PATIENT NOTICE

Our goal at HOPES is to provide quality medical care. Because of our concern for your health and well-being, there are certain types of medications we may not be able to prescribe to you. Examples include the following:

- Oxycontin
- Oxycodone
- Hydrocodone
- Percocet
- Percodan
- Lortab
- Lorcet
- Morphine
- Tylenol #3
- Tylox
- Ultram/Tramadol
- Xanax
- Valium
- Restoril
- Klonopin
- Tranxene
- Ativan
- Ambien
- Soma
- Methadone
- Vicodin
- Stimulants for Adults

If you are already taking any of the above medications, your provider may want to talk to you about alternative treatments.

If you are a new patient, please be aware that it is highly unlikely we will be able to prescribe any of these medications for you.

If you have questions and concerns about this policy, please feel free to discuss them with your provider or with the Chief Medical Officer.

NORTHERN NEVADA HOPES *your partner in health.*

FOR OFFICE USE ONLY: PLEASE CHECK ONE

ADULT PRIMARY CARE	
PEDIATRIC PRIMARY CARE	
ADULT BEHAVIORAL HEALTH	
PEDIATRIC BEHAVIORAL HEALTH	
RELEASE OF INFORMATION SIGNED	

NORTHERN NEVADA HOPES *your partner in health.*

Pediatric Patient Registration

_____ _____/_____/_____

DATE SOCIAL SECURITY NUMBER

_____

FIRST NAME MIDDLE NAME LAST NAME

_____

NICK NAME (IF APPLICABLE) PHONE NUMBER

_____

HOME ADDRESS CITY STATE ZIP CODE

_____

AGE DATE OF BIRTH PLACE OF BIRTH SEX AT BIRTH

_____

FORM COMPLETED BY RELATIONSHIP TO PATIENT

Gender:

☐ Male ☐ Female ☐ Other

Race:

☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American

☐ Native Hawaiian/Pacific Islander ☐ White/Caucasian ☐ Other

Ethnicity:

☐ Hispanic ☐ Non-Hispanic

Preferred Language:

☐ English ☐ Spanish ☐ Other _____

How did you hear about us?

☐ By a current HOPES patient ☐ Billboard ☐ HOPES Website ☐TV Ad ☐Social Media

☐ Other_____

Student Status:

☐ Full-Time Student ☐ Part-Time Student ☐ Not a Student

Employment Status:

☐ Employed ☐ Not Employed ☐ Retired ☐ Active Military Duty ☐ Unknown

Parent/Legal Guardian Information #1

PARENT/LEGAL GUARDIAN NAME(S) | RELATIONSHIP TO PATIENT | PARENT/LEGAL GUARDIAN'S DOB

BEST PHONE NUMBER | ADDITIONAL PHONE NUMBER | EMAIL ADDRESS

HOME ADDRESS | CITY | STATE | ZIP CODE

Permission to Contact Parent/Legal Guardian #1 _____ (Initial)

Do you give us permission to:

Call you at home?	☐ Yes	☐ No	Call you at work?	☐ Yes	☐ No
Leave message(s) at home?	☐ Yes	☐ No	Leave message(s) at work?	☐ Yes	☐ No
Email you?	☐ Yes	☐ No	Send HOPES information?	☐ Yes	☐ No
Leave text messages (SMS)?*	☐ Yes	☐ No	Ask for survey participation?	☐ Yes	☐ No

* Fees may be applied by your service carrier.

Parent/Legal Guardian Information #2

PARENT/ LEGAL GUARDIAN NAME(S) | RELATIONSHIP TO PATIENT | PARENT/LEGAL GUARDIAN'S DOB

BEST PHONE NUMBER | ADDITIONAL PHONE NUMBER | EMAIL ADDRESS

HOME ADDRESS | CITY | STATE | ZIP CODE

Permission to Contact Parent/Legal Guardian #2 _____ (Initial)

Do you give us permission to:

Call you at home?	☐ Yes	☐ No	Call you at work?	☐ Yes	☐ No
Leave message(s) at home?	☐ Yes	☐ No	Leave message(s) at work?	☐ Yes	☐ No
Email you?	☐ Yes	☐ No	Send HOPES information?	☐ Yes	☐ No
Leave text messages (SMS)?*	☐ Yes	☐ No	Ask for survey participation?	☐ Yes	☐ No

* Fees may be applied by your service carrier.

