Pediatric History

Patient Name ____ Date ____________

- Regarding the patient's birth, please circle any of the following that apply AND provide details as to severity, treatment of condition, etc:

Abnormal hearing test-

Metabolic or endocrine disorder (PKU, galactosemia, hypothyroidism, etc)-

Premature birth-

Newborn jaundice-

Prolonged hospitalization for newborn sepsis (infection), prematurity, respiratory distress, or any other reason-

Genetic abnormalities apparent at birth OR genetic concerns (Down's syndrome, cystic fibrosis, etc.)-

- Has patient ever been diagnosed with Failure to Thrive-i.e-difficulty with growing, gaining weight, or reaching developmental milestones (walking, rolling over, learning alphabet, acquiring vocabulary, etc.)?

- Are the patient's immunizations up to date? Y N ***Please provide an immunization record that we can copy for our records.***

- Does the patient have any food or drug allergies of which Skyline Medicine should be aware?

- Please indicate in which grade and school the patient participates. If patient is not currently in school, simply write N/A.

- Any concerns regarding patient's inattentiveness and or hyperactivity at school, home or elsewhere? Y N

- Where applicable, does the patient have any history of substance abuse of which you're aware? Y N

- Please list any pertinent family medical history (diabetes, rheumatoid arthritis, depression, hypothyroidism, etc) that affects either the patient's parents or grandparents:

- Please list all over the counter and prescription medications this patient takes routinely:

PEDIATRIC

Patient Name__________________________________ Date of Birth _______________

Please Check Any Of The Following Symptoms That *Currently* or *Recently* Apply To You.

Seasonal Allergies

Respiratory

___Shortness of Breath

___Chest Pain

___Chest Congestion

___Cough

Cardiac

___Dizziness

___Chest Pain

___Fast Heart Rate

Constitutional

___Night Sweats

___Heat/Cold Intolerance

___Fever

___Weakness

___Weight Gain/Loss

___Loss of Appetite

___Fatigue

Skin

___Rash

___Mole

___Lumps

___Hives

Endocrine

___Diabetes

___Hypothyroidism

___Hyperthyroidism

ENT

___Hearing Loss

___Cough

___Sore Throat

Gynecology

___Pelvic Pain

___Breast Pain/Mass

Gastroenterology

___Nausea

___Vomiting

___Abdominal Pain

___Diarrhea

___Constipation

___Blood in Stool

Blood Disorders

___Anemia

___Swollen Glands

___Easy Bruising

Musculoskeletal

___Joint Stiffness/Pain/Swelling

Neurology

___Migraine Headache

___Tension Headache

___Numbness

___Seizures

___Insomnia

___Dizziness

Ophthalmology

___Diminished Vision

___Eye Irritation

___Blurring of Vision

Psychiatry

___Depression

___Suicidal Ideation

___Abuse Mental or Physical

Urology

___Difficulty Urinating

___Blood in Urine

___Frequent Urination

___Urinary Incontinence

Skyline Medicine recommends that all patients get an annual physical in order to deliver excellent, comprehensive primary care. Often during this appointment new or established problems are also addressed in order to not create the need for a second appointment on a separate day. **Please contact your insurance company to understand your coverage and costs.** Thank you for entrusting us with your care.

Patient Name ______________________________

HAVE ANY OF YOUR BLOOD RELATIVES EVER HAD:	Yes	List Relative Relation
Anemia		
Bleeding tendency		
Cancer		
Diabetes mellitus		
Epilepsy/seizures		
Heart attack or heart disease		
High blood pressure		
Mental or emotional problems		
Stroke		

FATHER - ALIVE: YES NO AGE_____ MOTHER - ALIVE: YES NO AGE_____

Number of BROTHERS:______ Number of SISTERS :________

PLEASE COMPLETE THE FOLLOWING INFORMATION FOR ALL FAMILY MEMBERS (WHERE POSSIBLE)

	Name		Date of Birth	Deceased	Living
Father					
Mother					

SKYLINE MEDICINE-PEDIATRIC
(Please Print)

PATIENT'S NAME:____
Last Name, First Name Middle Initial

ADDRESS:____ APT#_______________

CITY:______________________ STATE_______________ ZIP_________________________

PARENT/ GUARDIAN e-mail address ____

PHONE #:(_____)_______-__________ DATE OF BIRTH: _____/_____/_____ SEX: (M / F)
Month day year

Mothers Name ____

Address ***(if different from above)*** ____

Telephone number ***(if different from above)*** _________________ Cell # ________________________

Employer___________________________ Work # ____________________________________

Fathers Name ____

Address ***(if different from above)*** ____

Telephone number ***(if different from above)*** _________________ Cell # ________________________

Employer___________________________ Work # ____________________________________

Ethnicity (please circle) Hispanic Not Hispanic

Race (please circle) Asian Black or African American Hispanic White

Other (please specify) _______________________________________

Language (please circle) English Spanish

Other (please specify) _______________________________________

Primary Insurance

Insurance Company Name: ____

Insurance Company Claims Address: ____

Policy #:______________________________ Group #:_______________________________

Insured's name:__________________________ Insured's Date of Birth: _______________ M / F

Insured's Employer: ______________________ Insured's SS# ___________________________

Relationship to Patient:___________________________

Secondary Insurance

Insurance Company Name: ____

Insurance Company Claims Address: ____

Policy #:___________________________ Group #:____________________________

Insured's name:__________________________ Insured's Date of Birth: _______________ M / F

