ARTURO QUINTANILLA,MD,FAAP
35-900 BOB HOPE DR. STE. 140
RANCHO MIRAGE, CA 92270
760-770-0000

PATIENT INFORMATION SHEET

DATE_____ NEW PATIENT_____UPDATE_____

PATIENT'S NAME_____D.O.B._____

SOCIAL SECURITY#_____PHONE#_____MALE___FEMALE___

LOCAL ADDRESS_____

MAILING ADDRESS_____

FATHER'S NAME_____CELL PHONE #_____

EMPLOYER_____OCCUPATION_____

EMPLOYER ADDRESS_____

WORK PHONE_____DRIVER'S LICENSE#_____

SOCIAL SECURITY #_____

MOTHER'S NAME_____CELL PHONE #_____

EMPLOYER_____OCCUPATION_____

EMPLOYER ADDRESS_____

WORK PHONE_____DRIVER'S LICENSE#_____

SOCIAL SECURITY #_____

PERSON TO CONTACT IN EMERGENCY_____

HOME PHONE_____WORK PHONE_____

RELATIONSHIP_____

PERSON TO CONTACT IN EMERGENCY NOT LIVING WITH YOU_____

HOME PHONE_____ CELL PHONE_____

INSURANCE CO. NAME_____

SUBSCRIBERS NAME_____

SUBSCRIBER SS#_____D.O.B._____

CLAIMS MAILING ADDRESS_____

GROUP#_____COPAY_____

RELATIONSHIP TO PATIENT_____

REFERRED BY_____

ASSIGNMENT OF BENEFITS

I HEREBY ASSIGN ALL MEDICAL AND/OR SURGICAL INSURANCE BENEFITS OTHERWISE DUE ME TO ARTURO QUINTANILLA, MD, FOR ALL SERVICES RENDERED BY HIM. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT COVERED BY SAID INSURANCE. I ALSO AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENTS. IF COLLECTION ACTION BECOMES NECESSARY TO COLLECT BALANCE DUE, I WILL PAY ANY COLLECTION COSTS AND/OR ASSOCIATED ATTORNEY FEES. ALSO, I HAVE RECEIVED, UNDERSTAND AND ACCEPT THE PRACTICE POLICIES STATEMENT FROM ARTURO QUINTANILLA, MD.

SIGNATURE_____DATE_____

Arturo Quintanilla, MD, FAAP
Diplomate of the American Board of Pediatrics
Fellow of the American Academy of Pediatrics

35-900 Bob Hope Drive, Suite 140, Rancho Mirage, CA 92270
Tel (760) 770-0000 / Fax (760) 770-2727

MINOR/ CHILD CONSENT FORM

I am the parent, guardian, or personal representative of _____,
(Please print name of minor/ child)
and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the doctor and practice staff to perform necessary services for the child named above, including but not limited to x-rays, and treatment, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered and regardless of where that treatment is provided. This authorization is made under family code 6910.

Signature:_____ Date:_____

Print Name:_____

Please specify relationship to minor:

( ) Parent with legal custody
( ) Guardian or Representative with legal custody

AUTHORIZATION FOR AGENT TO CONSENT FOR MEDICAL CARE OF A MINOR

I hereby authorize Mr./ Mrs. _____,
(an adult into whose care the minor(s) has been entrusted)
to consent to any x-ray examination, anesthetic medical or surgical diagnosis or treatment and hospital care of_____,
(name and address of minor(s))
which are deemed advisable by licensed physician and surgeon and provided by that physician or under that physician's supervision, regardless of where the treatment is provided. This authorization is made under family code 6910.

Signature:_____ Date:_____

Print Name:_____

Please specify relationship to minor:

( ) Parent with legal custody
( ) Guardian or Representative with legal custody

ARTURO QUINTANILLA, MD, FAAP
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Patient Name:_____ DOB:_____

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving you **best possible health** requires a "partnership" between you and your doctor. As our "partner in health", we ask you to help us in the following ways:

Schedule Visits with My Doctor for Routine Physical Exams and Other Recommended Health Screening

I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender and personal and family history. I understand I will need to complete these recommended health screenings (immunizations etc). **These health screenings are tests that can help detect life-threatening diseases and conditions.** If I visit my doctor only for treatment for immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

Keep Follow-up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When You Do Not Hear the Results of Labs and Other Tests

I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physicians' office within the time specified, I will call the office for my test results.

