

American Academy of Pediatrics



BRIGHT FUTURES PREVISIT QUESTIONNAIRE

FIRST WEEK VISIT (3 TO 5 DAYS)

To provide you and your baby with the best possible health care, we would like to know how things are going. Please answer all the questions. Thank you.

WHAT WOULD YOU LIKE TO TALK ABOUT TODAY?

Do you have any concerns, questions, or problems that you would like to discuss today? No Yes, describe:

TELL US ABOUT YOUR BABY AND FAMILY.

What excites or delights you most about your baby?

Does your baby have special health care needs? No Yes, describe:

Have there been major changes lately in your family's life? No Yes, describe:

Have any of your baby's relatives developed new medical problems since your last visit? No Yes Unsure If yes or unsure, please describe:

Does your baby live with anyone who smokes or spend time in places where people smoke or use e-cigarettes? No Yes Unsure

YOUR GROWING AND DEVELOPING BABY

Do you have specific concerns about your baby's development, learning, or behavior? No Yes, describe:

Check off each of the tasks that your baby is able to do.

- | | | |
|--|--|---|
| <input type="checkbox"/> Stay awake for a short time to feed. | <input type="checkbox"/> Calm to an adult's voice. | <input type="checkbox"/> Move her arms and legs at the same time when startled. |
| <input type="checkbox"/> Make brief eye contact with an adult when held. | <input type="checkbox"/> Lift and turn his head to the side briefly when he is on his tummy. | <input type="checkbox"/> Keep his hands in a fist. |
| <input type="checkbox"/> Cry when she is uncomfortable. | | |

FIRST WEEK VISIT (3 TO 5 DAYS)

RISK ASSESSMENT

Vision	Do you have concerns about how your baby sees?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
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ANTICIPATORY GUIDANCE

How are things going for you, your baby, and your family?

YOUR FAMILY'S HEALTH AND WELL-BEING

Living Situation and Food Security			
Is permanent housing a worry for you?	<input type="radio"/> No	<input type="radio"/> Yes	
Do you have the things you need to take care of your baby, such as a crib, a car safety seat, and diapers?	<input type="radio"/> Yes	<input type="radio"/> No	
Does your home have enough heat, hot water, and electricity?	<input type="radio"/> Yes	<input type="radio"/> No	
Do you have health insurance for yourself?	<input type="radio"/> Yes	<input type="radio"/> No	
Within the past 12 months, were you ever worried whether your food would run out before you got money to buy more?	<input type="radio"/> No	<input type="radio"/> Yes	
Within the past 12 months, did the food you bought not last, and you did not have money to get more?	<input type="radio"/> No	<input type="radio"/> Yes	
Do you need help in finding community support services, such as WIC or food stamps?	<input type="radio"/> No	<input type="radio"/> Yes	
Family Support			
Do you search the Internet to learn about how to care for your baby?	<input type="radio"/> No	<input type="radio"/> Yes	

GETTING TO KNOW YOUR BABY

How You Are Feeling			
Do you sleep when the baby sleeps?	<input type="radio"/> Yes	<input type="radio"/> No	
Does your partner or do other family members help with the baby?	<input type="radio"/> Yes	<input type="radio"/> No	
If you have other children, are you able to spend time with them?	<input type="radio"/> NA	<input type="radio"/> Yes	<input type="radio"/> No

CARING FOR YOUR BABY

Do you read to your baby?	<input type="radio"/> Yes	<input type="radio"/> No	
Is a TV, computer, tablet, or smartphone on in the background when your baby is in the room?	<input type="radio"/> No	<input type="radio"/> Yes	
Is your baby able to fully awaken for feedings?	<input type="radio"/> Yes	<input type="radio"/> No	
Do you have questions about how to calm your baby?	<input type="radio"/> No	<input type="radio"/> Yes	
When to Call Your Doctor/Emergency Planning			
Do you know how to take your baby's temperature rectally?	<input type="radio"/> Yes	<input type="radio"/> No	
Do you have a list of emergency phone numbers?	<input type="radio"/> Yes	<input type="radio"/> No	
Do you have any questions about taking your baby out in public places?	<input type="radio"/> No	<input type="radio"/> Yes	

FEEDING YOUR BABY

General Information			
Does your baby feed well?	<input type="radio"/> Yes	<input type="radio"/> No	
Do you have any questions about how your baby is growing?	<input type="radio"/> No	<input type="radio"/> Yes	
Are you having problems burping your baby?	<input type="radio"/> Yes	<input type="radio"/> No	
Can you tell when your baby is hungry?	<input type="radio"/> Yes	<input type="radio"/> No	
Can you tell when your baby is full?	<input type="radio"/> Yes	<input type="radio"/> No	
Does your baby have 5 or 6 wet disposable diapers (or 6–8 cloth diapers) and 3 or 4 stools a day?	<input type="radio"/> Yes	<input type="radio"/> No	

Please print.