Emergency Contact Information

EMERGENCY CONTACT | PHONE NUMBER

RELATIONSHIP TO PATIENT

PRIMARY CARE PHYSICIAN (IF APPLICABLE) | PHONE NUMBER

To the best of my knowledge, all information on this registration form is true and correct. I understand that it is my responsibility to notify HOPES staff immediately if there are any changes in my name, address, telephone number, work status, and/or location, insurance coverage, SSI, SSD, or any other benefits received through outside agencies or community based organizations. I understand that any fields that are left blank will be recorded as 'unknown' in my health records.

PATIENT SIGNATURE | DATE

PARENT/ LEGAL GUARDIAN SIGNATURE | DATE

Authorization for Third Party to Consent to Treatment of Minor

I am the
____Parent
____Guardian
____Other person having legal custody_____
(*Describe legal relationship)*

of_____, a minor.
(Print *Name of Minor)*

I hereby authorize_____, to act as my agent to consent to all health
(*Print Name of Agent)*
services which are recommended by, and delivered under any licensed provider at Northern Nevada HOPES, whether such diagnosis, treatment or transport/referral for hospital care is required.

I understand that this authorization is given in advance of any specific diagnosis, treatment, or transport/referral for hospital care being required, but is given to provide authority to the above-named agent to give consent to any and all such diagnosis, treatment, or transport/referral for hospital care which a licensed provider, from Northern Nevada HOPES, recommends.

I have carefully read and fully understand this consent and agreement. I have received a copy of this consent/agreement and am duly authorized to execute the above, and I accept the terms as described. I understand this consent/agreement is effective for one year from today, or until revoked in writing, whichever is sooner.

Signature: _____ Date/Time:_____
(***Parent, guardian, other person above having legal custody)***

Print Name: _____
(***Parent, guardian, other person above having legal custody)***

Witness to Signature:_____ Date/Time:_____

Print MINOR's Name: _____ Date of Birth:_____

_____ Copy given to Agent _____ Consent scanned in Minor's chart _____ Original sent to Compliance Department

---

I acknowledge that I have the right to revoke these authorizations at any time, (Which may be in writing, in person, or by certified mail to the provider at the address above. The revocation will be affected only upon receipt, except to the extent that the Provider has acted in reliance on the authorization.

REVOKE AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

I hereby revoke these authorizations for third party consent to treatment of said minor.

Signature: _____ Date/Time:_____
(***Parent, guardian, other person above having legal custody)***

_____ Copy given to Agent _____ Consent scanned in Minor's chart _____ Original sent to Compliance Department

FOR OFFICE USE ONLY: PLEASE CHECK ONE

ADULT PRIMARY CARE	
PEDIATRIC PRIMARY CARE	
ADULT BEHAVIORAL HEALTH	
PEDIATRIC BEHAVIORAL HEALTH	

NORTHERN NEVADA HOPES *your partner in health.*

Consent to Treatment

I hereby consent to and authorize such treatment as prescribed and fully explained to me by HOPES. I further consent to and authorize such laboratory tests and procedures, x-ray examinations and other routine medical services that are deemed necessary by the HOPES providers. It is not possible to make guarantees concerning the results of the examination for treatment. I acknowledge no such guarantee has been made to me. I understand I will have the opportunity to discuss any and all care and/or treatment proposed to me with the HOPES providers and I may refuse to consent for care and/or treatment if I do not want to proceed with such course of treatment. I will provide HOPES with accurate information regarding my medical, sexual, drug, and/or alcohol history and personal or social concerns which may impact my health or medical care to ensure proper treatment, care, and referral for needed services. I am responsible for having all lab tests, x-rays, and other diagnostic procedures done in a timely manner, prior to my next scheduled clinic appointment, and I will report for all scheduled clinic appointment on time. A patient's acceptance of family planning services must not be a prerequisite to eligibility for, or receipt of, any other services, assistance from, or participation in any other program that is offered by Northern Nevada HOPES (42 CFR 59.5(a)(2)).

_____ I will be able to choose a HOPES provider based on availability. I understand that I may be seen by another HOPES provider if my regular provider is unavailable. I understand that if I am late for my appointment, I may not be seen by my scheduled provider. I understand that I must request medication refills by contacting the pharmacy at least three business days prior to my medication supply being exhausted.

_____ I acknowledge that the HOPES Clinic **does not operate an emergency care service**. Staff members are available to me during regular business hours to answer any questions or concerns regarding my need for urgent care. If my situation is an emergency, I will call 911 for assistance or go to the nearest emergency room. If I wish to speak to a provider after hours, I can call the HOPES clinic at (775) 786-4673. I will be directed to the answering service and a provider will return my call.