Inform My Doctor if I Decide Not to Follow His or Her Recommended Treatment Plan

I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs tests, or even asking me to return to the office within certain period of time. I understand that not following my treatment plans can have serious negative effects on my health. I will let my doctor know whenever I decide not to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patients, you have the right to be informed about your health care. We invite you, **at any time**, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

_____ _____ _____

Patient Signature Or Representative Date Physicians Signature

Initial History Questionnaire

Name _____

ID NUMBER _____

FORM COMPLETED BY _____ DATE COMPLETED _____

BIRTH DATE _____ AGE _____ M F

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names, ages, and where they live. _____

What is the child's living situation if not with both biological parents?
☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody
☐ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home? _____

Birth History ■ Don't know birth history

Birth weight _____ Was the baby born at term? _____ OR _____ weeks

Were there any prenatal or neonatal complications?
☐ Yes ☐ No Explain _____

Was a NICU stay required? ☐ Yes ☐ No Explain _____

During pregnancy, did mother
Use tobacco ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No
Use drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins
What _____ When _____

Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, why? _____

Was initial feeding ☐ Formula ☐ Breast milk How long breastfed? _____

Did your baby go home with mother from the hospital?
☐ Yes ☐ No Explain _____

General DK = don't know

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ DK Explain _____

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ DK Explain _____

Has your child had any surgery? ☐ Yes ☐ No ☐ DK Explain _____

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ DK Explain _____

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ DK Explain _____

Do you feel your family has enough to eat? ☐ Yes ☐ No ☐ DK Explain _____

Biological Family History DK = don't know

Have any family members had the following?

Childhood hearing loss	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Asthma	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tuberculosis	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Heart disease (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
High cholesterol/takes cholesterol medication	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Anemia	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bleeding disorder	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Dental decay	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Cancer (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

(Biological Family History continued on back side.)

Biological Family History *(Continued from front side.)* DK = don't know

Liver disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Kidney disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Diabetes (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bed-wetting (after 10 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Obesity	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Epilepsy or convulsions	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Alcohol abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Drug abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Mental illness/depression	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Developmental disability	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tobacco use	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

Additional family history _____

Past History DK = don't know

Does your child have, or has your child ever had,

Chickenpox	☐ Yes	☐ No	☐ DK	When _____
Frequent ear infections	☐ Yes	☐ No	☐ DK	Explain _____
Problems with ears or hearing	☐ Yes	☐ No	☐ DK	Explain _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Explain _____
Problems with eyes or vision	☐ Yes	☐ No	☐ DK	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	☐ DK	Explain _____
Any heart problem or heart murmur	☐ Yes	☐ No	☐ DK	Explain _____
Anemia or bleeding problem	☐ Yes	☐ No	☐ DK	Explain _____
Blood transfusion	☐ Yes	☐ No	☐ DK	Explain _____
HIV	☐ Yes	☐ No	☐ DK	Explain _____
Organ transplant	☐ Yes	☐ No	☐ DK	Explain _____
Malignancy/bone marrow transplant	☐ Yes	☐ No	☐ DK	Explain _____
Chemotherapy	☐ Yes	☐ No	☐ DK	Explain _____
Frequent abdominal pain	☐ Yes	☐ No	☐ DK	Explain _____
Constipation requiring doctor visits	☐ Yes	☐ No	☐ DK	Explain _____
Recurrent urinary tract infections and problems	☐ Yes	☐ No	☐ DK	Explain _____
Congenital cataracts/retinoblastoma	☐ Yes	☐ No	☐ DK	Explain _____
Metabolic/Genetic disorders	☐ Yes	☐ No	☐ DK	Explain _____
Cancer	☐ Yes	☐ No	☐ DK	Explain _____
Kidney disease or urologic malformations	☐ Yes	☐ No	☐ DK	Explain _____
Bed-wetting (after 5 years old)	☐ Yes	☐ No	☐ DK	Explain _____
Sleep problems; snoring	☐ Yes	☐ No	☐ DK	Explain _____
Chronic or recurrent skin problems (eg, acne, eczema)	☐ Yes	☐ No	☐ DK	Explain _____
Frequent headaches	☐ Yes	☐ No	☐ DK	Explain _____
Convulsions or other neurologic problems	☐ Yes	☐ No	☐ DK	Explain _____
Obesity	☐ Yes	☐ No	☐ DK	Explain _____
Diabetes	☐ Yes	☐ No	☐ DK	Explain _____
Thyroid or other endocrine problems	☐ Yes	☐ No	☐ DK	Explain _____
High blood pressure	☐ Yes	☐ No	☐ DK	Explain _____
History of serious injuries/fractures/concussions	☐ Yes	☐ No	☐ DK	Explain _____
Use of alcohol or drugs	☐ Yes	☐ No	☐ DK	Explain _____
Tobacco use	☐ Yes	☐ No	☐ DK	Explain _____
ADHD/anxiety/mood problems/depression	☐ Yes	☐ No	☐ DK	Explain _____
Developmental delay	☐ Yes	☐ No	☐ DK	Explain _____
Dental decay	☐ Yes	☐ No	☐ DK	Explain _____
History of family violence	☐ Yes	☐ No	☐ DK	Explain _____
Sexually transmitted infections	☐ Yes	☐ No	☐ DK	Explain _____
Pregnancy	☐ Yes	☐ No	☐ DK	Explain _____
(For girls) Problems with her periods	☐ Yes	☐ No	☐ DK	Explain _____

Has had first period ☐ Yes ☐ No Age of first period _____

Any other significant problem _____

This American Academy of Pediatrics Initial History Questionnaire is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 3rd Edition.

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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