FIRST WEEK VISIT (3 TO 5 DAYS)

FEEDING YOUR BABY (CONTINUED)

If you are breastfeeding, answer these questions.		
Is breastfeeding uncomfortable or painful?	<input type="radio"/> No	<input type="radio"/> Yes
Do you eat foods that are high in protein (such as eggs, lean meat, poultry, fish, or beans) every day?	<input type="radio"/> Yes	<input type="radio"/> No
Are you continuing to take prenatal vitamins?	<input type="radio"/> Yes	<input type="radio"/> No
Do you take medications (either over-the-counter or prescription) or herbal supplements?	<input type="radio"/> No	<input type="radio"/> Yes
Are you giving your baby vitamin D drops?	<input type="radio"/> Yes	<input type="radio"/> No
If you are formula feeding, or providing formula supplementation, answer these questions.		
Are you using iron-fortified formula?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have any questions about using formula, such as how much it costs or how to prepare it?	<input type="radio"/> No	<input type="radio"/> Yes

SAFETY

Car and Home Safety		
Is your baby fastened securely in a rear-facing car safety seat in the back seat every time she rides in a vehicle?	<input type="radio"/> Yes	<input type="radio"/> No
Are you having any problems with your car safety seat?	<input type="radio"/> No	<input type="radio"/> Yes
Have you started developing habits that will help prevent you from ever forgetting your baby in the car?	<input type="radio"/> Yes	<input type="radio"/> No
Is your water heater set so the temperature at the faucet is at or below 120°F/49°C?	<input type="radio"/> Yes	<input type="radio"/> No
Safe Sleep		
Does your baby sleep on his back?	<input type="radio"/> Yes	<input type="radio"/> No
Does your baby sleep in a crib?	<input type="radio"/> Yes	<input type="radio"/> No
Does your baby sleep in your room?	<input type="radio"/> Yes	<input type="radio"/> No

Consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 4th Edition

For more information, go to <https://brightfutures.aap.org>.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®



The information contained in this questionnaire should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances. Original questionnaire included as part of the *Bright Futures Tool and Resource Kit*, 2nd Edition.

The American Academy of Pediatrics (AAP) does not review or endorse any modifications made to this questionnaire and in no event shall the AAP be liable for any such changes.

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SOUTHERN PEDIATRIC CLINIC

WELCOME TO OUR PRACTICE

BRING COMPLETED FORMS TO YOUR FIRST APPOINTMENT

NEWBORN PACKET

Please complete the following documents and bring them with you to your first appointment. Any documents NOT completed will need to be completed **prior to being seen**. Having these documents completed can significantly decrease your wait time at your first appointment. For your convenience, we have provided you a checklist of items that will need to be brought with you to your first appointment.

CHILD

Last Name	First Name	MI	Date of Birth
PARENT/GUARDIAN			

Last Name	First name	MI	Contact Number
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I have received a copy of the following notices/policies from Southern Pediatric Clinic

Please check all that apply:

- Notice of Privacy Practices
- Insurance Information Requirements & Financial Policy
- No Show Policy
- Vaccination Policy

I have completed the following:

- Financial Consent
- Patient Information Form
- Patient Medical History
- Patient Consent for Use & Disclosure of PHI & Statement of Persons
- Allowed to Accompany Patient to Office Visits

Signature of Parent/Guardian or Patient

Date



Financial Consent

1. **ASSIGNMENT OF BENEFITS/BILLING AUTHORIZATION CONSENT:**

- ___ Private Insurance: The cost of our services will be billed to your insurance company. If your private insurance denies coverage, or does not pay within 90 days of billing, you are financially responsible and will be billed directly for services rendered. The amount of fees for services will vary depending on changes in the patient's medical condition, progress, and physician order(s).
- ___ Private Pay: You are financially responsible of all fees due at time of service. The amount of fees for services may vary depending on changes in the patient's medical condition, progress, and physician order(s).
- ___ State Insurance: The cost of our services will be billed to your insurance company. If your state insurance denies coverage, or retro disenrolls the patient, you are financially responsible and will be billed directly for services rendered. The amount of fees for services will vary depending on changes in the patient's medical condition, progress, and physician order(s).
- ___ For those families where parents are separated or divorced, the parent who brings the child or children to the office visit and authorizes treatment is responsible for payment(s). Payments are due when services are rendered. If the divorced/custodial decree makes the non-custodial parent/guardian responsible for partial or all medical costs, it will be the responsibility of the authorizing parent to collect payment from the other parent.

