



**Kids First Pediatric Clinic, LLC**  
 18676 Willamette Dr. Suite 300, West Linn, OR 97068  
 Phone: (503) 699-3313 Fax: (503) 699 - 3365  
 Website: www.kidsfirstclinic.com

**Registration Form**

Today's date: \_\_\_\_\_

1. Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_

2. Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_

3. Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_

4. Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_

Address \_\_\_\_\_  
 Street City State Zip

Primary Home Phone \_\_\_\_\_ Primary E-mail \_\_\_\_\_

**GIVE BOTH PARENTS INFORMATION**

Parent Name \_\_\_\_\_ Other Parent Name \_\_\_\_\_

Soc Sec # \_\_\_\_\_ Soc Sec # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Date of Birth \_\_\_\_\_

Driver's License# \_\_\_\_\_ Driver's License# \_\_\_\_\_

Employer \_\_\_\_\_ Employer \_\_\_\_\_

Occupation \_\_\_\_\_ Occupation \_\_\_\_\_

Home Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Alternative Email Address: \_\_\_\_\_

Please provide the name of the person we will need to contact for the following: \_\_\_\_\_

**Medical Issues, Reminders, and General Notices** (Please circle only one)

Patient Email: \_\_\_\_\_ Home PH: \_\_\_\_\_ Work PH \_\_\_\_\_:

**Plcese Circle one of the following:**

**Ethnicity:** Hispanic/ Latino Not-Hispanic/ Latino Not Specified

**Preferred Language:** \_\_\_\_\_

**Race(s):** American Indian or Alaska Native/ Asian, Black or African American/ Native Hawaiian or Pacific Islander/ White/ not specified

How did you hear about our office?



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**Insurance Information**

Responsible party (**Card Holders Name**) \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Social Security Number \_\_\_\_\_ Gender \_\_\_\_\_  
 Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Effective Date \_\_\_\_\_  
 Claims Address \_\_\_\_\_  
 (On the back of the card) Street City State Zip  
 Card Holders Policy/Identification# \_\_\_\_\_ Group Number \_\_\_\_\_

**Child # 1**       **Check here if the insurance ID is the same as Card Holders**

Patients Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Policy/Identification Number \_\_\_\_\_ Group Number \_\_\_\_\_  
 Relationship to child \_\_\_\_\_

**Child # 2**       **Check here if the insurance ID is the same as Card Holders**

Patients Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Policy/Identification Number \_\_\_\_\_ Group Number \_\_\_\_\_  
 Relationship to child \_\_\_\_\_

**Child # 3**       **Check here if the insurance ID is the same as Card Holders**

Patients Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Policy/Identification Number \_\_\_\_\_ Group Number \_\_\_\_\_  
 Relationship to child \_\_\_\_\_

**Child # 4**       **Check here if the insurance ID is the same as Card Holders**

Patients Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Policy/Identification Number \_\_\_\_\_ Group Number \_\_\_\_\_  
 Relationship to child \_\_\_\_\_

**I verify that this information is correct and up-to-date. I understand that I am responsible for the charges accrued by my child/children regardless of insurance benefits. If in using the information I have provided today or on previous occasions Kids First Pediatric Clinic is unable to collect from my child's insurance company, I accept full responsibility for the payment of child's bills.**

**Responsible Party (print name)** \_\_\_\_\_

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



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## Welcome to Kids First Pediatric Clinic

### Office Policies

We are so happy that you have chosen to make us your child's medical home. We strive to create an atmosphere that is friendly and warm for our patients and look forward to taking care of your children for years to come. We hope the following information is helpful in informing everyone to our office policies and provides a more pleasant environment.

### Appointment Policy

#### Sick and Well Waiting:

We have provided sick and well waiting areas for your convenience. If you come to the office with more than one child and one of your children is sick, then you must report to the sick waiting room. Children who are newborns and children here for a well exam, recheck, or follow up exam from a previous illness but are feeling much better should report to the well waiting room.

#### Sick Appointments:

We strive to accommodate sick appointments as same day appointments.

#### Well Child Appointments:

We follow American Academy of Pediatrics schedule of well child and teen check up visits. Please schedule your child visit 6-8 weeks in advance. This assures that your child will have their well visit and immunizations on time.

#### Cancellations:

If you should need to cancel a scheduled well or other visit, please notify our office 24 hours in advance so that we may accommodate families who are on a waiting list for an earlier appointment.

#### No-Shows:

There may be a \$25.00 no show fee to your account for every no show appointment. Our office policy states that 3 or more no-shows are grounds for dismissal from the practice. This is not to be uncaring; it is an effort to continue consistent care to your child and prompt care throughout the day for other children.

#### Late for Schedule Appointments:

If you are going to be more than 15 minutes late, please call our office so we can reschedule your appointment for a more convenient time. If your child is sick, you may wait in the office and be worked in between patients. Please note there may be an extended wait time if you are late for your appointment.

#### After Hours Calls:

Dr. Jabbour is available to her patients 7 days a week for emergencies. For routine questions please call during office hours.