_____ I understand that HOPES has an integrated team approach to patient management and that medical information may be shared among physicians, Physician Assistants, pharmacists, behavioral health providers, RNs, case managers, medical assistants, trainees, medical students, or interns without consent. This information is used solely for the purpose of coordination of clinical care and social service's needs.

PAYMENT FEES FOR SERVICES

Northern Nevada HOPES provides services to clients who have no third party insurance coverage using a sliding fee scale, adhering to the Health and Human Services Poverty Guidelines. I understand that charges for services are contingent upon my income and can change as my income increases or decreases. In the event that I am entitled to benefits arising out of any policy of private or commercial insurance, said benefits will be applied for and assigned to Northern Nevada HOPES. If I am covered by Medicare, or Medicaid a claim will be sent to the appropriate agency. However, I understand that I am responsible for any copays, deductibles, or other charges required by any insurance policy or government agency and that such copays are payable at the time of rendered services unless other prior arrangements have been made.

I have carefully read and fully understand this consent and agreement. I have received a copy of this consent/agreement and am duly authorized to execute the above, and I accept the terms as described. I understand this consent/agreement is effective until revoked in writing.

_____

PATIENT/LEGAL GUARDIAN SIGNATURE DATE

_____

WITNESS SIGNATURE DATE

NORTHERN NEVADA HOPES *your partner in health.*

As a patient, you have the right to:

- Be treated with respect and dignity in a safe and private setting.
- Change medical providers at Northern Nevada HOPES.
- Get another opinion about your illness or treatment.
- Respect for your cultural, social, spiritual, and personal values and beliefs.
- Know the cost of your care and ways you may pay for your care.
- Access the on-call doctor through an after-hours answering service.
- Access interpretive services if you do not understand English or other assistance if you are hearing or sight impaired. Such services are free of charge.
- Receive services regardless of your ability to pay.
- Be informed about your illness and treatment, including options for your care.
- Know about services available through HOPES.
- Know that HOPES does not provide dental services on site, but you can be referred to external dentists.
- Ask for special arrangements if you have a disability.
- Refuse to be included in any research program without limiting medical care or treatment.
- Be informed that HOPES does not manage chronic pain or provide disability assessments.
- Be informed that taping your office visit with your provider without disclosing the same does not foster a trusting provider-patient relationship.
- Be informed of HOPES pharmacy hours and timelines for filling new and existing prescriptions.
- Be informed of electronic access of your patient records through HOPES patient web portal.
- Privacy of your health records as determined by HIPAA / 42 CFR Part 2.
- Know that HOPES has a legal duty to report certain information and it will make such reports to the proper authorities.
- Refuse treatment care and services as allowed by law.
- File a complaint or a formal grievance, if you are not satisfied with the care at HOPES.
- Know about philosophy and characteristics of the patient management program.
- Have personal health information shared with the patient management program(s) only in accordance with state and federal law.
- Identify HOPES specific program's staff members, including their job title, and to speak with a staff member's supervisor if requested.
- Speak to a health professional and receive information about patient management program.
- Receive administrative information regarding changes in, or termination of, the patient management program at HOPES.
- Decline participation, revoke consent, or dis-enroll as a patient at HOPES at any point in time.

NORTHERN NEVADA HOPES *your partner in health.*

As a patient, you have the responsibility to:

- Inform your medical provider about your illness o problems.
- Ask questions about your illness or care.
- Show respect to HOPES employees, volunteers, and contractors and other patients.
- Cancel or reschedule appointments in advance so that another person may have that timeslot.
- Inform the hospital or ER that you are a patient of HOPES for coordination of care.
- Not arrive at Northern Nevada HOPES or appointments intoxicated or under the influence of drugs.
- Use medications or medical devices for yourself only.
- Inform a medical provider if you become worse or have an unexpected reaction to a medication.
- Follow prescriber's directions on all aspects of prescriptions.
- Give written permission to release your health records when necessary.
- Provide HOPES a copy of your living will or durable power of attorney for health care matters.
- Pay your co-pays and bills on time.
- Meet with financial counselors to set up payment plan
- Submit forms that are necessary to participate in a program, to the extent required by law.
- Give accurate clinical and contact information and to notify the patient management program of changes in this information.
- Notify your treating provider of their participation in the patient management program, if applicable.

If you have any questions, please ask a HOPES employee.

