Staying Healthy Assessment

12 – 17 Years

Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	Grade in School:
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Other (Specify)			School Attendance Regular? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

#	Question				***Clinic Use Only:***
1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	Nutrition
2	Do you eat fruits and vegetables at least 2 times per day?	Yes	No	Skip	
3	Do you eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Yes	Skip	
4	Do you drink more than 12 oz. (1 soda can) per day of juice drink, sports drink, energy drink, or sweetened coffee drink?	No	Yes	Skip	
5	Do you exercise or play sports most days of the week?	Yes	No	Skip	Physical Activity
6	Are you concerned about your weight?	No	Yes	Skip	
7	Do you watch TV or play video games less than 2 hours per day?	Yes	No	Skip	
8	Does your home have a working smoke detector?	Yes	No	Skip	Safety
9	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	
10	Do you always wear a seatbelt when riding in a car?	Yes	No	Skip	
11	Do you spend time in a home where a gun is kept?	No	Yes	Skip	
12	Do you spend time with anyone who carries a gun, knife, or other weapon?	No	Yes	Skip	
13	Do you always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	Skip	
14	Have you ever witnessed abuse or violence?	No	Yes	Skip	
15	Have you been hit, slapped, kicked, or physically hurt by someone (or have you hurt someone) in the past year?	No	Yes	Skip	
16	Have you ever been bullied or felt unsafe at school or in your neighborhood (or been cyber-bullied)?	No	Yes	Skip	
17	Do you brush and floss your teeth daily?	Yes	No	Skip	Dental Health
18	Do you often feel sad, down, or hopeless?	No	Yes	Skip	Mental Health
19	Do you spend time with anyone who smokes?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
20	Do you smoke cigarettes or chew tobacco?	No	Yes	Skip	
21	Do you use or sniff any substance to get high, such as marijuana, cocaine, crack, Methamphetamine (meth), ecstasy, etc.?	No	Yes	Skip	

22	Do you use medicines not prescribed for you?	No	Yes	Skip	
23	Do you drink alcohol once a week or more?	No	Yes	Skip	
24	If you drink alcohol, do you drink enough to get drunk or pass out?	No	Yes	Skip	
25	Do you have friends or family members who have a problem with drugs or alcohol?	No	Yes	Skip	
26	Do you drive a car after drinking, or ride in a car driven by someone who has been drinking or using drugs?	No	Yes	Skip	
	Your answers about sex and family planning cannot be shared with anyone, including your parents, without your permission.				
27	Have you ever been forced or pressured to have sex?	No	Yes	Skip	Sexual Issues
28	Have you ever had sex (oral, vaginal, or anal)? *If no, skip to question 35.*	No	Yes	Skip	
29	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	
30	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
31	Have you or your partner(s) had sex without using birth control in the past year?	No	Yes	Skip	
32	The last time you had sex, did you use birth control?	Yes	No	Skip	
33	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
34	Did you or your partner use a condom the last time you had sex?	Yes	No	Skip	
35	Do you have concerns about liking someone of the same sex?	No	Yes	Skip	
36	Do you have any other questions or concerns about your health?	Yes	No	Skip	

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Mental Health	☐	☐	☐	☐	
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐	
☐ Sexual Issues	☐	☐	☐	☐	☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

SHA ANNUAL REVIEW		
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:

Black Ink Only

DATE ______________________

Riverwalk Pediatric Clinic, Inc.

HASMUKH C. AMIN, M.D.
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9508 STOCKDALE HWY., SUITE 150~ BAKERSFIELD, CA 93311
PHONE: (661) 663-7500~ FAX : (661) 663-3063

CHART NO. ______________________

Primary Language Spoken
- ☐ English
- ☐ Spanish
- ☐ Other ____________

- ☐ American Indian
- ☐ Asian
- ☐ Black
- ☐ Flipino
- ☐ Mex. Amer/Hisp
- ☐ White
- ☐ Other
- ☐ Pacific Islander

PATIENT INFORMATION

	LAST	FIRST	MIDDLE	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER
NAME						

	NUMBER AND STREET	CITY	STATE/ZIP	PHONE
ADDRESS				

SECTION 1 – INFORMATION REQUIRED IF PATIENT IS A MINOR – INDICATE RESPONSIBLE PARTY BY (X)

FATHER'S NAME	MOTHER'S NAME
DATE OF BIRTH SOC. SEC. NO.	DATE OF BIRTH SOC. SEC. NO.
ADDRESS	ADDRESS
PHONE	PHONE
CELL	CELL
EMAIL	EMAIL
EMPLOYER'S NAME	EMPLOYER'S NAME

SECTION 2 – INSURANCE INFORMATION

PRIMARY INSURANCE	**SECONDARY INSURANCE**
SUBSCRIBER'S NAME	SUBSCRIBER NAME
I.D. # GROUP #	I.D. # GROUP #

RESPONSIBLE PARTY ______________________

REFERRED BY ______________________

IN CASE OF EMERGENCY CONTACT (Other than Parent) ______________________

NUMBER AND STREET	CITY, STATE ZIP	PHONE
		CELL

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize Riverwalk Pediatric Clinic, Inc. to furnish information concerning this illness and I hereby assign to them all payments for medical services rendered. A copy of this authorization is valid as the original. I understand that I am financially responsible for the charges not covered by this authorization.

