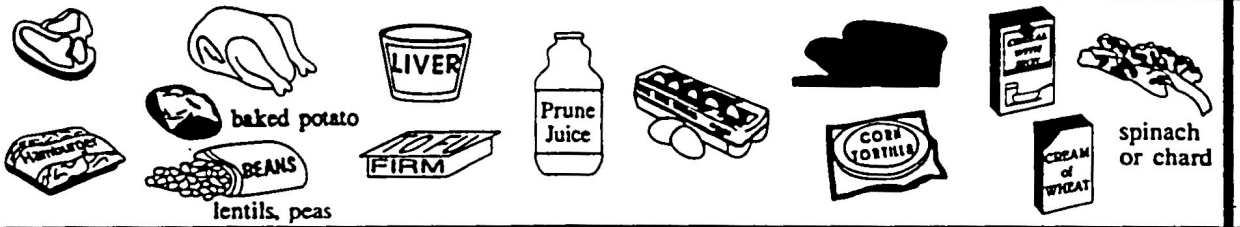
How does your baby or child feel about mealtimes?

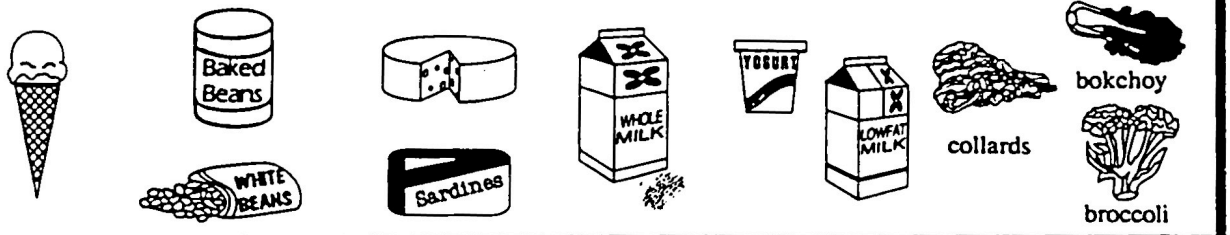
Circle if your baby or child receives food from:

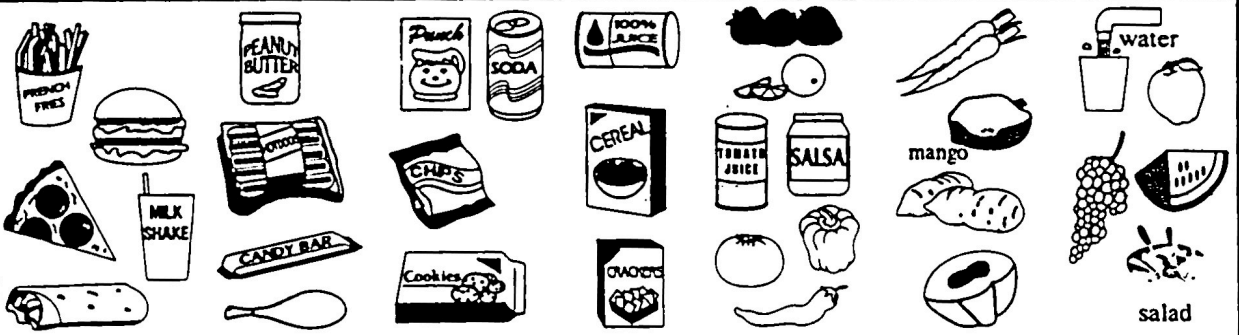
Food Stamps **School Lunch** **Head Start** **WIC**

Circle if your baby or child uses:









Circle activities your baby or child does every day:

Baby or Child's Name: _____ **Date:** _____

Office Use Only

✓one topic/visit

Food Recall:
- __ set meal & snack times
- __ Variety/Basic 4
- __ # srvgs: 5-7-2-2

Mealtime:
- __ pleasant mealtimes
- __ good food supply
- __ nutrition referral
- __ supplement use
- __ bottle tooth decay
- __ soft toothbrush & tiny amt toothpaste
- __ parent helps with brushing until 5 yr.

Baby:
- __ breastfeeding
- __ formula prep
- __ starting solids
- __ all food groups
- __ weaning/cup
- __ no honey or Karo Syrup until 1 yr.
- __ cow milk at 1 year

Iron:
- __ 2 - 3 srvgs/day
- __ try new foods
- __ read cereal labels
- __ vitamin C with meal
- __ pica behavior

Calcium:
- __ 2 - 3 srvgs/day : 1-10 yr: 16 oz/day
- __ too much milk
- __ type of milk : whole: 1-2 yr low/non: 2 & up

Snacks/Fast Foods:
- __ foods lower in fat & sugar

Fruits & Vegetables
- __ 5 -9 svg/day
- __ vitamin A & C rich foods daily
- __ give water daily

Activity:
Frequency: _____
Duration: _____

TV: 2 hr. or less/day

CHILD HEALTH AND DISABILITY PREVENTION (CHDP) PROGRAM
PRE-ENROLLMENT APPLICATION

Instructions to the Parent or Patient:

- In order to receive a health examination today at no charge, you must provide the information required on this form. The information you give is confidential. This is a voluntary program.

  Is the patient less than 19 years of age? ☐ Yes ☐ No

  How many people are in your family? _____

  How much money does your family make before taxes? $_____ (Monthly) Or $_____ (Yearly)

- You or your child may be eligible for continued health care coverage through Medi-Cal or Healthy Families.

  I want to apply for continuing coverage through Medi-Cal or Healthy Families. ☐ Yes ☐ No

  If you answered *yes* to this question, an application will be mailed to you in a few days. Please return it promptly. If you answered *no* to this question (or if you answered *yes* but do not return the application), the patient's coverage for health, dental, and vision benefits will stop at the end of next month unless the county Department of Social Services notifies you otherwise.

Patient Information

Does the patient have a State of California Benefits Identification Card (BIC) or Medi-Cal card? ☐ Yes ☐ No

If yes, what is the identification number on the BIC card (if available)? _____

Patient's name—Last	First	Middle initial

Date of birth (month/day/year)	Gender ☐ Male ☐ Female	Patient's social security number (SSN) *(optional)*

☐ If you are homeless, check here. Enter the general location in the "Home address" section and complete the "Mailing address" section.

Home address	Apartment number	City	State	ZIP code

County of residence

Mailing address (if different from home address)	Apartment number	City	State	ZIP code

Mother's name—Last	First	Middle initial

For patients under one year of age, please complete this section.

If less than one year of age, did the infant live with the mother in the month of birth? ☐ Yes ☐ No

Mother's date of birth (month/day/year)	Mother's BIC or Medi-Cal card number or social security number

Parent/Legal Guardian Information

Name of parent/legal guardian or emancipated minor patient—Last	First	Middle initial

Home telephone number	Work telephone number	Message telephone number
( )	( )	( )

What language do you speak at home?	What language do you read best?

Certification

I am requesting a CHDP health examination today. I certify that I have read and understand this form. I declare that the information I have provided is true, correct, and complete.

Signature of parent/guardian or emancipated minor	Relationship to patient	Date

An individual has a right to review records containing his/her personal information. The official entity responsible for keeping the information is the Department of Health Services, MS 8100, P.O. Box 997413, Sacramento, CA 95899-7413. A copy of this information may be shared with the county Department of Social Services in the county in which you reside and will be kept with your child's medical record by your child's CHDP provider.