#### Release of Medical Records:

Our office has 15 business days to release your child's medical records. There will be a \$25.00 charge for copying your child's chart for the first 30 pages, \$0.25 for any additional page. Medical records may be transferred to another physician at no charge.

#### Shot Records/School Forms:

Immunization records will be released within 2-3 business days after request. Please allow 3-5 business days for your school, camp, and sports physical forms.

#### Medication Refills:

Please allow our office 72 hours for prescription refills. Medication refills will only be done during our normal business hours. For new prescriptions, the patient must be seen prior to any new prescriptions.

By signing our Consent Acknowledgement Form, you acknowledge, you agree and fully understand the Office Appointment Policy.



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## Financial Obligation

**Payments are due at the time of service.**

For Billing Questions please call: (503) 810 - 8166

This office is contracted with many different insurance plans. All patients are expected to provide our office with current insurance information and to understand their benefits. For the convenience of our patients, our providers participate in a variety of managed care plans. Our office also acts as an advocate for our patients with their managed care plans. This may include completing pre-certifications, eligibility verification, or other similar paperwork on behalf of the patient. **Ultimately, the patient is responsible for understanding their benefits and providing our office with current information so that we can handle this paperwork on their behalf in a timely manner.**

### Patient Financial Responsibilities

- The patient's guardian is ultimately responsible for the payment for the patient's treatment and care.
- Patients are responsible for the payment of co-pays, coinsurance, deductibles, and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of service, and for your convenience, we accept cash and most major credit cards at our office.
- Primary Care Physician: If you are required by your insurance company to select a primary care physician, this must be done prior to your child's appointment.
- Our mission as a practice is to provide for the health and well-being of our patients. Your health insurance is a contract between you and your health insurance company. You are financially responsible for any non-covered services.

By signing our Consent Acknowledgement Form, you acknowledge you agree and fully understand the Financial Obligation Policy.

## HIPAA (Health Insurance Portability and Accountability Act)

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. Obtain payments from third-party payers and conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that as part of my healthcare, Kids First Pediatric Clinic originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices. By signing our Consent Acknowledgement Form, you acknowledge you agree and fully understand the Health Insurance Portability & Accountability Act.



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## Consent Acknowledgement

1. Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_
2. Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_
3. Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_
4. Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_

1. **HIPAA (Health Insurance Portability and Accountability Act)** I hereby acknowledge that I have been presented with a copy of Kids First Pediatric Clinic Notice of Privacy. I understand that I may request in writing that you restrict how my privacy information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to Kids First Pediatric Clinic requested restrictions, but if parents agree, then parent is bound to abide by such restrictions.

**Parent/ Guardian Initials** \_\_\_\_\_

2. **Financial Obligation Policy.** I understand that I am responsible for the charges accrued by my child/children regardless of insurance benefits. If in using the information I have provided today or on previous occasions, Kids First Pediatric Clinic is unable to collect from my child's insurance company, I accept full responsibility for the payment of child's bills.

**Parent/ Guardian Initials** \_\_\_\_\_

3. **Appointment Policy/ Office Policies:** I hereby acknowledge that I have been presented with a copy of Kids First Pediatric Clinic Office/Appointment policies handout and understand my responsibilities. I have read and understand them.

**Parent/ Guardian Initials** \_\_\_\_\_

The office policies and protocols will be updated periodically as the practice grows, and changes will be made accordingly.

**I acknowledge that I have read this document in its entirety and fully understand it and will comply with all of Kids First Pediatric Clinic policies and protocols. I also acknowledge I have been given copies of all the policies mentioned above, and I was given the opportunity to ask any questions.**

Today's Date: \_\_\_\_\_

Print Parent/Guarantor name: \_\_\_\_\_ Signature: \_\_\_\_\_



## NEW PATIENT QUESTIONNAIRE

Patient's Name \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date \_\_\_\_\_

Mother's Name \_\_\_\_\_ Age \_\_\_\_\_ Father's Name \_\_\_\_\_ Age \_\_\_\_\_

### PREGNANCY AND BIRTH

Mother's age at child's birth \_\_\_\_\_  
 What number pregnancy was this child? \_\_\_\_\_  
 Did mother have any illness during pregnancy? Y / N  
 Did she take any medications other than vitamins and iron? Y / N  
 If yes, what? \_\_\_\_\_  
 Was the baby on time? Y / N  
 If no, how early was your baby? \_\_\_\_\_  
 Were there any complications with the baby during delivery? Y / N  
 \_\_\_\_\_

Was the delivery **vaginal** or by **C-section**? (circle one) Y / N

Did the baby go home at the same time as mom? Y / N

Did the baby have any trouble while in the hospital? (Jaundice, Infections, other?) Y / N  
 What kind?  
 \_\_\_\_\_

Did the baby go to the NICU? Y / N

If yes, please give a brief synopsis of the course:

