



Last Name: _____ First Name: _____ MI: _____ DOB: _____ Sex: M/F _____
 Marital Status: Married Single Widowed/Widower Ethnicity: Hispanic/Latino NonHispanic/Latino
 Preferred Language: _____ Race: White Black/African American Native Indian Alaskan Asian
 Native Hawaiian/Pacific Islander _____ Other Declined To Answer SSN# _____
 Email: _____ Drivers License: _____
 Occupation: _____ Employer: _____
 Responsible Party:(If a minor or full time student) _____ Relationship: _____

Patient Information

Mailing Address: _____ City: _____ State: _____ Zip: _____
 Phone# _____ Work Phone # _____ Mobile Phone# _____
 Emergency Contact Name: _____ Emergency Contact # _____ Relationship: _____
 Do You Have Medical Insurance? Yes No Primary Insurance: _____ Policy# _____
 Secondary Insurance: _____ Policy # _____ Subscriber SSN # _____
 Subscriber Name: _____ D.O.B _____ Other Coverage: _____

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosure we have already made in reliance of your prior Consent. Jones & Jones Medical Associates provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- Jones & Jones Medical Associates has a Notice of Privacy Practices and the patient has the opportunity to review this notice.
- Jones & Jones Medical Associates reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information, but Jones & Jones Medical Associates does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- Jones & Jones Medical Associates may condition treatment upon the execution of this consent.

My signature below authorizes Jones & Jones Medical Associates to bill my Insurance for all medical services rendered. I understand that I am financially responsible for all charges not covered by my insurance company. I authorize release of my medical information to my Insurance carrier and it's agents. Additionally my signature provides willing consent to any procedures that may be required, including emergency treatment or services. I acknowledge receipt of Jones & Jones Medical Associates privacy policy, and have read, or have had it read to me. I understand and agree to the provisions and terms listed above.

Signature Of Patient or Responsible Party: _____
 Date: _____

Witness:(Practice Representative): _____
 Date: _____

JONES & JONES MEDICAL ASSOCIATES
18660 OUTER HWY. 18
APPLE VALLEY, CA 92307
(760) 946-2112

PRACTICE'S REQUIREMENTS:

4. Jones & Jones Medical Associates Inc.:

- (a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
- (b) Is required by State law to maintain a higher level of confidentiality with respect to certain portions of your medical information that is provided for under federal law. In particular, Jones & Jones Medical Associates Inc. is required to comply with the following State statutes: State of California.
- (c) Is required to abide by the terms of this Privacy Notice.
- (d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.
- (e) Will distribute any revised Privacy Notice to you prior to implementation.
- (f) Will not retaliate against you for filing a complaint.

EFFECTIVE DATE:

This Notice is in effect as of 04/14/2003.

By signing below, I acknowledge that I have received and reviewed this notice and all of my questions have been answered to my satisfaction in language that I can understand. I have crossed out or otherwise amended anything to which I do not agree and placed my initials next to such exclusions or amendments.

Name of Individual (Printed) _____

Signature of individual _____

Date signed ____/____/____

Signature of Legal Representative: _____

Date signed ____/____/____

Relationship _____

(e.g., Attorney-In-Fact, Guardian, Parent if a minor)

Witness: _____ Date Signed ____/____/____

What Does Your Child Eat?

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

Baby Foods 		How does your child feel about mealtimes?
Breads, Grains, and Cereals 		
Fruits and Vegetables/Vitamin A, C, Folic Acid, and Fiber Rich Foods 		
Milk Products/Calcium Rich Foods 		Protein/Iron Rich Foods
Other Foods 		
Circle if baby/child uses: 		
Circle if your baby or child receives food from: Food Stamps School Lunch Head Start WIC		Child: 2 to 8 years Yes / No <input type="checkbox"/> <input type="checkbox"/> Eats recommended variety and amounts of foods daily for age from the food guide pyramid?
Circle activities your baby or child does every day. 		
Drinks water? 		Referral for identified nutrition problem? Where? _____ _____ _____

Office Use Only
Feeding milestones to check/visit

Baby: Birth to 24 months
Yes / No

Breast-fed 8–12 times/24 hours during early weeks of lactation OR every 3–4 hours/day for older infants?

Formula-fed w/iron no less than 20 ounces/day? Correct dilution?

No honey/Karo Syrup until 1 year?

4–6 months: Start on baby cereal with iron?

5–7 months: Start on pureed vegetables and fruits?

6–7 months: Drink from a cup?