PATIENT NAME

PATIENT/LEGAL GUARDIAN SIGNATURE DATE

NORTHERN NEVADA HOPES *your partner in health.*

FOR OFFICE USE ONLY: PLEASE CHECK ONE

ADULT PRIMARY CARE	
PEDIATRIC PRIMARY CARE	
ADULT BEHAVIORAL HEALTH	
PEDIATRIC BEHAVIORAL HEALTH	

Notice of Privacy Practice and Complaint/ Grievance Acknowledgement:

NOTICE OF PRIVACY PRACTICE

I hereby acknowledge that I have read or received HOPES Notice of Privacy Practice (or have had it read to me in a language I can understand). I have had all my questions answered about this Notice of Privacy Practice.

I acknowledge that I have been informed that HOPES' Notice of Privacy Practice is located on HOPES' webpage and at each reception area.

I understand that I will receive a paper copy of the Notice of Privacy Practice when I request one.

____I would like a paper copy of HOPES Notice of Privacy Practice

____Individual was provided a paper copy of the Notice of Privacy Practice

COMPLAINTS & GRIEVANCES

Northern Nevada HOPES takes complaints and/or grievances of all kinds seriously and invites discussion with clients or legal guardians about their concerns. HOPES will provide a forum to address complaints, striving for a satisfactory resolution prior to a grievance being filed. In the event a satisfactory resolution is not achieved, a client may file a formal grievance. During the formal grievance process, HOPES strives to work with clients to find mutually satisfying conclusions.

If you would like a copy of the complaint or grievance form with instructions, please contact the Privacy Officer.

Patient Name:_____

_____

SIGNATURE OF PERSON GIVING ACKNOWLEDGEMENT OF LEGAL REPRESENTATIVE DATE

PRINT NAME OF PERSON GIVING ACKNOWLEDGEMENT _____

RELATIONSHIP TO INDIVIDUAL: ___Self ___Parent ___Guardian ___Authorized Representative

Acknowledgement Refused

On this date, the undersigned patient refused or failed to acknowledge receipt of the Notice of Privacy Practice and Complaints/Grievances.

Patient Name:_____ Date:_____

Reason for refusal/failure: _____

_____

_____

_____

A signed copy of this page is to be filed with the patient's record.

NORTHERN NEVADA HOPES *your partner in health.*

Email Consent: Non-Secure E-Mail/Text (SMS) Messaging

PATIENT NAME DATE OF BIRTH

PATIENT EMAIL ADDRESS

Northern Nevada HOPES' team cannot guarantee the security and confidentiality of an e-mail or text (SMS) message transmission. Employers and online services have the right to access and archive e-mail and text (SMS) transmitted through their systems. If your e-mail is a family address, other family members may see your messages. If you allow others access to your cell phone they may see your messages. Therefore, please be aware that you e-mail and/or text (SMS) at your own risk. Because of the many internet and e-mail factors beyond our control, we cannot be responsible for misaddressed, misdelivered or interrupted e-mail or text (SMS) messages. Northern Nevada HOPES and your health care provider are not liable for breaches of confidentiality caused by yourself or a third party.

Northern Nevada HOPES will only send text (SMS) messages pursuant to the Federal Communications Commission's (FCC) Declaratory Ruling and Order. HOPES will not receive text (SMS) messages.

E-mail is best suited for routine matters and simple questions. You should not send e-mail for urgent or emergency situations or for matters requiring an immediate response. Your provider will attempt to read and respond promptly to e-mail, but cannot guarantee that an e-mail will be read and responded to within any particular period of time. Time sensitive issues should be taken care of by telephone.

Please do not use e-mail for communications regarding sensitive health information, such as sexually transmitted diseases, AIDS/HIV, mental health or substance abuse.

Please include your full name, birthdate and telephone number in all e-mails. List the subject of your e-mail in the "Subject" line of your message.

All e-mails between you and your provider regarding diagnosis or treatment will be printed and made part of your permanent health record. Your provider may forward your e-mail to other staff members as necessary for response. However, your e-mail will not be forwarded outside the Health Team without your authorization. In order to prevent the introduction of computer viruses into our system, do not send attachments to us in your e-mail.

You are responsible for protecting your password or other means of access to e-mail and text (SMS) messages.