Insured's Employer: ______________________ Insured's SS# ___________________________

Relationship to Patient:___________________________

PHARMACY NAME & TELEPHONE ____

Emergency Contact
Name/Number/Relationship____

Who may receive information regarding your Protected Health Information? (Check all that apply)

Parent/Guardian____ Name: ____________________________ Date of Birth:___/____/______
Name: ____________________________ Date of Birth:___/____/______
Other ____ Name: ____________________________ Date of Birth:___/____/______
Name: ____________________________ Date of Birth:___/____/______

May we leave messages regarding test results and appointments on your answering machine? _____Yes _____No

Whom may we thank for referring you to our office? ______________________________________

I have received a copy of the Privacy Rules from this provider and authorized the above list of persons who may receive my Protected Health Information. I may revoke this at any time by giving written notification to this provider.

I also give permission to Skyline Medicine to forward my (or my dependent's) medical records to my insurance company. I recognize that my insurance company may request these records to verify eligibility and medical claims Skyline Family Medicine submits thereto. I also recognize that payment to Skyline Medicine is my responsibility and that my insurance company may or may not cover services provided during this or any other visit.

Date:__________ Signature____
Circle One (PATIENT/ PARENT/ GUARDIAN)

SKYLINE MEDICINE POLICIES
(Please read and initial each line and sign and date below.)

Initial

______*In the event I become responsible for services provided myself, (**SELF PAY PATIENT**), I understand that* ***payment of cash or credit card is due at time of service.***

______ I understand that a physical will be done and my New Patient appointment; then yearly when due.

_____ I understand that a physical is for prevention, and an office visit will also be charged for any other service done at the time of the physical.

______I have insurance and have provided that information to Skyline Medicine. I realize that it is ***my responsibility*** to notify Skyline Medicine of any insurance or address changes.

______I understand that ***co-pays are due at the time of service*** and that this is a contract between me and my insurance company.

______I understand that some services recommended by Skyline Medicine may or may not be covered by my insurance company and that ***non-covered services are still my responsibility. Failure to provide accurate insurance information will result in all charges being assigned directly to patient/guardian.***

______ I understand that it is my responsibility to contact my insurance to find out what procedures will or will not be covered in my office visits (i.e, immunizations).

______I understand that the estimate of benefits by my insurance is not a guarantee of payment and may not be accurate at the time of my visit. I will be responsible to pay for those procedures not covered by my policy. It is the patient/guardian responsibility to know what their benefits are.

______I understand that after **45 days from date of service if my insurance company has not made a payment on my claim, it will be my responsibility to pay Skyline Medicine and follow up with my insurance company.**

______I understand that a ***$25.00 late fee*** will be added to my account on any unpaid patient balances and after 60 days my account will be turned over to a collection agency.

______I understand that a ***$50.00 no show fee*** will be added to my account for any appointments that I do not call to cancel or reschedule, or any appointment cancelled or rescheduled the same day of the scheduled appointment.

______I understand that a ***$25.00 fee will be added for all returned checks.***

______ I understand that **refills on medications must be written in an appointment setting. If this is done at your yearly physical, it is an office visit in addition to yearly physical.** *Please have medications and refill expiration dates available to discuss with the doctor. Depending on the medication will determine how often a prescription needs to be refilled.*

______ Of late we've had patients request medical services for themselves (refills, evaluation, opinions) while accompanying their loved one(s) during their appointment. ***While minimal commentary from the physician may be appropriate and deemed "pro bono" (i.e.—Tylenol dosing), I understand that, at the discretion of the Skyline provider, I may be billed for an appointment while requesting the aforementioned services. I understand, too, however, that while accompanying a loved one to an appointment I may request an appointment for myself at the front desk and oftentimes be accommodated for such a request.***

______________________________	______________________________	____________
Signature	Print Name	Date

If you would like a copy of this form please ask the receptionist at the front desk. Updated 01/29/2025

6112 E. Brown Rd. Mesa, AZ 85205
(480) 924-4422

Patient Information

Sick Visits vs. Well visits or BOTH?

- **Sick Visit** – This is an office visit for an acute problem or flare-up of a chronic problem. This could also be an office visit to follow-up on chronic problems (Diabetes, Cholesterol, Blood Pressure, etc.).

- **Well Visit** – This is an office visit for a routine physical exam or yearly health maintenance exam.

- **Sick/Well Visit** – This is a ***combination visit*** of a routine physical exam where an acute or chronic issue is addressed as well. For example, if you presented today for a well visit and you have an acute or chronic issue you would like addressed, it is considered a ***combination visit*** and must be billed differently than just a well visit or just a sick visit.

- **Why is it billed differently?** - It is billed differently to account for the additional work, expertise and time required for a combination visit (additional lab work, x-ray, referrals, and/or prescription medications). It involves additional documentation as well. For example, think about taking your vehicle in for an oil change (routine maintenance), and mentioning to the mechanic that your brakes are squeaking and your windshield wipers were not working well. In addition to the oil change, you might require additional brake work if a problem was found and replacement windshield wipers. Since additional services were provided, you would be charged more than just for the oil change.

- **How does this affect me?** Although many insurance companies acknowledge the sick/well visit combination, some of them still require the patient to pay two co-pays or have additional costs applied to his/her annual deductible.

We realize this can be confusing and if you have ANY questions or concerns after reviewing this material, please ask.