Ahmad Pediatrics

Patient Registration Form

Name (Last, First, MI): _____ Sex: Male Female Race: _____ Ethnicity: _____

Date of Birth: _____ Social Security Number: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell: _____ Message Phone: _____

Mother's Name: _____ Date of Birth: _____ Social Security: _____

Place of Employment: _____ Work Phone: _____

Address: _____ City: _____ Zip: _____

Father's Name: _____ Date of Birth: _____ Social Security: _____

Place of Employment: _____ Work Phone: _____

Address: _____ City: _____ Zip: _____

Responsible Party: _____ Relationship to Patient: _____

Responsible Party Address: Same as above Different from above

Address: _____ City: _____ Zip: _____

In Case Emergency Contact: _____ Phone: _____

Referred to us by: _____

Insurance Information

Primary Insurance Name: _____

ID Number: _____

Group ID: _____

Name of Policy Holder: _____

Relationship to patient: _____

Policy Holder's Address: _____

_____

Policy Holder's DOB _____ SSN _____

Employer: _____ Work Number: _____

Insurance Phone Number: _____

Insurance Address: _____

Deductible $ _____ Co-pay $ _____

Secondary Insurance: _____

ID Number: _____

Group ID: _____

Name of Policy Holder: _____

Relationship to patient: _____

Policy Holder's Address: _____

_____

Policy Holder's DOB _____ SSN _____

Employer: _____ Work Number: _____

Insurance Phone Number: _____

Insurance Address: _____

Deductible $ _____ Co-pay $ _____

The above information is true to the best of my knowledge. I give my consent for treatment and authorize that my insurance benefits for covered services be paid directly to AHMAD PEDIATRICS.I understand that I am financially responsible for my balance or service not covered by my insurance company. I authorize the clinic or the insurance company to release any information requires to process my claim. I also authorize a copy of this consent to be used. I further authorize the release of private information to other providers involved in my child's care.

_____

Responsible Party Signature Relationship Date

Medication List

Patient Name:		Date:
DOB:	SS#:	SC#:
Tobacco:	Alcohol:	Street Drugs:
Allergies/Adverse Reactions:		

Medications – Including Prescriptions, Over-the-Counter Medications, and Herbal Supplements

Drug Name/Strength/Dose/Route/Frequency	Start Date	Stop Date	Reconciliation Date	Initials

Provider Signature: _____ Date: _____

The list of medications and allergies provided is complete and accurate.

Patient Signature: _____ Date: _____

As a policy of Ahmad Pediatrics in order for a patient to receive any type of treatment, if the patient is not with his/her parent or legal guardian. At the time of the appointment who has the permission to bring the patient in for the visit.

Please List Below:

Name _____ Relation _____

Name _____ Relation _____

Name _____ Relation _____

Name _____ Relation _____

This statement gives permission for the names stated above to bring

_____

_____ to

Ahmad Pediatrics

Parent/Guardian Signature _____ Date _____

PROBLEM LIST

Patient Name:			Date:
DOB:	SS#:		SC#:
Male:	Female:	Marital Status:	
Tobacco:	Alcohol:		Street Drugs:
Allergies:			

Onset Date:	Significant Illnesses/Medical Conditions:

Referral Date:	Specialist Referred Conditions:

Ahmad Pediatrics

Financial Policy

At Ahmad Pediatrics, we help coordinate your medical expenses by filling to most major insurance plans. To fully understand your individual insurance policy, it is your responsibility to contact your insurance to discuss your benefits. To assist you with maximizing your benefits, we have provided a list of financial responsibilities with us.

*******Attention Please initial each box below*******

- You must provide an insurance card at the time of service.
- If a co- pay is required for your policy, it is due prior to services are rendered .
- If your insurance changes, it is your responsibility to provide updated information for your child's account.
- If you have an HMO/Tricare plan with group insurance, you must select a Primary Care Physician prior to services being rendered.
- All newborns must be added to your insurance within 30 days from the date of birth. If a newborn is not added in that timeframe, you may be subject to pay in full for any services done.
- Your insurance is a contact between you and your employer/insurance company.
- It is possible that your insurance may not cover all the services that are rendered. It is your responsibility to know your policy limitations.
- In the event that you have a balance after your insurance has paid, it is your responsibility to make arrangements to pay the balance due.
- If a patient doesn't have any type of insurance balance will need to be pay in full on time of service.

PLEASE READ THE ABOVE CAREFULLY BEFORE SIGNING. By signing below, I acknowledge that I have read and understand the policy.

_____ _____

Signature Date

Acknowledgment Of Receipt
Of
Notice Of Privacy Practice
For Protected Health Information

I acknowledge that I have received a copy of Ahmad Pediatrics **Notice of Privacy Practices** for Protected Health Information on the date set below.