SIGNED (INSURED PERSON) ______________________ DATE ______________

Reorder KVP 327-1772

Medical Record: ___________

Riverwalk Pediatric Clinic, Inc. 9508 Stockdale Hwy # 150, Bakersfield Ca, 93311, 661-663-7500

Immunization Registry Notice to Patients and Parents

Immunizations or 'shots' prevent serious diseases. Keeping track of shots you have received can be hard. It's especially hard if more than one doctor gave them. Today, doctors use a secure computer system called an *immunization registry* to keep track of shots. If you change doctors, your new doctor can use the registry to see the shot record. It's your right to choose if you want shot records shared in the *California Immunization Registry*.

How Does a Registry Help You?

- Keeps track of all shots, so you don't miss any or get too many
- Sends reminders when you or your child need shots
- Gives you a copy of the shot record from the doctor
- Can show proof about shots needed to start child care, school, or a new job

How Does a Registry Help Your Health Care Team?

Doctors, nurses, health plans, and public health agencies use the registry to:

- See which shots are needed
- Remind you about shots needed
- Prevent disease in your community
- Help with record-keeping

Can Schools or Other Programs See the Registry?

Yes, but this is limited. Schools, child care, and other agencies allowed under California law may:

- See which shots children in their programs need
- Make sure children have all shots needed to start child care or school

What Information Can Be Shared in a Registry?

- patient's name, sex, and birth place
- parents' or guardians' names
- limited information to identify patients
- details about a patient's shots

What's entered in the registry is treated like other private medical information. Misuse of the registry can be punished by law. Under California law, only your doctor's office, health plan, or public health department may see your address and phone number.

Patient and Parent Rights

It's your legal right to ask:

- not to share your (or your child's) registry shot records with others besides your doctor*
- not to get shot appointment reminders from your doctor's office
- to look at a copy of your or your child's shot records
- who has seen the records or to have the doctor change any mistakes

<u>If you DO want your or your child's records in the registry, do nothing. You're all done.</u>

<u>If you DO NOT want your doctor's office to share your immunization information in the registry: Please request an "*Immunization Registry Refusal Form*" from your doctor's office.</u>

For more information about your rights, call **(800) 578-7889**

Patient Name: ______________________________ **D.O.B.**___________________________

* *By law, public health officials can also look at the registry in the case of a public health emergency.*

rev 1/08

California Child Health and Disability Prevention Program

CONSENT FORM

I hereby give my consent for ______________________ (Name of patient) to receive the health screening tests and immunizations recommended by the CHDP Program from ______________________ (Name of provider).

I hereby authorize release of information concerning the results of these screening tests to CHDP Program personnel. I also authorize release of the information to the locations checked below.

I understand that information provided to CHDP Program personnel will be strictly confidential and will be used only to make the provision of health services easier and to permit statistical reporting on the results of screening.

☐ School

Name			
Address (number, street)	City	State	ZIP code

☐ Health care provider

Name			
Address (number, street)	City	State	ZIP code

☐ Other

Name			
Address (number, street)	City	State	ZIP code

Name of parent, guardian, or emancipated minor

Signature of parent, guardian, or emancipated minor	Date

Screening Provider: This form, signed by parent, guardian, or emancipated minor, must be retained in patient's file.

FORM 15 -1

NOTICE OF PRIVACY PRACTICES:
Acknowledgement of Receipt

HASMUKH AMIN, M.D. ACKNOWLEDGEMENT OF RECEIPT

Patient Name: ______________________________ Date of Birth: ________________

By signing this form. you acknowledge receipt of the *Notice of Privacy Practices* of Dr. Amin's office. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice by coming by the office at 9508 Stockdale Hwy., Suite 150 Bakersfield, CA 93311.

If you have any questions about our *Notice of Privacy Practices,* please contact:

Tina Lujan, Privacy Officer at: 661-663-7500
D'ln Brown at: 661-663-7500

I acknowledge receipt of the *Notice of Privacy Practices* of Dr. Amin's office.

Patient/Parent Name: ____________________________________

Signature: ____ Date: __________________
(patient/parent/conservator/guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT

Complete only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

Patient's Name: ____

Reasons why the acknowledgment was not obtained:

- ☐ Patient refused to sign this acknowledgement even though the patient was asked to do so and the patient was given the *Notice of Privacy Practices*
- ☐ *Other:*____

Signature of provider representative: ______________________________ Date: __________

Chart # _______________

Riverwalk Pediatric Clinic, Inc.
9508 Stockdale Hwy, Suite 150
Bakersfield, CA 93311

Patient Name: __________________________________ D.O.B ________________

IMPORTANT INFORMATION REGARDING YOUR FINANCIAL RESPONSIBILITY

Riverwalk Pediatric Clinic, Inc. is contracted with most major health plans. Insurance coverage is an agreement between you and your insurance company. We will be happy to bill your insurance company directly for medical services rendered. It is your responsibility to contact the insurance company to verify coverage when being treated at Riverwalk Pediatric Clinic, Inc. If problems arise regarding coverage issues, we will attempt to work with you and your insurance company to resolve them.

It is your responsibility to keep your insurance and personal information current in our files. We ask that you present your insurance card at every visit. Copayments and coinsurance are due at time of service.

If you do not have medical insurance at time of service, you must pay in full before services are provided. We accept cash, personal checks, and Visa, Master Card, Discover, and American Express. If your financial situation is such that you are unable to pay in full, please contact our billing office to discuss possible payment options.

Cash Patients:
As a courtesy, we are able to provide information, which may assist you in obtaining specific medical services at a minimal/or no cost.

Riverwalk Pediatric Clinic, Inc. is committed to providing quality service. Thank you in advance for your cooperation and patience

____ ________________________
Patient/Parent/or Guardian Name Date

____
Patient/Parent/or Guardian Signature