6–8 months: Start on pureed or ground meat, i.e., poultry, beef, pork, fish, egg yolk, beans, tofu?

7–9 months: Eats finger foods and mashed/chopped foods, NO grapes, nuts, popcorn, hotdogs, hard candy?

1 year: Drinks regular milk no less than 16 ounces/day?

9–12 months: Feeds self, joins family meal and snack times?

12–24 months: Eats variety of foods: small portions, i.e., 1–2 Tbsp., 1/2 c juice, 1/2 slice of bread.

Child: 2 to 8 years
Yes / No

Eats recommended variety and amounts of foods daily for age from the food guide pyramid?

Mealtime/Others:
Yes / No

Set meal and snack times?

Brush teeth by himself at 5 years?

Good food supply?

Takes vitamins, iron, or fluoride?

Growing normally according to his/her growth patterns?

Does child play with or eat dirt, plaster, clay, and paint chips?

Any food intolerances or allergies?

Activity:

Actively plays everyday, i.e., running, biking, sports, 1 hour/day?

TV viewing: 2 hours or less/day?

Child's name: _____ Record #: _____

Age: _____ yrs. _____ mos. Wt: _____ lbs. Ht: _____ in. Date: ____/____/____

PEDIATRIC HEALTH HISTORY QUESTIONNAIRE

Child's Name _____ Birthdate _____
last first middle Initial mo/day/year

Sex Male Female

Has anyone in the family ever had any serious illnesses or abnormalities (eg., heart disease, diabetes, tuberculosis, asthma, etc.)?

Yes No If yes, please explain _____

Were there any problems with the pregnancy of this child? Yes No If yes, please explain _____

How much did this child weigh at birth? _____ Were there any problems with this child immediately after birth?

Yes No If yes, please explain _____

Has this child ever had the following illnesses (check if yes and provide date):

	Yes	Date		Yes	Date		Yes	Date
Diphtheria	<input type="checkbox"/>	_____	Ear/Nose/Throat Problems	<input type="checkbox"/>	_____	Joint Problems	<input type="checkbox"/>	_____
Whooping Cough	<input type="checkbox"/>	_____	Urinary/Kidney Problems	<input type="checkbox"/>	_____	Eye Problems	<input type="checkbox"/>	_____
Polio	<input type="checkbox"/>	_____	Muscle/Bone Problems	<input type="checkbox"/>	_____	Heart Disease	<input type="checkbox"/>	_____
Measles	<input type="checkbox"/>	_____	Anemia/Blood Problems	<input type="checkbox"/>	_____	Pneumonia	<input type="checkbox"/>	_____
Mumps	<input type="checkbox"/>	_____	Convulsions/Seizures	<input type="checkbox"/>	_____	Tuberculosis	<input type="checkbox"/>	_____
Chicken Pox	<input type="checkbox"/>	_____	Intestinal Problems	<input type="checkbox"/>	_____	Nervous Problems	<input type="checkbox"/>	_____
Scarlet Fever	<input type="checkbox"/>	_____	Asthma	<input type="checkbox"/>	_____	Epilepsy	<input type="checkbox"/>	_____
Rheumatic Fever	<input type="checkbox"/>	_____	Hay Fever	<input type="checkbox"/>	_____	Typhoid	<input type="checkbox"/>	_____

Has this child ever had any of the following (check if yes, provide date and explain):

	Yes	Date	
Hospitalizations:	<input type="checkbox"/>	_____	_____
	<input type="checkbox"/>	_____	_____
Operations:	<input type="checkbox"/>	_____	_____
	<input type="checkbox"/>	_____	_____
Serious injuries	<input type="checkbox"/>	_____	_____
	<input type="checkbox"/>	_____	_____

Has this child ever had any serious health problems? Yes No If yes, please explain _____

Is this child taking any medicines at this time? Yes No If yes, please explain _____

Does this child have any allergies (eg., to medicines such as penicillin, foods, grasses/pollens, etc.)? Yes No
 If yes, please explain _____

Has this child ever had a tuberculosis skin test? Yes No If yes, give DATE _____ RESULT _____

Give month and year for each immunization this child has received:

Diphtheria/Whooping Cough/Tetanus (DTP or Td)	1 _____	2 _____	3 _____	4 _____	5 _____
Polio	1 _____	2 _____	3 _____	4 _____	5 _____
Measles	1 _____				
Mumps	1 _____				
Rubella ("German Measles")	1 _____				
Tuberculosis (BCG)	1 _____				

Name of Person Completing Form _____ Relationship to Child _____

Date _____