



Healing Hearts Pediatrics, P.L.C.

Dear Parents,

Welcome to Healing Hearts Pediatrics, PLC – the office of Dr. Elizabeth Homans McKenna and Dr. Nilam Patel Khurana. We are happy to have the opportunity to care for your children and wish to make your child's medical care as easy and pleasant as possible. We wanted to tell you a little about our clinic and provide you with some important information in this letter.

We are currently open Monday through Friday from 8am until 5pm with lunch from 12pm to 1:30pm. We have some extended hours Monday thru Thursday. We also have clinic hours two Saturdays a month. If your child has any urgent problems that cannot wait until the next business day, a doctor or triage nurse is always available to discuss your problems. If it is a life-threatening emergency, we ask that you call 911. When you call our main number, follow the prompts and leave a message with our answering service. Your call will be forwarded to the appropriate person and returned as soon as possible.

We have a large number of forms that we would like you to complete on or by your first visit. We understand it is a lot of information, but it will help us to better care for your child, so please complete the form in its entirety to the best of your ability. You can complete these and fax them to us prior to the visit or bring them in on the day of your visit. Our fax number is (480) 821-2210.

We believe immunizations are very important and have a list of the immunizations that your child will be receiving available at the office. This series of shots will hopefully give your child life long protection from some horrible diseases including liver disease, pneumonia, meningitis, and many others.

Please feel free to ask our staff or the doctors any question you have and we hope you enjoy your care here with us at Healing Hearts Pediatrics, PLC. Our website is under construction at this time, but soon you will have access to important information 24 hours a day. The address is www.healingheartspeds.com.

We look forward to serving you and caring for your children.

Sincerely,

Dr. Elizabeth Homans McKenna

and

Dr. Nilam Patel Khurana

SECONDARY INSURANCE (AHCCCS IS ALWAYS SECONDARY TO PRIVATE INSURANCE)

PATIENT INFORMATION

NAME (Last, First, Middle Initial)		SSN#	BIRTHDATE	SEX
ADDRESS		CITY, STATE, ZIP		
HOME PHONE	ALTERNATE PHONE	DOES CHILD HAVE SIBLINGS THAT ARE PATIENTS HERE? <input type="checkbox"/> Yes <input type="checkbox"/> No	SIBLING NAMES:	
STUDENT STATUS <input type="checkbox"/> Full-time <input type="checkbox"/> Part-Time	SMOKER(if applicable) <input type="checkbox"/> Yes <input type="checkbox"/> No	EMPLOYER (if applicable)		

GUARANTOR INFORMATION (FINANCIALLY RESPONSIBLE PARENT/OR GUARDIAN PATIENT LIVES WITH)

NAME (Last, First, Middle Initial)		SSN#	BIRTHDATE	SEX
ADDRESS		CITY, STATE, ZIP		
HOME PHONE	ALTERNATE PHONE	EMPLOYER		
EMPLOYER NUMBER	MARITAL STATUS: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow		RELATIONSHIP TO PATIENT	

OTHER PARENT/GUARDIAN INFORMATION

NAME (Last, First, Middle Initial)		SSN#	BIRTHDATE	SEX
ADDRESS		CITY, STATE, ZIP		
HOME PHONE	ALTERNATE PHONE	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow		RELATIONSHIP TO PATIENT

PRIMARY INSURANCE

Name of Insurance Company (If AHCCCS - Name of Plan)		Policy/Subscriber ID #	Group Number
Name of Owner of Policy (If AHCCCS - CHILD is Owner of Policy)		Relationship of Owner of Policy to Patient	
Owner of Policy Date of Birth (If AHCCCS - CHILD'S)	Owner of Policy Sex	Owner of Policy Employer	
Co-payment Amount	Deductible/Co-Insurance Amount	Owner of Policy Social Security Number	
Name of Insurance Company (If AHCCCS - Name of Plan)		Policy/Subscriber ID #	Group Number
Name of Owner of Policy (If AHCCCS - CHILD is Owner of Policy)		Relationship of Owner of Policy to Patient	
Owner of Policy Date of Birth (If AHCCCS - CHILD'S)	Owner of Policy Sex	Owner of Policy Employer	
Co-payment Amount	Deductible/Co-Insurance Amount	Owner of Policy Social Security Number	

PHARMACY INFORMATION

NAME OF PHARMACY

ADDRESS/or CROSSROADS

PHARMACY PHONE

OTHER INFORMATION

PRIMARY LANGUAGE

- English
- Spanish
- Chinese
- Vietnamese
- Other _____

REFERRED TO HEALING HEARTS PEDISTRICS BY:

