London Health Center, Inc • 2376 Main Street Suite 3 • Ferndale, WA 98248 • (360) 384-2900 Fax (360) 384-2955

Pediatric Intake

Please fill out both sides of this form

Legal Name:_____ Today's Date:_____

Wishes to be called:_____ Date of Birth:_____

Gender Identity: □ Female □ Male □ Neither □ Both □ Other

Demographics (optional): Check most appropriate box.

Race: □ Caucasian □ American Indian or Alaska Native □ Asian □ African American/Black □ Other

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Decline to specify

Contact Information: Please check parent/guardian responsible for account

□ Parent/Guardian:_____ □ Other Parent/Guardian:_____

Please check preferred phone number.

□ Cell Phone: _____ □ Work Phone: _____

□ Home Phone: _____ Email address:_____

Automated Text/Email okay? □ Yes □ No Is it okay to leave a message? □ Yes □ No

Address:_____ City, State, Zip_____

Employer:_____ Occupation: _____

In case of emergency, who should we contact? Name/Relationship:_____

Cell #: _____ Work #:_____ Home #:_____

Insurance Information

We will make a photocopy of your insurance card

Primary Insurance_____ **Subscriber's Name**_____ **DOB**_____

Secondary Insurance_____ **Subscriber's Name**_____ **DOB**_____

Authorization and Release

I hereby authorize the direct payment of medical benefits to London Health Center, Inc. for services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

I hereby authorize London Health Center, Inc., to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

I acknowledge that a portion or all of my child's care may not be covered by my insurance provider under the terms of my policy. The portions of my child's care that may not be covered may include, but are not limited to: deductibles, co-payments, and supplements.

X_____ _____

Signature of parent or guardian Date

Thank you for filling out this form completely. The information you have provided will help us serve your health care needs more effectively and efficiently. If you have any questions at anytime, please ask. We are always happy to help.

A photocopy of these assignments shall be as valid as the original.

London Health Center, Inc • 2376 Main Street Suite 3 • Ferndale, WA 98248 • (360) 384-2900 Fax (360) 384-2955

Pediatric Intake

Please fill out both sides of this form

Name:_____ Date of Birth: _____

Reason for visit: _____

Has parent or guardian every consulted a Naturopathic Physician before? □ Yes □ No

ADOPTED? □ YES □ NO	If yes, please fill out information for biological relatives if known.

IF ANY IMMEDIATE FAMILY HAS HAD ANY OF THE FOLLOWING - PLEASE CIRCLE THE # AND INDICATE RELATIVE

1) ALCOHOLISM	4) ASTHMA	7) ECZEMA	10) MENTAL ILLNESS
2) ANEMIA	5) ALLERGIES	8) HEART DISEASE	11) MIGRAINE
3) ARTHRITIS	6) CANCER (SPECIFY)	9) HYPERTENSION	12) TUBERCULOSIS
OTHER:			

FATHER	Living? □YES □ NO		MOTHER	Living? □YES □ NO		Primary guardian(s):
BROTHERS	# Alive:	# Deceased:	SISTERS	# Alive:	# Deceased:	

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

Mother's age at child's birth:_____

Mother's health during pregnancy: □ Bleeding □ Nausea □ hypertension □ diabetes □ cigarettes, alcohol, drugs □ Illness □ Thyroid problems □ Physical or emotional trauma

How often do you eat organic foods? Always Frequently Occasionally Never

What foods do you exclude from your child's diet?

***Vaccines*:** □ MMR	□ Polio	□ DPT	□ HIB	□ Influenza □ Hep B □ Chicken Pox
***Medications*:**	□ Antibiotics #	□ Anti-histamine	□ Aspirin #	□ Decongestants #
□ Inhalers	□ Tylenol #	□ Topical Steroids	□ Others	

ALLERGIES TO MEDICATIONS

□ No known Allergies, or please list allergies:

□ Chicken pox	□ Blood in urine	□ Asthma/wheezing	□ Acne	□ Behavioral problems
□ Measles	□ Cough/croup	□ Eczema/rash	□ Anemia	□ Dizzy spells
□ Mumps	□ Freq headaches	□ Hives	□ Body/breath odor	□ Epilepsy
□ Rubella	□ High fevers	□ Constipation	□ Easy bruising	□ Cries easily
□ Scarlet fever	□ Hearing loss	□ Diarrhea	□ Fatigue	□ Nervous
□ Whooping cough	□ Jaundice	□ Gas	□ Canker sores	□ Sleep problems
□ Bronchitis	□ Night sweats	□ No appetite	□ Heart murmur	□ Sensitive to light
□ Pneumonia	□ Pain with urinating	□ Stomach aches	□ Joint pains	□ Nightmares
□ Frequent colds	□ Sore throats	□ Vomiting spells	□ Nose bleeds	□ Unusual fears
□ Tonsillitis # of times:		□ Ear infections # of times:		□ Other:

I certify that the above information is correct to the best of my knowledge. I will not hold my provider or any members of his or her staff responsible for any errors or omissions that I may have made in the completion of this form.

X_____

Signature of parent or guardian Date

London Health Center, Inc • 2376 Main Street Suite 3 • Ferndale, WA 98248 • (360) 384-2900 Fax (360) 384-2955

NOTICE OF PRIVACY PRACTICE SUMMARY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

London Health Center, Inc. (the "Practice"), in accordance with applicable federal and state law, is committed to maintaining the privacy of you protected health information ("PHI"). In other words, information about your health condition and the care and treatment you receive from the Practice. We will use and disclose elements of your PHI in the following ways:

- Treatment
- Payment
- Health Care Operations
- When release is required by law, including judicial settings and to health oversight regulatory agencies and law enforcement.
- In emergency situations or to avert serious health/safety situations.
- To medical examiners, coroners or funeral directors to aid in identifying you or to help them in their duties.
- To organ, tissue and other donation organizations, upon or proximate to your death, if we have no indication on hand about your donation preferences.

Special Cases:

- Appointment reminders, treatment alternatives and other health related benefits and services
- Office newsletter
- Sponsor of your health plan

All other uses and disclosure by us will require us to obtain from you a written authorization in addition to any other permission you will provide us.

Your rights: You have the following rights concerning your PHI:

- **Restrictions**: To request access to all or part of your PHI. To do this, please make this request in writing. We are not required to grant your request.
- **Confidential communications**: To receive correspondence of confidential information by alternate means or location. To do this, please make your request in writing.
- **Access**: To inspect or receive copies of your PHI. To do this, please make your request in writing.
- Accounting: To recieve an accounting of the disclosures by us of your PHI in the six years prior to your request. To do this, please make your request in writing.
- This notice: to get updates or reissue of this notice at your request.
- Complaints: To complain to our office or the US Department of Health & Human Services if you feel your privacy rights have been violated. To register a complaint with us, please submit this request in writing. The law forbids us from taking retaliatory action against you if you complain.

Our Duties: We are required by law to maintain the privacy of your PHI. We must abide by the terms of this notice or any update of this notice.

Privacy Contact: To obtain more information on or have your questions about your rights answered: you may contact the Practice's Privacy Office, Dr. Angela London at London Health Center, Inc. 2376 Main Street, Ferndale, WA 98248.

Patient Acknowledgement: By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

_____ _____

Parent/guardian Signature Date

_____

Print Patient Name