

# Evaluación de Salud

(Staying Healthy Assessment)

**7 – 12 meses** (7 – 12 Months)

Nombre del niño ( nombre y apellido)	Fecha de nacimiento	<input type="checkbox"/> mujer <input type="checkbox"/> hombre	Fecha de hoy	¿Asiste a una guardería? <input type="checkbox"/> Sí <input type="checkbox"/> No
Persona que llena el formulario	<input type="checkbox"/> Padre/madre <input type="checkbox"/> Familiar <input type="checkbox"/> Amigo <input type="checkbox"/> Tutor <input type="checkbox"/> Otro (especifique)			¿Necesita ayuda para llenar el formulario? <input type="checkbox"/> Sí <input type="checkbox"/> No

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

¿Necesita un intérprete?  
 Sí  No

**Clinic Use Only**

1	¿Amamanta a su bebé? <i>(Breastfeeds baby?)</i>	Sí	No	Omitir	Nutrition
2	¿Su bebé bebe o come 3 porciones al día de alimentos ricos en calcio, como fórmula, leche, queso, yogur, leche de soja o tofu? <i>(¿Baby drinks/eats 3 servings of calcium rich foods daily?)</i>	Sí	No	Omitir	
3	¿Le preocupa el peso de su bebé? <i>(Concerned about baby's weight?)</i>	No	Sí	Omitir	Physical Activity
4	¿Su bebé ve televisión? <i>(Baby watches any TV?)</i>	No	Sí	Omitir	
5	En su hogar, ¿hay un detector de humo que funcione? <i>(Home has working smoke detector?)</i>	Sí	No	Omitir	Safety
6	¿Ha cambiado la temperatura del agua a tibia (menos de 120 grados)? <i>(Water temperature turned down to low-warm?)</i>	Sí	No	Omitir	
7	Si en su hogar hay más de un piso, ¿tiene protección de seguridad en las ventanas y accesos a las escaleras? <i>(Safety guards on windows and gates for stairs in multi-level home?)</i>	Sí	No	Omitir	
8	En su hogar, ¿los artículos de limpieza, medicamentos y fósforos están en un lugar cerrado con llave? <i>(Cleaning supplies, medicines, and matches locked away?)</i>	Sí	No	Omitir	
9	En su hogar, ¿está pegado cerca del teléfono el número del Centro de control de intoxicaciones (800-222-1222)? <i>(Home has phone # of Poison Control Center posted by phone?)</i>	Sí	No	Omitir	

10	¿Siempre acuesta a su bebé boca arriba para dormir? <i>(Always puts baby to sleep on her/his back?)</i>	Sí	No	Omitir	
11	Cuando su bebé está en la tina, ¿permanece con él en todo momento? <i>(Always stays with baby when in the bathtub?)</i>	Sí	No	Omitir	
12	¿Su bebé siempre viaja en un asiento de seguridad para automóvil orientado hacia atrás, en el asiento de atrás? <i>(Always places baby in a rear facing car seat in the back seat?)</i>	Sí	No	Omitir	
13	¿El asiento de seguridad para automóvil que utiliza es el adecuado para la edad y el tamaño de su bebé? <i>(Car seat used is correct size for age and size of baby?)</i>	Sí	No	Omitir	
14	¿Su bebé pasa tiempo cerca de una piscina, río o lago? <i>(Baby spends time near a swimming pool, river, or lake?)</i>	No	Sí	Omitir	
15	¿Su bebé pasa tiempo en un hogar donde hay un arma de fuego? <i>(Baby spends time in a home where a gun is kept?)</i>	No	Sí	Omitir	
16	En el biberón de su bebé, ¿coloca algo que no sea fórmula, leche o agua? <i>(Gives baby a bottle with anything in it except formula, milk, or water?)</i>	No	Sí	Omitir	Dental Health
17	¿Su bebé pasa tiempo con alguna persona que fuma? <i>(Baby spends time with anyone who smokes?)</i>	No	Sí	Omitir	Tobacco Exposure
18	¿Tiene alguna pregunta o inquietud sobre la salud, el desarrollo o la conducta de su bebé? <i>(Any other questions or concerns about baby's health, development, or behavior?)</i>	No	Sí	Omitir	

*Si la respuesta es afirmativa, describa, por favor:*

<b>Clinic Use Only</b>	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
<input type="checkbox"/> Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Dental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Tobacco Exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/> <b>Patient Declined the SHA</b>
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.

FECHA \_\_\_\_\_

No. DE EXPEDIENTE \_\_\_\_\_

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

Indio Americano  
Asiatico  
Moreno  
Filipino  
Mex-Amer/Hisp  
Blanco  
Otro  
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 \_\_\_\_\_

NOMBRE DE MADRE \_\_\_\_\_

FECHA DE NACIMIENTO \_\_\_\_\_ SS# \_\_\_\_\_

FECHA DE NACIMIENTO \_\_\_\_\_ SS# \_\_\_\_\_

OCUPACION \_\_\_\_\_

OCUPACION \_\_\_\_\_

NOMBRE DEL EMPLEADOR \_\_\_\_\_

NOMBRE DEL EMPLEADOR \_\_\_\_\_

DIRECCION \_\_\_\_\_

DIRECCION \_\_\_\_\_

TELEFONO \_\_\_\_\_

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 autorizo Has Mukh C. Amin, M.D. proporcionar 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 autorizacion es valida como la original. Entiendo que soy financieramente responsable por los cobros que no son cubiertos por esta autorizacion.

FIRMA (de la persona Asegurada) \_\_\_\_\_ FECHA \_\_\_\_\_



**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

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

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.

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.

## California Child Health and Disability Prevention Program

### CONSENT FORM

I hereby give my consent for \_\_\_\_\_ to receive the health screening tests and immunizations recommended by the CHDP Program from \_\_\_\_\_.

(Name of patient)

(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
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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
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*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

# NOTICE OF PRIVACY PRACTICES:

## *Acknowledgement of Receipt*

### HASMU KH 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: \_\_\_\_\_