

INSURANCE COVERAGE: Must have all insurance cards front and back.		
Check all that apply: None <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private Insurance <input type="checkbox"/> Blue Chip <input type="checkbox"/> Indian Health Center <input type="checkbox"/> VA <input type="checkbox"/>		
Primary Insurance Company/Address	ID Number	Group Number
	SS #	
Name of Insured	Relationship to Patient: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____	
Secondary Insurance Company/Address	ID Number	Group Number
	SS #	
Name of Insured	Relationship to Patient: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____	

**PARTNERSHIP HEALTH CENTER
323 WEST ALDER STREET
MISSOULA, MT 59802**

AUTHORIZATION AND ASSIGNMENT

The information given on this form is true to the best of my knowledge.

Treatment/Payment Agreement for Partnership Health Center (PHC).

I request the above to provide me and/or my family with medical care. I accept responsibility to pay for this care according to the fees established. Furthermore, I authorize assignment of benefits for medical/dental service to be paid to PHC. Also, I authorize PHC to bill my insurance and release information to the insurance company if requested.

Signed _____ **Date** _____

FOR PHC USE: STAFF INITIALS	DATE:	SLIDING SCALE: A B C D E NONE
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FINANCIAL STATUS WORKSHEET

VERIFY ALL SOURCES OF GROSS INCOME (PROOF OF INCOME IS NECESSARY TO QUALIFY FOR SLIDING FEE)

Family Income	Yes	No
Wages		
Self Employment		
Unemployment		
Workers Compensation		
Retirement/Pension		
Social Security		
Disability		
Food Stamps		
Child Support		
Alimony		
Other (please indicate)		

TOTAL GROSS INCOME: _____

**PARTNERSHIP HEALTH CENTER
PEDIATRIC HEALTH HISTORY
(Ages Birth through 12 years)**

Patient's Name: _____ Date of Birth: _____

Is your child receiving well child care? Yes _____ No _____

If yes, from whom? _____

Has your child had any serious illness or birth defects? _____

Has your child had any injuries? _____

Has your child had any hospitalizations? _____

Is your child taking any medications? _____

If yes, please list: _____

Does your child have any allergies? _____

If yes, please list: _____

Does anyone in your household smoke? Yes _____ No _____

Do you heat with wood? Yes _____ No _____

Does your child have or has he or she ever had any of the following:

1. Crossed or wandering eyes? Yes _____ No _____

2. Wear glasses or contact lenses? Yes _____ No _____

3. Repeated ear infections or ear drainage? Yes _____ No _____

4. Ear Tubes? Yes _____ No _____

5. Speech problems or speech delay? Yes _____ No _____

6. Deafness or decreased hearing? Yes _____ No _____

7. Trouble breathing through the nose? Yes _____ No _____

8. Frequent colds or sore throats? Yes _____ No _____

9. Recurrent strep throat? Yes _____ No _____

10. Tooth decay or tooth defects? Yes _____ No _____

11. Date of last visit to dentist? _____

12. Acne or other skin problems? Yes _____ No _____

13. Chronic cough? Yes _____ No _____

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Pediatric Health History
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14. Shortness of breath with activity/asthma?
Yes _____ No _____
15. Positive skin test for TB (tuberculosis)?
Yes _____ No _____
16. Heart murmur?
Yes _____ No _____
17. Irregular heart beat?
Yes _____ No _____
18. High blood pressure?
Yes _____ No _____
19. Blood cholesterol test?
Yes _____ No _____
20. Anemia or low blood?
Yes _____ No _____
21. Chronic or frequent diarrhea?
Yes _____ No _____
22. Bowel movements in underwear?
Yes _____ No _____
23. Constipation?
Yes _____ No _____
24. Recurrent vomiting?
Yes _____ No _____
25. Recurrent abdominal pain?
Yes _____ No _____
26. Bed wetting problems or daytime wetting?
Yes _____ No _____
27. Painful or frequent urination?
Yes _____ No _____
28. Painful or swollen joints?
Yes _____ No _____
29. Problems with coordination?
Yes _____ No _____
30. Scoliosis or abnormal curve of back?
Yes _____ No _____

- 31. Headaches?
Yes _____ No _____
- 32. Loss of balance?
Yes _____ No _____
- 33. Any bedtime or sleep problems?
Yes _____ No _____
- 34. Any concerns about your child's diet or growth?
Yes _____ No _____
- 35. Was (is) your child breast or bottle fed?
Yes _____ No _____
- 36. Does your child currently use a bottle?
Yes _____ No _____
- 37. Does your child take a bottle to bed?
Yes _____ No _____
- 38. Does your child take fluoride?
Yes _____ No _____
- 39. Does your child take vitamins or other supplements?
Yes _____ No _____

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Pediatric Health History

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SAFETY AND ACCIDENT PREVENTION

- 1. Does your child always use a car seat or safety belt? Yes ___ No ___
- 2. Are medicines, cleaning agents and other dangerous substances kept locked up or out of the way? Yes ___ No ___
- 3. Do you have Ipecac in the home? Yes ___ No ___
- 4. Do you have the number to poison control center? Yes ___ No ___
- 5. Does your child know how to swim? Yes ___ No ___
- 6. Is your hot water heater temperature set low? (Below 125 degrees) Yes ___ No ___
- 7. Is your home equipped with an adequate number of smoke alarms? Yes ___ No ___
- 8. Do you have stairs? If yes:
Do you have a safety gate? Yes ___ No ___
- 9. Do you have safety plugs in unused wall sockets? Yes ___ No ___
- 10. Do you have questions about child-proofing your home? Yes ___ No ___
- 11. Does your child use sunscreen when outdoors? Yes ___ No ___
- 12. Has your child been tested for lead poisoning? Yes ___ No ___
- 13. Do you know CPR? Yes ___ No ___
- 14. Does your child go to bed with a bottle? Yes ___ No ___
- 15. Does your infant sleep on his/her side or back? _____

FAMILY HEALTH HISTORY

Have any blood relatives had any of the following illnesses? If so, indicate which family member in relation to the child.

ILLNESS	FAMILY MEMBER (Mother, Father, Brother, Sister, Grandparent)
Asthma _____	_____
Eczema _____	_____
Diabetes _____	_____
Cancer (type) _____	_____
Blood Disease _____	_____
Epilepsy/Seizures _____	_____
Birth Defects _____	_____
Tuberculosis _____	_____
Rheumatoid Arthritis _____	_____
High Blood Pressure _____	_____
Heart Disease or Attacks _____	_____
Thyroid Disease _____	_____
Kidney Disease _____	_____
Mental Health Problems _____	_____
Scoliosis _____	_____
Crossed/Lazy Eye _____	_____
High Cholesterol _____	_____
Hepatitis B _____	_____
Alcoholism, Drug abuse _____	_____
Cystic Fibrosis _____	_____

PERINATAL HISTORY

1. Did you have prenatal care? Yes_____ No_____
2. What prescription or non-prescription medications did you use during your pregnancy?

3. How much did you smoke during your pregnancy? _____ # per day _____
4. How much alcohol did you drink during your pregnancy?
a day_____ # a week_____ # a month_____
5. Was your baby born on time? Yes_____ No_____
6. How much did your baby weigh? _____
7. How was baby's health during its first week? _____

THANK YOU FOR COMPLETING THIS FORM. DO YOU HAVE ANY SPECIAL CONCERNS THAT YOU WOULD LIKE TO DISCUSS?

History form reviewed by: _____

PROVIDER