Date _____

Patient Name _____

Print Name of Authorized Personal Representative _____

Signature of Patient _____

Signature of Authorized Personal Representative _____

Please Indicate Relationship to Patient _____

For Use By Ahmad Pediatrics Personnel Only:

Signature Of Ahmad Pediatrics Representative _____ Date _____

- Patient has receive copy of Notice of Privacy Practices
- Patient refuse to sign Acknowledgment
- Patient refuse to accept copy only sign form
- Other _____

Medical Home Agreement

Principles of Medical Home

As identified by the patient centered Medical Home collaborative and adopted by OHCA, the principles of a Medical Home are as follows:

A. **Personal Physician/Provider** – each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
B. **Physician/Provider Directed Medical Practice** – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
C. **Whole Person Orientation** – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.
D. **Care is coordinated and/or integrated** across all elements of the complex health care system (e.g. subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g. family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.
E. **Quality and safety** are hallmarks of the medical home.
F. **Enhanced access to care** is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

Patient Information and Responsibilities

As a SoonerCare member, there are rules you must follow.
It is your responsibility to:

- Be aware of PCP's office hours so you will know when you can be seen.
- Call for an appointment as early as possible, keep your appointments.
- You may have to wait up to three (3) weeks to be seen for checkups and shots.
- Even if you have an appointment, you may have to wait past that time to see your PCP. You should ask to reschedule if you cannot wait.
- If you cannot keep your appointment, you must call the provider's office at least 24 hours before your appointment. Your provider may ask to dismiss you as a patient if you continually miss appointments.

When you call your PCP you should always:

- Tell the staff why you need an appointment.
- Have your medical ID card available.
- Call your PCP's office if your problem gets worse before your scheduled visit. Ask to speak to the nurse. Tell the nurse what symptoms you have and ask if you should be seen sooner because of them.

Medical Home Agreement

During your PCP visit you should always:

- Give staff the information they need to help you. This includes telling them about your symptoms.
- Tell your PCP your medical history.
- Take shot records to PCP appointment.
- Inform PCP of all prescription drugs, over-the-counter medications, and herbal supplements you are taking.
- Inform PCP of any medical equipment you are using.
- Inform PCP of any other health care appointments.
- Follow the treatment plans and guidelines that your PCP gives you.

Please also keep in mind:

- Your PCP will refer you to a specialist as needed. You will get a referral only if indicated by your PCP. The specialist must be a SoonerCare provider.
- You must get a referral BEFORE you go to a specialist.
- Do not ask your PCP for a referral AFTER you have seen specialist.
- If your PCP gives you a referral for a service that is not covered under SoonerCare, you will have to pay for it.
- If you do not keep your appointment, the specialist may not give you another one.
- Provider will not give a prescription he/she does not determine is needed.
- In most cases provider will not see you in the office the same day you call.
- SoonerCare allows unlimited PCP visits monthly.
- SoonerCare limits specialty visits to 4 times per month.

After-Hours Coverage:

- Provider will arrange for call coverage when unavailable to members and provide all panel members with the information necessary to ensure member access;
- If you think you have a true *medical* emergency, go to the nearest emergency room or call 911 (or your local emergency number).

As a patient you should expect Provider and staff to treat you professionally and respectfully. It is also expected that you and your family members will treat Provider and office staff respectfully and will refrain from using rude, offensive, or threatening behavior. You may call the SoonerCare Helpline to report complaints or concerns regarding provider and staff: 1-800-987-7767.

I have read and understand the Patient Rights and Responsibilities. I agree to follow the rules as listed above and as stated in the SC Member Handbook.

*Patient Name Printed: _____

*Patient Signature: _____ Date: _____

*Provider or Designee Signature: _____ *Date: _____

Child's Name: _____ **Birthdate:** _____

Child's Previous doctor: _____

Child's Dentist:_____ Regular Visits? Yes No

Your Regular Pharmacy (Name/Street): _____

Current Problems/Concerns:

_____

_____

Allergies/Reactions to Medicines, Foods, or Environment (Please list nature of reaction:)

_____

Current Medicines:

_____

Pregnancy & Birth:
Were there any problems with the pregnancy?
___No ___Yes (please specify:) _____

Was the baby full term _____ or premature? _____ if so, how early?_____

Delivered by: ____vaginal birth ____caesarian (please explain why:) _____

Birth weight: _____ Birth length: _____

Delivery Hospital:_____ Your Ob: _____

Past Medical History:
Has your child had any of the following conditions? Please circle all that apply:

Asthma / hay fever / eczema	RSV/Bronchiolitis	Pneumonia
Attention/Learning problems	Seizures/convulsions	Developmental delays
Broken bones/major injuries	Anemia/Bleeding problems	Urinary tract infections
Heart problem or murmur	Chicken pox	Other
Frequent ear infections	Frequent strep infections	_____

Past Surgical History:
Has your child had any operations such as ear tubes, hernia repair, or tonsillectomy?
_____No _____Yes (Please explain- type of surgery, location, dates):

