Sancta Familia Medical Clinic
10506 Burt Circle
Omaha, NE 68114-2094
Phone: 402-991-3393 Fax: 402-991-3390

Notice of Privacy Practices Receipt & Permission to Disclose Protected Health Information

This notice describes how medical/protected health information about you may be used and disclosed. Please read this carefully. This form is to accompany the Notice of Privacy Practices.

Summary: As a patient you:
1. Can inspect and copy your health information. 2. Can request corrections to your health information.
3. Can request that your information be restricted. 4. Can request confidential communication.
5. Can obtain a report of disclosures of your information. 6. Can obtain a paper copy of this notice.

We want to help assure you that your medical/protected health information (PHI) is secure. This notice contains information about how we will help ensure that your information remains private.

Disclosing health information:
Your personal health information may be disclosed to necessary parties to provide for treatment, payment and health care operations. You may also authorize release to family members or other persons.

Patient's Name (please print)_____ DOB:_____

Persons to whom information may be disclosed:
Name: _____ Relationship: _____ Phone#:_____

☐ Add as an Emergency Contact

Name: _____ Relationship: _____ Phone#:_____

☐ Add as an Emergency Contact

Receiving health information:
Please indicate the phone number that you wish to be used for receiving calls about your appointments, lab and testing results, and other health information. Be aware that a cell phone number is not considered a secure and private line. You may list both a cell and home if you wish.
Phone number(s): _____

___ Yes, you may leave confidential detailed messages on my telephone voicemail listed above.

___ Yes, you may leave a message for a returned call.

___ No, you may NOT leave confidential detailed messages on my telephone voicemail listed above.

I acknowledge that I was provided with the Notice of Privacy Practices of Sancta Familia Medical Clinic.

_____ _____ _____
Signature of patient/ legal guardian if under 19 years **Relationship** **Date**

*This authorization is effective until a written request from the patient is submitted, revoking authority.

Sancta Familia Medical Apostolate

10506 Burt Circle Omaha, NE 68114-2094

Phone: 402-991-3393 Fax: 402-991-3390

ACKNOWLEDGEMENT AND AUTHORIZATION:

- I hereby assign my insurance benefits to be paid directly to the healthcare provider.
- I authorize Sancta Familia Medical Apostolate to release medical information required to process my claim.
- I have read and understand the Financial Policy for Sancta Familia Medical Apostolate.
- I authorize Sancta Familia Medical Apostolate to obtain/have access to my medication history.
- I authorize my provider's office to contact me by mobile phone.

Print Patient's Name:_____ **DOB**:_____

Signed:_____ **Date**:_____

(Patient, Parent, legal guardian or authorized representative-Please denote 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.

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

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.

HE0328

9-223/0109

Sancta Familia Medical Apostolate
10506 Burt Circle
Omaha, NE 68114-2094
Phone: 402-991-3393 Fax: 402-991-3390

Request for Access to Medical Records

Notice to Patient: You may use this form to request to inspect or copy information maintained about you. This type of request is described in our Practice's Notice of Privacy Practices. To revoke this request provide a written notice to our office.

Patient Name _____ **Date of Birth** _____

Please FAX a copy of my records to Sancta Familia Medical Apostolate.

Doctor Name _____

Name and Location _____

_____

Phone _____ **Fax** _____

Please send the following health information:

( ) Complete Medical Record

( ) Medical Records from _____ **to** _____
Date Date

( ) Specific Records Listed: _____

If applicable, include, health information related to testing, diagnosis, and/or treatment of (initial applicable line): _____ HIV (AIDS) _____ Sexually Transmitted Diseases

_____ Mental Health _____ Drug and/or Alcohol Abuse

Patient Name Print _____

Patient Signature _____ **Date:** _____

For Personal Representative of Patient or To Access Patient Information
I hereby certify that I have the legal authority under applicable law to make this request on behalf of the patient identified above or the Patient has requested that I can receive medical information.

Print Representative Name _____

Relationship _____

Signature of Representative _____ **Date:** _____