PATIENT/LEGAL GUARDIAN SIGNATURE DATE

SIGNATURE OF WITNESS DATE

NORTHERN NEVADA HOPES *your partner in health.*

FOR OFFICE USE ONLY: PLEASE CHECK ONE

ADULT PRIMARY CARE	
PEDIATRIC PRIMARY CARE	
ADULT BEHAVIORAL HEALTH	
PEDIATRIC BEHAVIORAL HEALTH	

Household Dependents

Please complete the following information for all partners, children, and others living in your home:

1. _____
   FIRST NAME MIDDLE NAME LAST NAME

   _____
   DATE OF BIRTH ETHNICITY RELATIONSHIP

2. _____
   FIRST NAME MIDDLE NAME LAST NAME

   _____
   DATE OF BIRTH ETHNICITY RELATIONSHIP

3. _____
   FIRST NAME MIDDLE NAME LAST NAME

   _____
   DATE OF BIRTH ETHNICITY RELATIONSHIP

4. _____
   FIRST NAME MIDDLE NAME LAST NAME

   _____
   DATE OF BIRTH ETHNICITY RELATIONSHIP

5. _____
   FIRST NAME MIDDLE NAME LAST NAME

   _____
   DATE OF BIRTH ETHNICITY RELATIONSHIP

6. _____
   FIRST NAME MIDDLE NAME LAST NAME

   _____
   DATE OF BIRTH ETHNICITY RELATIONSHIP

COMMENTS:

_____

_____

_____

_____

_____

_____

ACCT # _____

NORTHERN NEVADA HOPES
FPL SURVEY

ANNUAL INCOME

Please provide your annual income. The first step is to find the family size column and mark the number people in your household. You'll then check the box which represents the dollar amount that is closest to the annual household income. For example, a household of 5 people without an income would be marked at the family of five and Level 1 < 138% FPL (0 - $44,809).

INGRESOS ANUALES

Por favor, proporcione su ingreso anual. El primer paso es encontrar la columna del tamaño de la familia y marcar el número de personas en su hogar. Luego, marcará la casilla que representa el monto en dólares más cercano al ingreso anual del hogar. Por ejemplo, un hogar de 5 personas sin ingresos se marcaría en la familia de cinco y Nivel 1 <138% FPL (0 - $ 44,809).

Family Size	Level 1<138% FPL	Level 2 <150% FPL	Level 3 <175% FPL	Level 4 < 200% FPL	Level 5 <300% FPL	Level 6 >300% FPL	Level 7 >400% FPL
1	0 – 18,754 ☐	18,755 – 20,385 ☐	20,386 – 23,783 ☐	23,784 – 27,180 ☐	27,181 – 40,770 ☐	40,771 – 54,360 ☐	54,361 and above ☐
2	0 – 25,268 ☐	25,267 – 27,465 ☐	27,466 – 32,043 ☐	32,044 – 36,620 ☐	36,621 – 54,930 ☐	54,931 – 73,240 ☐	73,241 and above ☐
3	0 – 31,781 ☐	31,782 – 34,545 ☐	34,546 – 40,303 ☐	40,304 – 46,060 ☐	46,061 – 69,090 ☐	69,091 – 92,120 ☐	92,121 and above ☐
4	0 – 38,295 ☐	38,296 – 41,625 ☐	41,626 – 48,563 ☐	48,564 – 55,500 ☐	55,501 – 83,250 ☐	83,251 – 111,000 ☐	111,001 and above ☐
5	0 – 44,809 ☐	44,810 – 48,705 ☐	48,706 – 56,823 ☐	56,824 – 64,940 ☐	64,941 – 97,410 ☐	97,411 – 129,880 ☐	129,881 and above ☐
6	0 – 51,322 ☐	51,323 – 55,785 ☐	55,786 – 65,083 ☐	65,084 – 74,380 ☐	74,381 – 111,570 ☐	111,571 – 148,760 ☐	148,761 and above ☐
7	0 – 57,836 ☐	57,837 – 62,865 ☐	62,866 – 73,343 ☐	73,344 – 83,820 ☐	83,821 – 125,730 ☐	125,731 – 167,640 ☐	167,641 and above ☐
8	0 – 64,349 ☐	64,350 – 69,945 ☐	69,946 – 81,603 ☐	81,604 – 93,260 ☐	93,261 – 139,890 ☐	139,891 – 186,520 ☐	186,521 and above ☐

Name/Nombre: _____ **Date/Fecha**: _____

First-Last Name/ Nombre-Apellido

Revised 02/09/2022

NORTHERN NEVADA HOPES *your partner in health.*

PEDIATRIC HEALTH HISTORY | New Patient Today's Date:_____

_____

CHILD FIRST NAME MIDDLE NAME LAST NAME

_____

Nickname AGE DATE OF BIRTH

Form completed by: _____

Reason for visit?_____

Previous healthcare provider? _____ Last visit?_____

Specialists (past or present)?_____

Living Arrangements:

Who does the child live with? (ex. Mother, Father, Siblings, Grandparents)

_____

_____

If parents are not living together or if child does not live with both biological parents, what is the child's custody status? _____

_____

Occupations of adults living with child?

