Ivinson MEMORIAL HOSPITAL
MEDICAL GROUP
AN AFFILIATE OF UCHealth

Kelly Follett, MD
Pediatrician

Daiva Olipra, MD
Pediatrician

Chelsea Raymer, DNP
Family Nurse Practitioner

Patient Paperwork

Child's Information

Name: ____
LAST FIRST M.I.

Preferred Name:_______________________ Social Security Number: ______________

Address: ____
STREET CITY STATE ZIP CODE

Date of Birth: ______/______/_______ Age: ____________ Sex: Male ☐ Female ☐

Previous Doctor: ____

Child's cell phone number (over 13 years of age): (______)________________ **optional

Mother/Guardian Information

Name: ____
LAST FIRST M.I.

Preferred Name:_______________________ Social Security Number: ______________

Address: ____
STREET CITY STATE ZIP CODE

Date of Birth: ______/______/_______ Age: ____________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Employer:___________________________ Occupation: ____________________

Home/Work Phone: (_____)_______________ Cell phone: (_____)________________

e-mail:____

I wish to be set up for IMH's patient portal using the email address above: ☐Yes ☐No

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Father/Guardian Information

Name: ____
LAST FIRST M.I.

Preferred Name:____________________ Social Security Number: ______________

Address: ____
STREET CITY STATE ZIP CODE

Date of Birth: ______/______/_______ Age: _____________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Employer:____________________ Occupation: ______________

Home/Work Phone: (_____)______________ Cell phone: (_____)______________

e-mail:____

I wish to be set up for IMH's patient portal using the email address above: ☐Yes ☐No

Insurance

This section does NOT need to be filled out if you presented your insurance card to the receptionist.

Primary Insurance: ____________________ Policy Holder's Name: ____________________

Policy Holder's Date of Birth: ____ / ____ / ____ Policy Holder's SSN: ____________________

Policy Number: ____________________ Group Number: ____________________ Co-Pay $: ________

Secondary Insurance: ____________________ Policy Holder's Name: ____________________

Policy Holder's Date of Birth: ____ / ____ / ____ Policy Holder's SSN: ____________________

Policy Number: ____________________ Group Number: ____________________

RX

Local Pharmacy:____________________ Mail Order Pharmacy:____________________

Emergency Contacts

Name:____
LAST FIRST M.I.

Phone Number: (_____)______________ Relationship:____________________

Name:____
LAST FIRST M.I.

Phone Number: (_____)______________ Relationship:____________________

Medical Releases

Please list people who are authorized to bring child to appointments, make medical decisions on their behalf and with whom we can discuss your child's care and leave messages:

Name:____
LAST FIRST M.I.

Phone Number: (_____)__________________ Relationship:____________________________

Name:____
LAST FIRST M.I.

Phone Number: (_____)______________ Relationship:______________________________

Patients are responsible for payment in full at the time of services. Our office makes reminder calls 24 hours before appointments, and will charge a $50 no-show fee if two or more appointments are missed without notifying our office. Your signature below indicates that you understand and accept this policy.

I hereby authorize for payment of medical benefits, when a claim is filed by the office, to be made to Ivinson Memorial Hospital and any assisting clinicians, for the service/s rendered. I understand that I am financially responsible for all charges, whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original. I also acknowledge that I have reviewed the copies of the **IMH Notice of Privacy Practices and the IMH Patient Rights and Responsibilities.**

____

Patient/Representative Signature Date

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Name:______________________________

How did you hear about us? ____

Current Medications		
MEDICATION	DOSE	HOW OFTEN

Do you take any alternative or herbal medications? ☐ *Yes ☐ No

*If yes, please list____

Allergies	
MEDICATION	REACTION

Do you have any other allergies (latex, iodine, food or environment)?

____

____

Birth History

Only needs to be completed if the child is under 3 years of age

Delivery Type: ☐ Vaginal ☐ *Cesarean
*Why: ____

Birth Weight: _______ Was your child premature? ☐ *Yes ☐ No *If yes, how many weeks __________

Were there any problems with your child's delivery? ☐ *Yes ☐ No
*If yes, please list: ____

____

Did your child have any unusual problems in the hospital such as oxygen, transfusions, or phototherapy for jaundice? ☐ *Yes ☐ No *If yes, please list: ______________________________

____

Name:______________________________

Medical History

Any hospitalizations other than birth? ☐ *Yes ☐ No *If yes, please explain: ____________________

____

Any chronic illnesses? ☐ *Yes ☐ No *If yes, please explain: ____________________________

____

Has your child seen a specialist? ☐ *Yes ☐ No
*If yes, please provide name and date of the most recent visit: ____________________________

____

Review of Systems

System	Yes	No	Explanation of any problems
Lungs			
Heart			
Kidney/Urinary			
Bone/Muscle			
Gastrointestinal			
Brain/Nervous			
Genital			
Skin			
Ear/Nose/Throat			
Developmental concerns or learning problems			
Behavioral problems or eating disorders			
If female: age of first menstrual period			Age:

Surgical History

Has your child had any surgeries? ☐ *Yes ☐ No

*If yes, please list surgery and approximate date: ______________________________

____

____

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Name:________________________________

Social History

Any special communication needs? ☐ Yes ☐ No

Primary language other than English? ☐ Yes ☐ No

Child's primary language__________________ Parent/Guardian(s)'s primary language__________________

***Language line is available to help us better communicate if English is not your first language. Please let the nurse know if you would like to use the language line.**

Parents: ☐ Married ☐ Separated ☐ Divorced ☐ Single

How many people live in your home? ___________Adults _________________ Children

Are there smokers in the home? ☐ Yes ☐ No

Any pets at home? ☐ *Yes ☐ No *If yes, please explain: ______________________

____

Are there smoke detectors in your home? ☐ Yes ☐ No

Are there carbon monoxide detectors in your home? ☐ Yes ☐ No

Does your child attend: ☐ Daycare ☐ Preschool ☐ Grade K-12

What school? ____

Sibling's Name	Date of Birth
1.	
2.	
3.	
4.	

Family History

List any medical conditions of the child's family members listed below:	
Mother	
Father	
Maternal Grandmother	
Material Grandfather	
Paternal Grandmother	
Paternal Grandfather	
Siblings	
Other Relatives (Aunt, Uncle, Cousin, etc.)	