If so, how long were they there? \_\_\_\_\_

If on ventilator, how long? \_\_\_\_\_

If on oxygen, how long? \_\_\_\_\_

Other info (infections, surgeries, interventions) while in NICU:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Birth Weight \_\_\_\_\_ Birth Length \_\_\_\_\_

**Are your child's vaccinations up to date? Y N**  
**If not, Why?**  
 \_\_\_\_\_  
 \_\_\_\_\_

### FEEDING AND NUTRITION

Is your child's appetite usually good? Y / N

Was there severe colic or any unusual feeding problems during the first 3 months? Y / N

Do any foods disagree with him/her? Y / N

If so, what? \_\_\_\_\_

For the first 6 months, is he/she (was he/she) breast-fed or bottle-fed? \_\_\_\_\_

If still on formula, which one? \_\_\_\_\_

Does he/she take vitamins? Y / N

### DEVELOPMENT/BEHAVIOR

At what age did child sit alone? \_\_\_\_\_

At what age did child walk alone? \_\_\_\_\_

Did child say any words by the time he/she was 1 ½ years old? Y / N

How does child compare to others of same age?  
 \_\_\_\_\_

Does child have any trouble sleeping? Y / N

What grade is the child in? \_\_\_\_\_

Has child had any trouble in school? Y / N

Does child get along with other children? Y / N

Does child have any of the following? (circle all that apply)

Thumb sucking                      Nail biting

Bed wetting                              Bad temper

Problems with toilet training      Hyperactivity

Problems with discipline              Nightmares

Speech problems                      Other



**PAST MEDICAL HISTORY**

Where has your child gone for check-ups until now?  
 \_\_\_\_\_

Date of last check-up? \_\_\_\_\_

Date of last dental check-up? \_\_\_\_\_

Are any medications taken regularly? Y / N

Please list names, dosages and frequency taken?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

If female, have periods started? Y / N

When? \_\_\_\_\_

If female, any problems with periods?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**SAFETY/ENVIRONMENT**

Do you live in a: (please circle)

Private home Apartment

Mobile home Other: \_\_\_\_\_

Day Care? \_\_\_\_\_ Sitter? \_\_\_\_\_

Do you know the hottest temperature of the water in your pipes? Y / N

Is there a working smoke alarm on each floor in the house? Y / N

Does your child always use a car seat/seat belt when riding in the car?

Are there any smokers in the household? Y / N

**Has your child had any of the following medical problems? Please circle**

- |  |                            |
|--|----------------------------|
| Serious injuries or accidents                  | Surgeries                  |
| Hospitalizations                               | Chickenpox disease         |
| Frequent ear infections                        | Hearing loss               |
| Heart problem or murmur                        | Anemia or bleeding problem |
| Blood transfusion                              | Frequent abdominal pain    |
| Bladder or kidney infection                    | Kidney problem             |
| Bedwetting (after 6 years of age)              | Eczema                     |
| Use of alcohol or drugs                        | Learning disorder          |
| Constipation requiring Dr Visits               |                            |
| Asthma/wheezing/pneumonia                      |                            |
| Allergies-seasonal, animals, indoor, foods     |                            |
| Allergic reactions - medications, vaccinations |                            |
| Frequent headaches                             |                            |
| Convulsions or other neurologic problems       |                            |
| Diabetes/blood sugar problems                  |                            |
| Thyroid or other endocrine problems            |                            |
| Other significant problem                      |                            |

Are there any problems with the condition of your home?

Peeling paint, insects, rats or mice? Y / N

Are there any guns in the house? Y / N

Are there any pets in the house? Y / N





**FAMILY HISTORY**

(Mark if present in any of your child's siblings, aunts/uncles, first cousins or grandparents)

- |  |                       |
|--|-----------------------|
| Spina Bifida                               | vision/eye problems   |
| Bone disorder                              | cerebral Palsy        |
| Cleft lip/palate                           | ADD/learning disorder |
| Hearing loss/deafness                      | Convulsions           |
| Heart disease/defect                       | Infertility           |
| Neurofibromatosis                          | Limb defects          |
| Mental retardation                         | Down Syndrome         |
| Neurological disorder                      | Cystic fibrosis       |
| Mental Illness                             | Short stature (<5ft)  |
| Tuberculosis                               | Diabetes              |
| Hay fever/allergies                        | Drug/alcohol problems |
| Sickle Cell Anemia                         | Bleeding disorder     |
| Muscle disorder                            | Kidney disease        |
| Skin disease                               | Genital abnormality   |
| High blood pressure                        | Asthma                |
| Urinary tract abnormality                  | AIDS (HIV)            |
| High cholesterol/triglycerides             |                       |
| Chromosome abnormality                     |                       |
| Brain anomalies (includes Hydrocephaly)    |                       |
| Anemia (includes Thalassemia)              |                       |
| Patient's mother was exposed to DES        |                       |
| Other birth defect/malformations/problems? |                       |

Please list:

\_\_\_\_\_

List age, sex, and health problems of brothers and sisters (are they living)?

\_\_\_\_\_