2. **NOTICE OF PATIENT RESPONSIBILITY FOR CO-PAYS, PERCENTAGES & DEDUCTIBLES:**

Southern Pediatric Clinic will attempt to verify your insurance benefits and eligibility. The information we receive is based on the information you and your insurance company provide to us. As a courtesy, we will bill your insurance company for their portion of your bill. Ultimately it is your responsibility to see that we are paid appropriately by your insurance company. If the information given to us by you or your insurance company proves to be inaccurate and a balance remains, you will be billed for that balance and are responsible for payment within thirty (30) days unless you set up a payment plan with our billing specialists.

BY SIGNING BELOW, YOU INDICATE THAT:

1. You agree with the provisions of the payment source as described above. You understand that if you accept the services we have provided, you are ultimately responsible for payment. Should it be necessary to use collection services, any additional fees will also be your responsibility.
2. You authorize payment of any insurance benefits directly to Southern Pediatric Clinic.
3. You authorize the release of medical information to and from Southern Pediatric Clinic.
4. You agree to pay all co-pays, percentages, and deductibles at the time of service.

Patient Name Date of Birth

Responsible Party Name and Signature Today's Date

MEDICAL INSURANCE INFORMATION: PROVIDE A COPY OF INSURANCE CARD(S)

Primary Policy Holder Name		Primary Insurance	Primary Insurance Policy Number
M	F		
Primary Policy Sex / Date of Birth		Secondary Ins./Medicaid	Secondary Ins./Medicaid Policy Number

Office Staff Initials



Patient Medical History

PATIENT

Last Name

First Name

MI

Date of Birth

1. Please answer the following questions about your child's birth.

City and hospital where child was born. _____ Birth weight? _____
 Was baby born vaginally or by C- section? _____ Was baby premature? no yes How many weeks? _____
 Was baby breech? no yes Did baby have a hip problem? no yes _____
 Were there any complications at birth? no yes _____
 Did baby have any problems after birth? no yes _____

2. Please answer the following questions about your child's social history.

Who takes care of your child most of the time? _____
 Who lives at home with the child? _____
 Does child attend daycare/school? Where? _____
 Does anyone smoke inside or outside the home? _____

3. Please list all medications that your child is currently taking. _____

4. Does your child have any medicine or food allergies? _____

5. Does your child have a history of any of the following? Please check all that apply.

ADHD blood disorders eczema pneumonia other: _____
 allergies bronchiolitis/RSV febrile seizures psychiatric disorder _____
 anemia chronic ear infections heart condition urinary tract infections _____
 asthma/wheezing developmental disorder kidney problem vision/eye problems _____

6. If your child has ever been hospitalized or had surgery, please list approximate dates and reasons.

7. If your child has ever been injured please list injuries, approximate dates and any treatment given.

8. Is there a family history of any of the following? Check all that apply & indicate which member had/has the condition.

Mom

Dad

Brother

Sister

Mom's parents/siblings
(please specify)

Dad's parents/siblings
(please specify)

<input type="checkbox"/> asthma						
<input type="checkbox"/> allergies						
<input type="checkbox"/> eczema						
<input type="checkbox"/> diabetes						
<input type="checkbox"/> obesity						
<input type="checkbox"/> high cholesterol						
<input type="checkbox"/> hypertension						
<input type="checkbox"/> heart disease						
<input type="checkbox"/> ADHD/ADD						
<input type="checkbox"/> seizures						
<input type="checkbox"/> developmental delay						
<input type="checkbox"/> mental disorder						
<input type="checkbox"/> anemia/blood disorder						
<input type="checkbox"/> thyroid disorder						
<input type="checkbox"/> cancer						
<input type="checkbox"/> other						



**Consent & Disclosure of PHI & Treatment of Patient &
 Statement of Persons Allowed to Accompany Patient to Office Visits**

Patient Consent for Use and Disclosure of Protected Health Information (PHI) and for Treatment

Patient's Name: _____ Date of Birth: _____

MOTHER'S NAME WHO IS LEGAL GUARDIAN _____ Birthdate _____

FATHER'S NAME WHO IS LEGAL GUARDIAN _____ Birthdate _____

Southern Pediatric Clinic, LLC and employees., may use and disclose PHI about the said patient above to carry out treatment, payment and healthcare operations (TPO). Please review the Notice of Privacy Practices for full information regarding this statement.