- Friend
- Previous Patient
- Physician, Name _____
- Phone Book/Yellow Pages/ Newspaper _____
- Internet
- Insurance
- Other _____

I agree that the information provided is correct and accurate:

Patient Name (Please print)

Signature of Parent or Guardian

Printed Name of Parent or Guardian

Date

FINANCIAL POLICY AGREEMENT

Thank you for choosing Healing Hearts Pediatrics P.L.C. for your child's health care. We are committed to providing quality medical care for your children. In order to reduce potential misunderstandings, our office has adopted the following Financial Policy. We require that you read it and agree to abide by it prior beginning treatment.

Insurance

Your insurance policy is a contract between you and your insurance plan. We cannot efficiently bill your insurance company unless you provide us with current and valid insurance information. We will file claims to those plans with which we have a contractual agreement. As a courtesy, we will file claims to those plans with which we do not have a contractual agreement as unassigned and the insurance company will send the payment directly to you, therefore full payment is expected at the time of service.

All health plans are not the same and they do not always cover the same services or facilities. In the event that your health plan determines that a service is "not covered" you will be responsible for the entire charge. This office is not responsible for disputing decisions made by your insurance carrier regarding coverage. Payment for services rendered is due by the 1st day of the month after the charge has printed on your statement.

Non-covered or allowed services will only be charged to you per the contract Healing Hearts Pediatrics P.L.C. has with your insurance company. Examples of this would include screening exams and/or telephone encounters.

We expect you to familiarize yourself with the benefits and limitations of your insurance policy including, but not limited to: deductible and co-payment amount as well as approved labs, radiology facilities, and hospitals contracted with your plan. It is your responsibility to notify our office when either your insurance plan or benefits change. Any cost incurred by this office because of incorrect information you provided to us will be passed on to you.

If you have insurance coverage with a plan with which Healing Hearts Pediatrics does not participate or you currently have no health insurance, charges for your child's care and treatment are due at the time of service, unless prior financial arrangements have been set up by calling the Office manager, Janet Forrester at 480-821-1400 extension 204.

No Insurance

If you have no insurance coverage Healing Hearts Pediatrics has implemented a Sliding Fee Scale for those services that are 'Medical Necessary'. Elective services are not eligible for the Sliding Fee Scale and an example of elective services would be a Well child Exam. The Sliding Fee scale is based on the number of persons in the family unit along with the gross income of the parents of the child Exam. The Sliding Fee Scale is based on the number of persons in the family unit along with the gross income of the parents of the child. An 'Application for Uncompensated Services' is available for completion, but must be completed prior to the service.

Deductibles/Co pays/Payments

Our insurance contracts require us to collect deductible amounts and co pays at the time of service. These amounts will be collected prior to service being rendered. For your convenience we accept VISA, MasterCard, and American Express in addition to personnel checks and cash. If your check is returned to us for insufficient funds, we will assess a service charge equal to the bank fees assessed to Healing Hearts Pediatrics.

Appointments

Our goal is to provide the best possible care and physician availability to each of our patients. Our policy is to request you to call and cancel appointments 24 hours prior to scheduled appointment. Please call us, as early as possible, when you know you will need to reschedule and/or cancel an appointment.



Minor Patients

For all services that are rendered to minor patients (under the age of 18), the parent and/or guardian of the patient is held financially responsible for payment.

Information

I hereby agree that the above enrollment information is correct and I also agree that any changes to the enrollment information will be communicated to Healing Hearts Pediatrics P.L.C. as required to fulfill the medical and financial obligation for services rendered.

Authorization

I hereby request and consent that my medical records and non written records be sent to my referring physicians, those physicians or ancillary facilities that I am referred to by the Healing Hearts Pediatrics P.L.C. and to my insurance company or its agents that may be authorizing treatment. I further understand that my medical records may contain sensitive information and hereby authorize the release of all confidential HIV related information, communicable diseases related information, drug and alcohol abuse/treatment information and mental health diagnosis/treatment information to the above.

I also consent to release of immunization records and medication information to my child’s school and/or pre-school which is deemed pertinent and necessary for my child’s enrollment and/or healthcare in the school district in which my child attends.

Financial Authorization

I hereby authorize payment directly to the attending physician for medical and/or surgical benefits, if any from the insurance carrier to Healing Hearts Pediatrics, P.L.C. If paying cash, I am responsible to pay at the time of service.

