JJMA Jones & Jones Medical Associates Patient Information Sheet **Date:**_____

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:_____

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	☐	_____	Ear/Nose/Throat Problems	☐	_____	Joint Problems	☐	_____
Whooping Cough	☐	_____	Urinary/Kidney Problems	☐	_____	Eye Problems	☐	_____
Polio	☐	_____	Muscle/Bone Problems	☐	_____	Heart Disease	☐	_____
Measles	☐	_____	Anemia/Blood Problems	☐	_____	Pneumonia	☐	_____
Mumps	☐	_____	Convulsions/Seizures	☐	_____	Tuberculosis	☐	_____
Chicken Pox	☐	_____	Intestinal Problems	☐	_____	Nervous Problems	☐	_____
Scarlet Fever	☐	_____	Asthma	☐	_____	Epilepsy	☐	_____
Rheumatic Fever	☐	_____	Hay Fever	☐	_____	Typhoid	☐	_____

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

	Yes	Date	
Hospitalizations:	☐	_____	_____
	☐	_____	_____
Operations:	☐	_____	_____
	☐	_____	_____
Serious Injuries	☐	_____	_____
	☐	_____	_____

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 _____

State of California—Health and Human Services Agency

What do you eat?

Department of Health Care Services

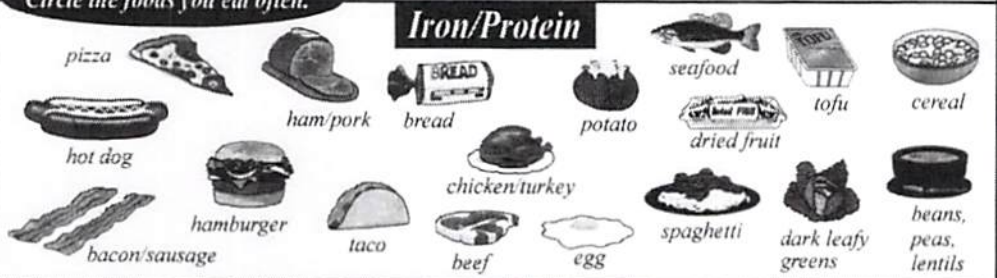
What did you eat yesterday? List everything you ate and drank. How much? What time?

Time	*Amount*	*Food or Drink*
10:00 a.m.	*½ cup*	*Carrots*

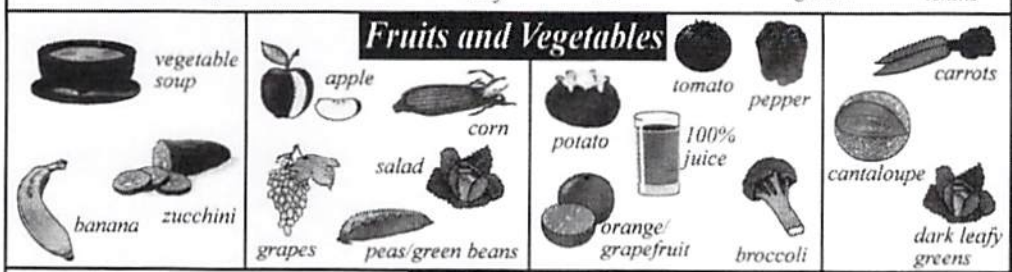
Was yesterday a typical day? _____Yes _____No

Circle the foods you eat often.