1. I have reviewed the Notice of Privacy Practices for Southern Pediatric Clinic and I acknowledge that Southern Pediatric Clinic has the right to revise its Notice of Privacy Practices at any time and that I will have access to revisions.
2. I have read and understand the Notices of Privacy Practices that are in place and that I may contact the Privacy Officer listed for further questions.
3. Southern Pediatric Clinic, and all those associated, may call my home or other designated location and leave a message on voice mail or in person in reference that assist the practice in carrying out TPO, such as appointment reminders and patient statements.
4. Southern Pediatric Clinic may treat my child and order diagnostic tests and labs for diagnosis and treatment.
5. Southern Pediatric Clinic may disclose Individually Identifiable Health Information (IIHI) that will be used to carry out TPO as referred to above, to anyone specified below who brings my child(ren) to the office for treatment.
6. Southern Pediatric Clinic will not act as mediator in separation, divorced, and/or custody battles. We must abide by the laws set forth in court-ordered documents for your child. Please make sure we have a copy on file.

DUE TO HIPAA REQUIREMENTS, PATIENTS CAN ONLY BE ACCOMPANIED TO OFFICE VISITS BY PARENTS, LEGAL GUARDIANS OR PERSONS WHOSE NAMES ARE DOCUMENTED IN THE PATIENT'S CHART. PLEASE INDICATE BELOW FOR BOTH IIHI AND HIPPA COMPLIANCE.

Name	Relationship to Patient	Disclose PHI		Accompany to Appointment	
		<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	_____	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	_____	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	_____	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	_____	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	_____	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	_____	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	_____	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no

I have the right to request that Southern Pediatric Clinic restricts how it uses or discloses my PHI to carry out TPO. However, the practices are not required to agree to my requested restrictions, but if it doesn't, it is bound by this agreement. By signing this form, I am consenting to the practice's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing, except to the extent that which the practice has already made disclosures upon my prior consent. If I do not sign this consent, providers for Southern Pediatric Clinic may decline to provide treatment for my child(ren).

 Signature of Parent/Guardian

 Date

 Printed Name of Parent/Guardian



Child's Name

DOB

CELL PHONE USE POLICY

The purpose of this policy is to outline the acceptable use of cellular phone (“cellphones”) and other communication devices, including but not limited to, mobiles phones, iPhones, iPads, iPods, tablets, or any other wireless device (collectively referred to as “communication devices”) at *Southern Pediatric Clinic, LLC*. These rules are in place to protect the workers and *Southern Pediatric Clinic, LLC*, along with the privacy of each of our patients. Inappropriate use of communication devices may harm others within the office by violating HIPAA laws and regulations.

1. **Who this Policy Applies To:**

This Policy applies to patients that are being seen within the office and their family members.

2. **What devices this Policy Applies To: (Video recording or pictures during vaccinations is PROHIBITED)**

- a. All devices that can be used for recording.
- b. All devices that can be used for communicating with others.
- c. All devices that may hinder the quality of care the patient may receive.

3. **Permitted Use:**

The devices mentioned can be used in the lobby if needed. However, it is recommended that the patient or family members be conscious of others that may be in the lobby.

4. **Violations of This Policy:**

Patients or family members that violate this policy may be asked to leave and are subject to dismissal depending on circumstances.

I have read and will abide by the terms of this policy regarding the use of communication devices in this office.

Signature of Parent/Guardian or Patient

Date



Patient Health Questionnaire-2

Over the past 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things.

- 0** = Not at all
- 1** = Several days
- 2** = More than half the days
- 3** = Nearly every day

Feeling down, depressed, or hopeless.

- 0** = Not at all
- 1** = Several days
- 2** = More than half the days
- 3** = Nearly every day

Total point score: _____

Information from Kroenke K, Spitzer RL, Williams JB. The Patient Health Questionnaire-2: validity of a two-item depression screener. *Med Care.* 2003;41:1284–1292

Source:

Thibault JM, Steiner RW. Efficient identification of adults with depression and dementia. *Am Fam Physician.* 2004;70:1101–1110



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