Bruce S. West, MD ~ Raeann Alboher, ARNP ~ Amelia. B. Phillips, ARNP
1340 S 18th St, Ste 203 ~ Fernandina Beach, FL 32034
Telephone (904) 261-7707 ~ Facsimile (904) 261-8616

Release Records ____To: ____From:
Physician/Facility:
Address:
City/State/ZIP
Phone: FAX:

Records pertaining to name(s)/date(s) of birth:
1
2
3

Records being released (please indicate):

• ___Entire record • ___History and Physical • ___Consultation Records • ___Discharge Summary • ___Emergency Department Records	• ___Laboratory Reports • ___Pathology Reports • ___Radiology Reports • ___Operative Reports • ___Immunization Records

Dates of Service: ___ All ___ Last visit only ___ From _____ To _____

Purpose of release: _____

- I hereby authorize, per the above instructions, the release/receipt of protected health information. I am aware that such records may contain information related to mental health, substance abuse, and sexually transmitted diseases (including HIV) and I specifically authorize the release of such information pursuant to the above instructions.
- I understand that this authorization will remain in effect for one year, but I may revoke it at any time in writing. I understand that any such revocation will not apply to records already released. I understand that I am under no obligation to sign this authorization, and that treatment by either of the above entities does not require this authorization. I may receive a copy of this document.
- I understand that State and federal law may prohibit the recipient from re-disclosing information provided pursuant to this authorization, but that neither Dr. West nor the above- referenced entity(s) has any control over the recipient and cannot, therefore, guarantee that the recipient will not re-disclose such information. I hereby release Dr. West and the above-referenced entity(s) from any and all liability related to (i) reliance upon this Authorization or (ii) the release of information pursuant to this Authorization.
- By signing below, I authorize the above-referenced entity(s) to release medical information about me as described above.

_____ _____
Signature of Patient Date Time

If the patient is (i) a minor, then the patient's parent or guardian should consent by signing below; or (ii) an adult but mentally or physically unable to consent for himself or herself, then the patient's guardian, legal representative, attorney-in-fact, surrogate or proxy should consent on the patient's behalf by signing below:

_____ _____
Signature of Representative Date Time Telephone number

_____ _____
Name of Representative Relationship to Patient

Initial History Questionnaire

Name

ID NUMBER

FORM COMPLETED BY

DATE COMPLETED

BIRTH DATE

AGE

☐ M ☐ F

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names, ages, and where they live. _____

What is the child's living situation if not with both biological parents?

☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody

☐ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

Birth History

☐ Don't know birth history

Birth weight _____ Was the baby born at term? _____ OR _____ weeks

Were there any prenatal or neonatal complications?

☐ Yes ☐ No Explain _____

Was a NICU stay required? ☐ Yes ☐ No Explain _____

During pregnancy, did mother

Use tobacco ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No

Use drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins

What _____ When _____

Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, why?

Was initial feeding ☐ Formula ☐ Breast milk How long breastfed? _____

Did your baby go home with mother from the hospital?

☐ Yes ☐ No Explain _____

General

DK = don't know

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ DK Explain _____

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ DK Explain _____

Has your child had any surgery? ☐ Yes ☐ No ☐ DK Explain _____

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ DK Explain _____

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ DK Explain _____

Do you feel your family has enough to eat? ☐ Yes ☐ No ☐ DK Explain _____

Biological Family History

DK = don't know

Have any family members had the following?

Childhood hearing loss	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Asthma	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tuberculosis	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Heart disease (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
High cholesterol/takes cholesterol medication	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Anemia	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bleeding disorder	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Dental decay	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Cancer (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

(Biological Family History continued on back side.)

Biological Family History *(Continued from front side.)* DK = don't know

Liver disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Kidney disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Diabetes (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bed-wetting (after 10 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Obesity	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Epilepsy or convulsions	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Alcohol abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Drug abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Mental illness/depression	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Developmental disability	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tobacco use	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