Patient Name (Please print)

Signature of Parent or Guardian

Printed Name of Parent or Guardian

Date



Acknowledgment of Receipt of Notice of Privacy Practices and Patient Rights and Responsibilities

I have been presented with a copy of the Notice of Privacy Practices for the office of Healing Hearts Pediatrics, P.L.C. detailing how my information may be used and disclosed as permitted under federal and state law. I understand that the copy presented is a copy for my reading and viewing while in the office and if I request I will be given a copy of the Notice of Privacy Practices.

I have been presented with a copy of the Patient Rights and Responsibilities and the Non-Compliance Reporting Form(s) for the office of Healing Hearts Pediatrics, P.L.C. and understand the process for reporting Non-Compliance incidents. I understand that the copy presented is a copy for my reading and viewing while in the office and if I request I will be given a copy of the Patient Rights and Responsibilities and reporting forms for Non-Compliance incidents.

Printed Patient Name

Signature of Parent or Guardian

Printed Name of Parent or Guardian

Date

I hereby authorize the following individuals to make medical decisions for my child in the event of my absence.
(Persons other than parents or guardians)

***Parents, please keep in mind, emergencies do come up and unless a person is listed on your child's chart, per HIPAA guidelines, they will NOT be able to have your child treated without documentation from you that they have authorization to have child seen without you being present. Please list ANYONE who may EVER need to bring your child in, in the event that you can not! Persons living outside of the state IS acceptable! Thank You!**

Examples: (Grandparents, Older Siblings, Aunt/Uncles, Child Care Providers)

Name of Person	Relationship to Child

Patient Name (Please print)

Printed Name of Parent or Guardian

Signature of Parent or Guardian

Effective Date



Well Child Check Notice

Dear Parent/Guardian:

Your child will probably be scheduled for a Well Child Check with Healing Hearts Pediatrics in the future. As your physicians, we believe that wellness exams are a reasonable and necessary part of your child's healthcare. These exams include a Well-Child Check, Sports Physical and Complete Physical Exam. As part of these exams a screening exam for vision and hearing will be conducted as indicated as a part of the exam and billed in addition to the exam. The diagnosis and procedure codes submitted to your insurance company for today's visit will be wellness codes and hearing and vision screens, if appropriate.

Please be aware that some insurance plans do not cover Wellness Visits or screening procedures. In addition, those plans that do cover Wellness Visits will often cover only one Wellness Visit during a specific interval of time. For example, one Complete Physical every 12 months or a 6-month Well-Child Check on or after the child is actually six months old.

Be advised, some insurance plans do not cover vision and hearing screening. We feel screening vision and hearing are an important part of the care of a growing child. The burden of researching if vision and hearing screens are covered, if any, lies with the policyholder and not with this office. If you have had a vision and hearing screen done elsewhere or do not wish to have these as part of the exam, please communicate this with us at the beginning of visit.

In addition, some insurance plans do not cover any immunizations or cover them only when administered according to a pre-defined schedule. Be advised that the burdens of researching which immunizations are covered, if any, also lies with the policyholder and not with this office.

Should your insurance company deny payment for any portion of today's visit, you will be responsible for the balance that is not paid for by your insurance.

Thank you for your cooperation in this matter.

Patient Name (Please print)

Signature of Parent or Guardian

Printed Name of Parent or Guardian

Date

TO OUR PATIENTS:

In our continuing effort to provide the very best care possible for you, our valued patient, we have added an additional service. This service will allow you to quickly access information such as lab test results, doctor instructions and other pertinent information by calling our private patient information line. We have implemented new technology that will help make us more effective in providing you with timely information. Please review this information and feel free to ask the nurse if you have questions. **It is also very important that you notify us with any changes in your home phone number, as this will affect our success in contacting you.**

Lab: When you have lab work done or tests performed in our office, your results will be called in to a private mail box on our patient information line. We will then contact you, to let you know you have a message to retrieve. You can call the Patient Information Line at **480-423-2088** and follow the easy instructions to retrieve your message. The information you will be given will be very specific and you should listen to the entire message for further instructions or information regarding medication changes. Please listen to the entire message to ensure you receive all the information that our staff has left on the Patient Information Line.

At the end of your message you will be given three options:

Press 1 to repeat the message,

Press 2 to delete the message,

And press 3 to save the message,

The maximum amount you can save a message is two days from the time you first listen to the message. At the end of the two days, the message will be automatically deleted from the system. If you have questions after receiving your results you may call our main office phone at **480-821-1400** during normal business hours. You may need to leave a message with the receptionist as to the nature of your questions and the phone number where you can be reached so we can have your chart available when we call you back.

