Evaluación de Salud

(Staying Healthy Assessment)

12 – 17 años *(12 – 17 Years)*

Nombre (primer nombre y apellido)	Fecha de nacimiento	☐ mujer ☐ hombre	Fecha de hoy	Año escolar:
Persona que completa el formulario	☐ Padre/madre ☐ Familiar ☐ Amigo ☐ Tutor ☐ Otro (especifique)			Asistencia escolar ¿Regular? ☐ Sí ☐ No

Por favor intente responder todas las preguntas de este formulario lo mejor que pueda. Encierre en un círculo la palabra "Omitir" si no conoce una respuesta o no desea responder. Asegúrese de hablar con el médico si tiene preguntas sobre algún punto de este formulario. Sus respuestas estarán protegidas como parte de su expediente médico.

¿Necesita un intérprete? ☐ Sí ☐ No

#	Pregunta				***Clinic Use Only:***
1	¿Bebe o come 3 porciones al día de alimentos ricos en calcio, como leche, queso, yogur, leche de soja o tofu? *(Drinks/eats 3 servings of calcium-rich foods daily?)*	Sí	No	Omitir	Nutrition
2	¿Come frutas y verduras, al menos, 2 veces al día? *(Eats fruits and vegetables at least 2 times per day?)*	Sí	No	Omitir	
3	¿Come comidas con alto contenido de grasa, como comidas fritas, papitas, helado o pizza más de una vez por semana? *(Eats high fat foods more than once per week?)*	No	Sí	Omitir	
4	¿Bebe más de 12 oz (1 lata de refresco) por día de jugo, bebida deportiva, bebida energizante o bebida de café endulzada? *(Drinks more than 12 oz. per day of juice/sports/energy drink, or sweetened coffee drink?)*	No	Sí	Omitir	
5	¿Hace ejercicio o deporte la mayoría de los días? *(Exercises or plays sports most days of the week?)*	Sí	No	Omitir	Physical Activity
6	¿Le preocupa su peso? *(Concerned about weight?)*	No	Sí	Omitir	
7	¿Mira televisión o juega juegos de video menos de 2 horas al día? *(Watches TV or plays video games less than 2 hours per day?)*	Sí	No	Saltar	
8	En su hogar, ¿hay un detector de humo que funcione? *(Home has working smoke detector?)*	Sí	No	Omitir	Safety
9	En su hogar, ¿está pegado cerca del teléfono el número del Centro de intoxicaciones (800-222-1222)? *(Home has phone # of the Poison Control Center posted by phone?)*	Sí	No	Omitir	
10	¿Siempre usa cinturón de seguridad cuando viaja en automóvil? *(Always wears a seatbelt when riding in a car?)*	Sí	No	Omitir	
11	¿Pasa tiempo en un hogar donde hay un revólver? *(Spends time in a home where a gun is kept?)*	No	Sí	Omitir	
12	¿Pasa tiempo con alguna persona que lleve un revólver, un cuchillo u otra arma? *(Spends time with anyone who carries a gun, knife, or other weapon?)*	No	Sí	Omitir	

#	Question				Category
13	¿Siempre usa casco cuando va en bicicleta, patineta o *scooter*? *(Always wears a helmet when riding a bike, skateboard, or scooter?)*	Sí	No	Omitir	
14	¿Alguna vez ha presenciado un acto de abuso o violencia? *(Ever witnessed abuse or violence?)*	No	Sí	Omitir	
15	Durante el último año, ¿alguien lo ha golpeado, abofeteado o lastimado físicamente (o ha lastimado usted a alguien)? *(Been hit, slapped, kicked, or physically hurt by someone (or has he/she hurt someone) in the past year?)*	No	Sí	Omitir	
16	¿Alguna vez lo han intimidado o se sintió inseguro en su escuela o barrio (o lo intimidaron por Internet)? *(Ever been bullied or felt unsafe at school/neighborhood (or been cyber-bullied)?*	No	Sí	Omitir	
17	¿Se cepilla los dientes y los limpia con hilo dental todos los días? *(Brushes and flosses teeth daily?)*	Sí	No	Omitir	Dental Health
18	¿Con frecuencia se siente triste, deprimido o desesperanzado? *(Often feels sad, down, or hopeless?)*	No	Sí	Omitir	Mental Health
19	¿Pasa tiempo con alguna persona que fuma? *(Spends time with anyone who smokes?)*	No	Sí	Omitir	Alcohol, Tobacco, Drug Use
20	¿Fuma cigarrillos o mastica tabaco? *(Smokes cigarettes or chews tobacco?)*	No	Sí	Omitir	
21	¿Consume o aspira alguna sustancia para drogarse, como marihuana, cocaína, *crack*, metanfetamina (“*meth*”), éxtasis, etc.? *(Uses or sniffs any substance to get high?)*	No	Sí	Omitir	
22	¿Utiliza medicamentos que no fueron recetados para usted? *(Uses medicines not prescribed for her/him?)*	No	Sí	Omitir	
23	¿Bebe alcohol una vez a la semana o más? *(Drinks alcohol once a week or more?)*	No	Sí	Omitir	
24	Si bebe alcohol, ¿bebe hasta emborracharse o desmayarse? *(If she/he drinks alcohol, drinks enough to get drunk or pass out?)*	No	Sí	Omitir	
25	¿Tiene amigos o familiares que tienen problemas con las drogas o el alcohol? *(Has friends/family members who have problems with drugs or alcohol?)*	No	Sí	Omitir	
26	¿Conduce un automóvil después de beber, o viaja en un automóvil conducido por una persona que ha bebido o consumido drogas? *(Drives a car after drinking, or rides in a car driven by someone who has been drinking or using drugs?)*	No	Sí	Omitir	
	Sus respuestas sobre relaciones sexuales o planificación familiar no serán divulgadas a nadie, ni siquiera a sus padres, sin su permiso.				
27	¿Alguna vez lo forzaron o presionaron para tener relaciones sexuales? *(Ever been forced or pressured to have sex?)*	No	Sí	Omitir	Sexual Issues
28	¿Alguna vez ha tenido relaciones sexuales (orales, vaginales o anales)? *(Ever had sex (oral, vaginal, or anal)?* *Si la respuesta es “no”, pase a la pregunta 35.*	No	Sí	Omitir	
29	¿Cree que usted o su pareja pueden tener una infección de transmisión sexual (sexually transmitted infection, STI), como clamidia, gonorrea, verrugas genitales, etc.? *(Thinks she/he or partner could have a STI)?*	No	Sí	Omitir	

