Sara Ohgushi, N.D.

Naturopathic Physician & Midwife
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CONFIDENTIAL PEDIATRIC PATIENT INFORMATION

Child's name_____Birthdate_____Age_____Gender_____

Parents/Guardians_____

Address_____City/State_____Zip_____

Best Contact Phone_____ Other phone_____

Email(s)_____

Emergency Contact Person_____Phone_____Relationship_____

Insurance Co._____ Policyholder:_____ DOB_____

Please allow us to copy your insurance card.

Authorization to treat (please initial):
_____I authorize Sara Ohgushi, ND to examine and treat my child.
_____I understand that treatments and therapies recommended by Sara Ohgushi, ND may be different than those offered by other licensed health care providers and I am at liberty to seek other care for my child.

Assignment and Release (please initial):
_____I hereby authorize my child's insurance benefits be paid directly to Sara Ohgushi ND, and I understand that I am financially responsible for non-covered services. I also authorize Sara Ohgushi ND to release any information required to process this claim.

_____ _____ _____

Parent/Guardian name Signature Date

What are your top health concerns for your child?

1)_____

2)_____

3)_____

List any medications (prescription or over the counter) and/or vitamins/supplements your child is taking:

_____

_____

List any known allergies to medications, foods or chemicals_____

Is your child currently under a physician's care?_____If yes, physician's name_____

Last physical exam_____Last blood work_____Last dental exam_____

Brief summary of the pregnancy carrying this child:_____

_____

Brief summary of your child's birth:_____

_____

_____

(Continued on back....)

Past medical problems:_____

_____

_____

Major illnesses/accidents/hospitalizations/surgeries:_____

_____

FAMILY MEDICAL HISTORY

Please note the diseases or medical conditions that each of the following members of your child's family has or had. If they are deceased please note the age at which they died and the cause of their death.

Mother:_____

Father:_____

Paternal Grandmother:_____

Paternal Grandfather_____

Maternal Grandmother:_____

Maternal Grandfather_____

Siblings:_____

_____

HEALTH HABITS

Exercise: Type & Frequency_____

Sleep: Average # of hrs at night_____ Waking at night?_____Naps?_____

Is your child breastfeeding?_____If not, how long were they breastfed?_____

Age at which solids were introduced:_____

Your child's typical diet:

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Drinks:_____

Does anyone in the home smoke?_____

List any weapons in your home:_____

Does your child ride in a carseat every car ride?_____

Does your child wear a helmet when riding a bicycle (if applicable)?_____

Lastly, how did you hear about my practice?_____

HIPAA (Health Insurance Portability & Accountability Act)
Privacy Practices Acknowledgment

I, **Sara Ohgushi ND**, respect and am vigilant in protecting patient confidentiality and the privacy of your child's health information. I am also required by law to maintain the privacy of your child's protected health information, to provide you with a HIPAA privacy practices notice and to abide by its terms.

You have a right to receive a paper copy of my HIPAA privacy practices notice upon request at any time. In signing this form you acknowledge that you have seen a copy of my HIPAA privacy practices notice (on paper and/or on my website) and you understand how your child's medical information may be used and shared with others involved in your child's healthcare. Should any of my privacy practices change, I will notify you that a change has been made if your child is still under my current care.

If you have any questions about my privacy practices or HIPAA, please contact me. You have the right to file a complaint with me if you believe your child's privacy rights have been violated. I will not retaliate against you for filing such a complaint. If you feel my response is unsatisfactory you may also file a complaint with the Oregon Board of Naturopathic Medicine or the Washington State Department of Health.

_____ _____ _____

Parent/Guardian name Signature Date

COMMUNICATION CHOICES

MOBILE PHONE: Do you give me permission to leave you messages on your mobile phone including your child's confidential health information such as lab results? ____yes ____no

TEXTING: Do you give me permission to text you your child's confidential health information such as lab results? ____yes ____no Note: If you text me, your permission to text you back is implied. Please note that texting is NOT compliant with HIPAA law as it is not secure.

EMAIL: Do you give me permission to email you your child's confidential health information such as lab results? ____yes ____no Note: If you email me, your permission to email you back is implied. Please note that my email is NOT compliant with HIPAA law as it does not have the required security.

_____ _____ _____

Parent/Guardian name Signature Date