Just Five Easy Steps Away! Just Follow this Simple Guide to Retrieve Your Information

STEP 1

Using a "Touch-Tone" Telephone (A phone that beeps when you dial) call:

480-423-2088

STEP 2

To Listen to the Prompts in English, Press 1.

STEP 3

Enter Your Identification Number.

(Please enter a 9 digit number, example a Social Security No. or your Phone number with out last digit).

ID#: _____ - _____ - _____

STEP 4

Record Your Name. End Your Recording by Pressing 1.

BE SURE TO LISTEN TO YOUR ENTIRE MESSAGE

STEP 5

After Listening to Your Message, Press 1 to Repeat, 2 to Delete or 3 to Save.

You Can Now Hang Up Your Phone! That's All There is to It.

PATIENT INTAKE FORM INFANCY, CHILDHOOD, ADOLESCENCE, HISTORY

PATIENT FULL NAME:

DATE OF BIRTH:

PREVIOUSLY SEEN/TREATED BY: (Name of Doctor/Practice)

CITY

STATE

ZIP CODE

PHONE

CHILD'S BIRTH HISTORY

During your pregnancy with this child:

Prenatal care given?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
How early did you start seeing the doctor?	_____ Month	
How long was your pregnancy?	_____ Months Or _____ Weeks	
Delivery Type:	<input type="checkbox"/> Vaginal	<input type="checkbox"/> Cesarean
Have a difficult labor/delivery?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Was this child born breech?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have more than one baby delivered?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Ultrasound Results	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Birth Weight	_____ lbs	_____ oz
Length	_____ in	_____ cm
Apgar Score	_____ 1 min	_____ 5 min
Oxygen required for baby?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Stayed in NICU?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Was your baby jaundiced at birth?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Was phototherapy (treatment with lights) required?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Were there birth defects?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Was newborn screen (PKU, sickle cell, etc) done at birth?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Were there medications given to baby at birth?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Number of days baby stayed in nursery	_____ days	
Was you baby circumcised at birth	<input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> N/A
Did your baby breathe/cry immediately at birth?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Did your baby have an RH problem?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Did your baby receive blood?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Maternal Blood Type _____	Baby Blood Type _____	Coombs: _____	
At birth, did your baby appear normal?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Was a hearing screen done? If yes, was the result normal or failed in one or both ears: _____		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Other pertinent information:			
Maternal Illness/Complications			
Surgery during pregnancy? If yes, list: _____		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have diabetes or sugar in your urine?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have high blood pressure or other cardiac problems? If high blood pressure, was this due to pregnancy or prior to pregnancy? _____		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have a urinary infection or other kidney problems? _____		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have albumin or protein in your urine?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Take any medicines? If yes list: _____		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Smoke cigarettes?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Drink alcohol?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Use other drugs? If yes, list: _____		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Other pertinent information:			
Maternal Infections			
<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Syphilis	<input type="checkbox"/> Chlamydia	<input type="checkbox"/> Parvovirus
<input type="checkbox"/> B Strep GBS)		<input type="checkbox"/> Rubella	<input type="checkbox"/> Cytomegalovirus (CMV)
Other:			
Childs First Year History 0-1 year			
During your baby's FIRST year, did you breast feed?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, how long?		_____ Month(s)	
During your baby's FIRST year did you formula feed?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, how long?		_____ Month(s)	
If feeding problems, explain:			
Weaning from breast completed at:		_____ Child's Age	
Whole Milk started at:		_____ Child's Age	
Problems or allergies with whole milk? If yes, explain:		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Solid food started at:		_____ Child's Age	
Problems or allergies with solid food? If yes, explain:		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Excessive bleeding at any point? If yes, explain:		<input type="checkbox"/> YES	<input type="checkbox"/> NO

IMPORTANT MEDICAL INFORMATION

SERIOUS ILLNESS/ACCIDENT/SURGERY/ HOSPITALIZATION		COMPLICATIONS/SEVERITY	AGE OF CHILD
1			
2			
3			
CHRONIC DISEASES (e.g. Allergies, Asthma, Recurrent Ear Infections)		COMPLICATIONS/SEVERITY	AGE OF CHILD
1			
2			
ALLERGIC REACTIONS TO: DRUGS, FOOD, ETC.			
1			
2			