Additional family history _____

Past History DK = don't know

Does your child have, or has your child ever had,

Chickenpox	☐ Yes	☐ No	☐ DK	When _____
Frequent ear infections	☐ Yes	☐ No	☐ DK	Explain _____
Problems with ears or hearing	☐ Yes	☐ No	☐ DK	Explain _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Explain _____
Problems with eyes or vision	☐ Yes	☐ No	☐ DK	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	☐ DK	Explain _____
Any heart problem or heart murmur	☐ Yes	☐ No	☐ DK	Explain _____
Anemia or bleeding problem	☐ Yes	☐ No	☐ DK	Explain _____
Blood transfusion	☐ Yes	☐ No	☐ DK	Explain _____
HIV	☐ Yes	☐ No	☐ DK	Explain _____
Organ transplant	☐ Yes	☐ No	☐ DK	Explain _____
Malignancy/bone marrow transplant	☐ Yes	☐ No	☐ DK	Explain _____
Chemotherapy	☐ Yes	☐ No	☐ DK	Explain _____
Frequent abdominal pain	☐ Yes	☐ No	☐ DK	Explain _____
Constipation requiring doctor visits	☐ Yes	☐ No	☐ DK	Explain _____
Recurrent urinary tract infections and problems	☐ Yes	☐ No	☐ DK	Explain _____
Congenital cataracts/retinoblastoma	☐ Yes	☐ No	☐ DK	Explain _____
Metabolic/Genetic disorders	☐ Yes	☐ No	☐ DK	Explain _____
Cancer	☐ Yes	☐ No	☐ DK	Explain _____
Kidney disease or urologic malformations	☐ Yes	☐ No	☐ DK	Explain _____
Bed-wetting (after 5 years old)	☐ Yes	☐ No	☐ DK	Explain _____
Sleep problems; snoring	☐ Yes	☐ No	☐ DK	Explain _____
Chronic or recurrent skin problems (eg, acne, eczema)	☐ Yes	☐ No	☐ DK	Explain _____
Frequent headaches	☐ Yes	☐ No	☐ DK	Explain _____
Convulsions or other neurologic problems	☐ Yes	☐ No	☐ DK	Explain _____
Obesity	☐ Yes	☐ No	☐ DK	Explain _____
Diabetes	☐ Yes	☐ No	☐ DK	Explain _____
Thyroid or other endocrine problems	☐ Yes	☐ No	☐ DK	Explain _____
High blood pressure	☐ Yes	☐ No	☐ DK	Explain _____
History of serious injuries/fractures/concussions	☐ Yes	☐ No	☐ DK	Explain _____
Use of alcohol or drugs	☐ Yes	☐ No	☐ DK	Explain _____
Tobacco use	☐ Yes	☐ No	☐ DK	Explain _____
ADHD/anxiety/mood problems/depression	☐ Yes	☐ No	☐ DK	Explain _____
Developmental delay	☐ Yes	☐ No	☐ DK	Explain _____
Dental decay	☐ Yes	☐ No	☐ DK	Explain _____
History of family violence	☐ Yes	☐ No	☐ DK	Explain _____
Sexually transmitted infections	☐ Yes	☐ No	☐ DK	Explain _____
Pregnancy	☐ Yes	☐ No	☐ DK	Explain _____
(For girls) Problems with her periods	☐ Yes	☐ No	☐ DK	Explain _____

Has had first period ☐ Yes ☐ No Age of first period _____

Any other significant problem _____

This American Academy of Pediatrics Initial History Questionnaire is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 3rd Edition.

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9-223/0109

Bruce S. West, M.D.
Raeann Alboher, ARNP
Amelia Phillips, ARNP
1340 S. 18th Street Suite 203
Fernandina Beach, Florida 32034

PATIENT INFORMATION

Patient Name:_____DOB:_____Date:_____
Sex: Male/Female (circle one)

Parent/Guardian Name:_____

Home Phone#:_____Work Phone#:_____Cell Phone:_____

Address:_____City/State:_____Zip:_____

Primary language spoken:_____Do you have communication needs:_____
_____

You are responsible for your own insurance.
Do you/your child have health insurance?:_____If a newborn need to know what insurance the child will be on.

Insurance Company:_____Policy Holder's Name:_____

Policy Holder's DOB:_____Insurance company's telephone#:_____

Insurance Co. Address:_____City/State:_____Zip:_____

Insurance Policy#:_____Group#_____
_____

Emergency Contact Person:_____Relationship:_____Phone#:_____
_____

List people other than yourself that are allowed to bring child to appointments and/or receive medical information:

1. _____
2. _____
3. _____

PAYMENT AT TIME OF SERVICE

It is our office policy that payments are due at the time of service. If we have a contract with your Insurance Company, we will file your Insurance. However, **YOU** are responsible for all copays, deductibles and noncovered services. I understand and agree that, regardless of my Insurance status, I am ultimately responsible for the balance of my account.

DATE:_____SIGNATURE:_____

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to Bruce S. West, M.D., for medical benefits, if any, otherwise payable to me under the terms of my insurance.

DATE:_____SIGNATURE:_____

HIPAA NOTICE OF PRIVACY PRACTICES

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number, 904-261-7707. Signature below acknowledges that you have reviewed and received (if you wanted it) our Notice of Privacy Practices.

PRINT NAME:_____SIGNATURE:_____

DATE:_____