_____

_____

MEDICATIONS

Does your child take any medications regularly? ☐ Yes ☐ No Explain:

_____

_____

Any vitamins, herbs or supplements? ☐ Yes ☐ No Explain:

_____

Is your child allergic to any medicines or drugs? ☐ Yes ☐ No Explain:

_____

_____

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PERSONAL MEDICAL HISTORY:

BIRTH HISTORY When was the baby born? ☐ At term (37+ weeks) ☐ Early ☐ Late
If early, weeks gestation? _____

Birth weight: _____ lbs _____oz **or:** _____kg _____g

Birthplace:_____

Delivered: ☐ Vaginal ☐ Cesarean If cesarean, why? _____

Did the baby have any problems right after birth? ☐ Yes ☐ No If yes, please explain: _____

Did the mother have any illness or problem with her pregnancy? ☐ Yes ☐ No

If yes, please explain: _____

During pregnancy, did the mother:

Smoke? ☐ Yes ☐ No Drink alcohol? ☐ Yes ☐ No Use drugs? ☐ Yes ☐ No Medications? ☐ Yes ☐ No

Date of adoption (if applicable): _____

How was the initial feeding given? ☐ Breast ☐ Bottle If breastfed, how long? _____

Did the baby go home with the mother from the hospital? ☐ Yes ☐ No

If no, please explain: _____

PAST HISTORY – if applicable, does your **child** have or has he/she ever had:

CONDITION	NOW	PAST	COMMENTS
ADHD/anxiety/mood problems/depression			
Alcohol/Drug use			
Anemia			
Asthma, bronchitis, pneumonia			
Bed wetting (after 5 years old)			
Bladder or kidney infection/malformation			
Bleeding or clotting problems			
Blood transfusion			
Cancer or bone marrow treatment			
Chemotherapy			
Chickenpox			
Chronic or recurrent skin problem			
Congenital cataracts or retinoblastoma			
Convulsions or neurological problems			
Dental decay			
Developmental delay			
Diabetes			

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CONDITION	NOW	PAST	COMMENTS
Environmental or food allergies			
Frequent abdominal pain/constipation			
Frequent ear infections or hearing loss			
Frequent headaches			
Gender transition			
Head injuries/concussion/ Loss of consciousness			
Heart problem or heart murmur			
Nasal allergies			
Obesity			
Organ transplant			
Persistent snoring			
Problems with eyes or vision			
Sexually transmitted infection problem			
Sleep problems			
Thyroid or other endocrine problems			
(F) Has she started her period?	YES	NO	
(F) Problems with periods	YES	NO	
Any other significant problems?	YES	NO	

GENERAL

Has your child had serious injuries or accidents? ☐ Yes ☐ No

Explain: _____

Has your child ever had **surgery**? ☐ Yes ☐ No

Explain: _____

Has your child ever been **hospitalized**? ☐ Yes ☐ No

Explain: _____

Are your child's vaccines up to date? ☐ Yes ☐ No

Explain: _____

Are any family members smokers? ☐ Yes ☐ No

Explain: _____

Are there any guns in the home? ☐ Yes ☐ No

If yes, locked away from kids?: _____

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FAMILY HISTORY: Adopted? ☐ Yes ☐ No

Please list any known medical conditions for the relatives listed below.

For example: diabetes, cancer, heart attack, stroke, high blood pressure, high cholesterol, alcohol abuse, drug abuse, depression.

Relative	Alive, age	Deceased, age of death	Medical Condition(s)	Cause of death (if applicable)
Mom				
Dad				
Mom's Dad				
Mom's Mom				
Dad's Dad				
Dad's Mom				
Siblings				
Other Relatives				

Additional Comments:

_____

_____

Is there anything else you would like to share with us about your child?

_____

_____

CASE MANAGEMENT

Do you have access to enough food? ☐ Yes ☐ No

Do you currently have housing? ☐ Yes ☐ No

Do you have transportation to your medical appointments? ☐ Yes ☐ No

Do you have current legal stressors? ☐ Yes ☐ No

Would you like to speak to a case manager today? ☐ Yes ☐ No