30	¿Usted o su(s) pareja(s) tuvieron relaciones sexuales con otras personas en el último año? *(She/he or partner(s) had sex with other people in the past year?)*	No	Sí	Omitir
31	¿Usted o su(s) pareja(s) tuvieron relaciones sexuales sin utilizar un método anticonceptivo en el último año? *(She/he or partner(s) had sex without using birth control in the past year?)*	No	Sí	Omitir
32	La última vez que tuvo relaciones sexuales, ¿utilizó un método anticonceptivo? *(Used birth control the last time she/he had sex?)*	Sí	No	Omitir
33	¿Usted o su(s) pareja(s) tuvieron relaciones sexuales sin condón en el último año? *(She/he or partner(s) had sex without a condom in the past year?)*	No	Sí	Omitir
34	¿Usted o su pareja usaron un condón la última vez que tuvieron relaciones sexuales? *(She/he or partner used a condom the last time they had sex?)*	Sí	No	Omitir
35	¿Le preocupa que le pueda gustar una persona del mismo sexo? *(Concerns about liking someone of the same sex?)*	No	Sí	Omitir
36	¿Tiene alguna otra pregunta o inquietud sobre su salud? *(Any other questions or concerns about health?)*	Sí	No	Omitir

Si la respuesta es afirmativa, describa, por favor:

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:

Riverwalk Pediatric Clinic, Inc.

HASMUKH C. AMIN, M.D.
MARIA C. RUERAS, M.D.
MARISSA Q. DeLEON, M.D.
VALERIE J. CAYABYAB-GARCIA, M.D.

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

FECHA ____________________

No. DE EXPEDIENTE ____________________

Indio Amricano
Asiatico
Moreno
Filipino
Mex-Amer/Hisp
Blanco
Otrro
Islas del Pacifico

INFORMACION DE EL PACIENTE

NOMBRE: ____________________
APELLIDO | PRIMER NOMBRE | 2do INICIAL | SEXO | FECHA DE NACIMIENTO | SS#

DIRECCION: ____________________
NUMERO Y NOMBRE DE LA CALLE | CIUDAD | ESTADO/ZONA POSTAL | TELEFONO

SECCION 1 – INFORMACION REQUERIDA SI EL PACIENTE ES MENOR DE EDAD –INDIQUE LA PERSONA RESPONSABLE CON UNA (X)

NOMBRE DE PADRE ____________________

FECHA DE NACIMIENTO ________ SS# ________

OCUPACION ____________________

NOMBRE DEL EMPLEADOR ____________________

DIRECCION ____________________

TELEFONO ____________________

NOMBRE DE MADRE ____________________

FECHA DE NACIMIENTO ________ SS# ________

OCUPACION ____________________

NOMBRE DEL EMPLEADOR ____________________

DIRECCION ____________________

TELEFONO ____________________

SECCION 2 – INFORMACION DE LA ASEGURANZA

ASEGURANZA PRIMARIA ____________________

NOMBRE DE EL SUBSCRITOR ____________________

ID# ________ Agrupe# ________

ASEGURANZA SECUNDARIA ____________________

NOMBRE DE EL SUBSCRITOR ____________________

ID# ________ Agrupe# ________

PERSONA(S) RESPONSABLES ____________________

REFERIDO POR ____________________

EN CASO DE EMERGENCIA CONTACTARSE CON ____________________

____
NUMERO Y NOMBRE DE LA CALLE | CIUDAD, ZONA POSTAL | TELEFONO

ASIGNAMIENTO DE LOS BENEFICIOS DE LA ASEGURANZA

Yo, por la presente authorizo Hasmukh C. Amin, M.D. poporcionar informacion con respecto a esta enfermedad y con respecto a yo por la presente asigno a ellos todos pagos para servicios medicos rendidos. Una copia de esta authorizacion es valida como la original. Entiendo que soy financieramente responsable por los cobros que no son cubiertos por esta authorizacion..

FIRMA (de la persona Asegurada) ____________________ FECHA ____________________

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 ______________________________ to receive the health screening tests and
(Name of patient)

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.

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

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 300 Old River Rd. Bakersfield, Ca. 93311

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

Tina Lujan, Privacy Officer 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: ____________