IMMUNIZATION INFORMATION

Are your child's immunizations current?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> UNKNOWN
Do you have your child's immunization record? If, yes please provide so a copy can be made for medical record.	<input type="checkbox"/> YES		<input type="checkbox"/> NO

SOCIAL/DEVELOPMENTAL HISTORY

Patient lives with:	<input type="checkbox"/> Mother	<input type="checkbox"/> Father
	<input type="checkbox"/> Foster Mother	<input type="checkbox"/> Foster Father
	<input type="checkbox"/> Adoptive Mother	<input type="checkbox"/> Adoptive Father
	<input type="checkbox"/> Stepmother	<input type="checkbox"/> Stepfather
	<input type="checkbox"/> Grandmother	<input type="checkbox"/> Grandfather
Who spends the most time caring for the child:	<input type="checkbox"/> Parent(s)	<input type="checkbox"/> Grandparent(s)
	<input type="checkbox"/> Sibling	<input type="checkbox"/> Nanny
	<input type="checkbox"/> Daycare	<input type="checkbox"/> Sitter
Child is <u>oldest/youngest/middle</u> in family.	<input type="checkbox"/> Oldest <input type="checkbox"/> Youngest <input type="checkbox"/> Middle <input type="checkbox"/> Only	
Child sat up at: ____Age	Child crawled at: ____Age	
Child walked at: ____Age	Child Started talking at: ____Age	
Does anyone in your household smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
What is the age of your home?		
What type of water does your home have?	<input type="checkbox"/> Tap Water	<input type="checkbox"/> Fluoridated <input type="checkbox"/> Well Water <input type="checkbox"/> Chlorinated
Has the water been tested for lead content?	<input type="checkbox"/> Lead Present	<input type="checkbox"/> Not tested

	<input type="checkbox"/> Lead Removed	<input type="checkbox"/> New Home, low risk
How many hours per week does your child exercise or participate in sports?		
How many hours per week does your child watch TV or play computer games?		
Uses bike/skating helmet:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Car restraints	<input type="checkbox"/> Car Seat <input type="checkbox"/> Booster Seat <input type="checkbox"/> Seat Belt <input type="checkbox"/> None	
Carbon monoxide detector. If 'no' do you have gas heater or range in the home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Firearms(weapon) in the home:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Smoke detectors:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Untested	
Pets/animals at home:	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, details:	

FAMILY MEDICAL HISTORY

Mother's Age _____	Father's Age _____	Patient Adopted/Foster Care? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Has any blood relative of your child ever had, been treated for or recently diagnosed with:

Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing Deficiency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease/Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mental Illness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No
Elevated Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Obesity	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bladder Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Neurological Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis (T.B.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Domestic Violence	<input type="checkbox"/> Yes <input type="checkbox"/> No	Developmental Delay	<input type="checkbox"/> Yes <input type="checkbox"/> No

Explain any 'Yes' answers to the above selections:

Other Chronic Illnesses:

ADDITIONAL CONCERNS/PROBLEMS

Does your child have any on-going problem(s) that concern you? If Yes, Put an 'X' in box

<input type="checkbox"/> Eats too little	<input type="checkbox"/> Speaks unclearly
<input type="checkbox"/> Cries a lot	<input type="checkbox"/> Doesn't always respond to noise or spoken word
<input type="checkbox"/> Won't sleep	<input type="checkbox"/> Seems small for age
<input type="checkbox"/> School problems	<input type="checkbox"/> Always has runny nose and/or cough
<input type="checkbox"/> Eats too much	<input type="checkbox"/> Sees poorly
<input type="checkbox"/> Has frequent temper tantrums	<input type="checkbox"/> Wets bed
<input type="checkbox"/> Frequently constipated	<input type="checkbox"/> Transportation available for Doctor appointments
<input type="checkbox"/> Behavior Problems	
<input type="checkbox"/> Are there any other problems? Please write them down: <hr/> <hr/> <hr/>	

Signature of Parent or Guardian

Printed Name of Parent or Guardian

Date

Date: _____

Name: _____

TUBERCULOSIS QUESTIONNAIRE

Please answer the following questions with either Yes or No.

YES	NO	
_____	_____	1. Does any one in your home have tuberculosis (TB) or a positive skin test for TB?
_____	_____	2. Is there anyone in your home who is from, or was a child born in Latin America, Asia, Africa, or the Middle East?
_____	_____	3. Do you or your child travel to Latin America, Asia, Africa, or the Middle East?
_____	_____	4. Does anyone in the house have contact with TB patients?
_____	_____	5. Does anyone in the house have contact with AIDS (or HIV positive) patients?