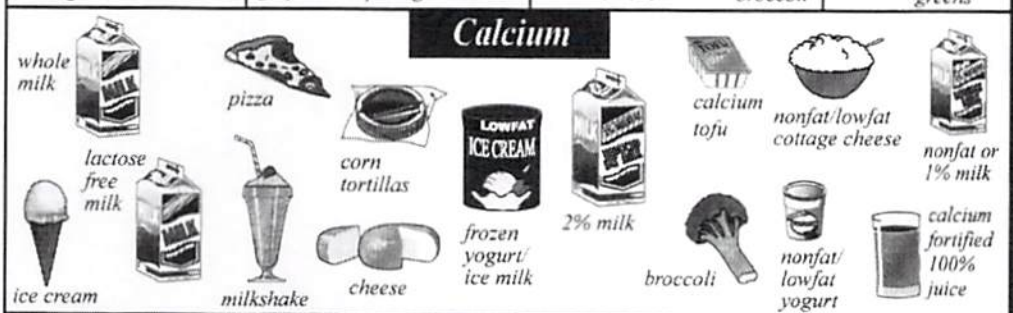
Iron/Protein



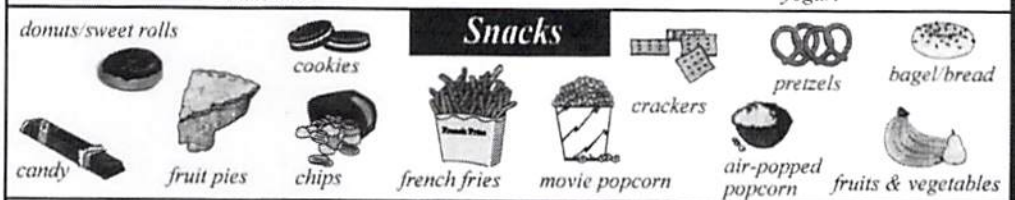
Fruits and Vegetables



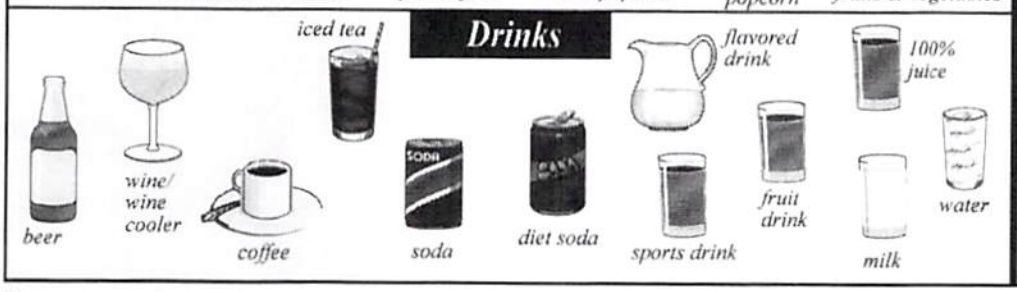
Calcium



Snacks



Drinks



For office use only

(Check (✓) topics discussed)

- ☐ Continue eating healthy
- ☐ ⬆ regular meals/snacks
- ☐ Encourage breakfast
- ☐ Inadequate food supply
- ☐ Encourage lower fat
- ☐ Encourage lower sugar
- ☐ Weight management
- ☐ Disordered eating
- ☐ Other_____

Iron/Protein

- ☐ 2 - 3 servings daily
- ☐ ⬆ high iron foods
- ☐ ⬆ alternate protein sources for vegetarian diets
- ☐ ⬆ beans, lentils, peas
- ☐ Limit high fat meats

Fruits and Vegetables

- ☐ 2 - 4 Fruits daily or more
- ☐ 3 - 5 Vegetables daily or more
- ☐ Vitamin C sources
- ☐ Vitamin A sources

Calcium

- ☐ 3 - 4 servings daily
- ☐ Encourage nonfat or 1% milk
- ☐ ⬇ high fat choices
- ☐ ⬆ low lactose alternatives
- ☐ ⬆ calcium-fortified foods

Snacks

- ☐ ⬇ high sugar snacks
- ☐ ⬇ high fat snacks
- ☐ ⬆ fruit/vegetable snacks
- ☐ ⬇ fast food

Drinks

- ☐ Limit juice: 1/day (4-8 oz. total)
- ☐ Drink 100% juice
- ☐ Drink 8-12 glasses water/day (8 oz. each)
- ☐ Discourage fruit drinks
- ☐ Discourage soda/caffeine
- ☐ Discourage alcohol

0306.172.H49

Name_____ **Age**_____ **Date of Birth**_____ **Date**_____

DHCS 4466 (09/07)

Don't Stop! Please turn me over. . .

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 ____/____/____