_____

Immunizations: ***Please bring your child's shot record.***

Are your child's immunizations up to date? ___Yes ____No

Social History/ Safety Issues:

The child's parents are: ____married ____ single
____divorced ____ other (specify)_____

Does your child attend daycare during the day or after school? ____Yes ___ No

Do any household members smoke? ____Yes ___No

Any concerns about lead exposure? (old home/plumbing/peeling paint) ___Yes ___No
Has your child had a previous lead test? If so, was it normal or low? ____ Yes ____No

Does your child attend preschool/school? ____Yes ___No Grade: _____

Name of School: _____

Any concerns about school performance? ____ Yes ___No

(specify:)_____

Are there any pets in your home? ____Yes ____No (specify:) _____

Family History:
Please circle any family history of the following and indicate who has/had the condition (mother, father, brother, sister, maternal/paternal grandparent, extended family):

Alcoholism/drug abuse	Yes/No_____
Attention Deficit Hyperactivity Disorder	Yes/No_____
Asthma/hay fever/ eczema	Yes/No_____
Bleeding / clotting problems	Yes/No_____
Cancer	Yes/No_____
Diabetes	Yes/No_____
Heart disease/attack before age 50	Yes/No_____
Hearing Loss/Deafness	Yes/No_____
High blood pressure	Yes/No_____
High Cholesterol	Yes/No_____
Hip problems/dislocations	Yes/No_____
Inherited/genetic diseases/birth defects	Yes/No_____
Kidney Disease	Yes/No_____
Learning Disabilities	Yes/No_____
Mental illness/anxiety/depression	Yes/No_____
Seizures	Yes/No_____
Sudden unexplained death before age 50	Yes/No_____
Thyroid disease	Yes/No_____
Other (please explain)	Yes/No_____

Thank you for taking the time to fill out this form. It will be reviewed by the physician and will become part of your record.

Oklahoma Childhood Lead Poisoning Prevention Program
2008 Lead Exposure Risk Assessment Questionnaire (LERAQ)

CHILD'S NAME _____ DATE OF BIRTH _____

Date: _____ Age: _____ Current Residential Zip Code: _____

1. Does your child have Medicaid (SoonerCare)? If yes this child must have a blood lead test at 12 and 24 months of age (or, if older than 24 months, at least one test before 6th birthday).	Yes	No	Don't Know
2. Does your child live in a high risk ZIP code area? (see a list of high risk ZIPs on this form)	Yes	No	Don't Know
3. Does your child live in or often visit a house or child care site with chipped or peeling paint that was built prior to 1950?	Yes	No	Don't Know
4. Does your child live in or often visit a house or child care site built prior to 1950 with renovation, repairs or remodeling that were done in the last 6 months?	Yes	No	Don't Know
5. Does your child live in or often visit a house or child care site that has vinyl or plastic mini blinds?	Yes	No	Don't Know
6. Does your child have friends, siblings, house mates, or a play mate that has or did have lead poisoning?	Yes	No	Don't Know
7. Does your child live with an adult who has a job or hobby where lead is used? Examples would be: oil field worker, bridge painter, demolition or renovation of buildings, automobile work with batteries or radiators, lead solder, metal plating, furniture refinishing, leaded glass, lead shot or bullets and lead fishing sinkers.	Yes	No	Don't Know
8. Is your child given any home or folk remedies or cosmetics such as imported items ~~called Greta, Azarcon, Rudea, Kohl or does your child eat food cooked in or served~~ from pottery made outside the United States?	Yes	No	Don't ~~Know~~
9. Does your child chew on or mouth trinket jewelry or toys found in vending machines?	Yes	No	Don't Know

Lead Poisoning Prevention Program
Screening and Special Services
Oklahoma State Department of Health
1000 NE 10th Street

Telephone: (405) 271-6617
Toll Free: 1-800-766-2223

HIGH RISK ZIP CODES

73106	73108	73111	73119	73521	74104	74110	74127	74401	74447
73107	73109	73117	73129	73701	74106	74115	74354	74403	74631
									74848

Purpose: The LERAQ is to be used to screen for possible lead exposure in children 6 - 72 months of age.
Use: This assessment may be administered by medical staff or teacher, or completed by the child's parent or guardian.
Any "Yes" or "don't know" answer is considered a positive answer thus requires the child to have a blood lead test.

~~According to OCLPPP Case Management Guidelines, if a child has a blood lead test < 10 µg/dL, reassess with the LERAQ in 1 year.~~
No additional testing is necessary unless an exposure risk change has occurred. This Guideline does not supersede the federal CMS requirement that children enrolled in SoonerCare receive a blood lead test at 12 and 24 months of age as defined in the Child Health Check Up, also known as Early and Periodic Screening, Diagnosis and Treatment (EPSDT).
Routing and Filing: Retain this record in the child's record to review annually.

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