

CHILD HEALTH HISTORY (Confidential)

Please take your time to be thorough and complete all the questions below.

Child's Name: _____ Date: _____

Address: _____ City, State, Zip: _____

Name of Mother _____

Name of Father _____

Home Phone: _____ Cell: _____ Email: _____

Date of Birth: _____ Age: _____ Sex: _____

Name of Health Insurance (if applicable): _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Home Phone: _____ Cell Phone: _____

Names of brothers and sisters, including their age and sex : _____

Social History

Birthplace: _____

Places child was raised: _____

Has child been outside of the U.S. in the last 12 months? _____ Where? _____

Current Health Care

Is child currently under the care of any health providers? _____

Please list:

Where and when did child last receive health care?

Please list your health concerns/goals:

Please rate your child's current status of health (Scale of 1-10: 1=poor 10=optimal):

1 2 3 4 5 6 7 8 9 10

Does child fall asleep easily and sleep soundly? _____

Does child awaken in the morning well rested? _____

Past Medical History

Was child born by vaginal delivery or C-Section? _____

Was child breast fed (or currently being breast fed)? _____

Did child have any childhood illnesses? _____ If so, which ones? _____

Does child have any serious injuries or disabilities? _____

Has child been hospitalized? _____

Year: _____ Operation or illness: _____

Name of Hospital: _____ Location: _____

Year: _____ Operation or illness: _____

Name of Hospital: _____ Location: _____

Year: _____ Operation or illness: _____

Name of Hospital: _____ Location: _____

Please list any allergies to medicines: _____

Please list any environmental or food allergies: _____

Medications

Please list all medications:

Medication	Dose	Date Started	Prescribed By

Please list every vitamin, supplement, or homeopathic remedy you take:

Supplement	Dose	Date Started

Family History

Father _____

Mother _____

Brother(s) _____

Sister(s) _____

Grandparents _____

Immunization and Test History

Please list the dates of your child's latest immunizations/tests:

	Date		Date		Date
Tetanus		Sigmoidoscopy		Other vaccinations:	
Polio		Blood in stool		EKG	
Rubella		TB Skin test			
Mumps		Physical Exam			
Measles		Flu Shot		Colonoscopy	
Hepatitis		Pneumonia Shot		Other:	

Problem Summary

Current Problem: _____

Chronic Problem: _____

Recurring Problem: _____

Finances

Payment for services are due at the time of visit in the form of cash or check. If payment on the day of your visit is a concern, please speak to Dr. Baer prior to your appointment.

If you have health insurance coverage, we will provide you with a coded receipt (superbill) to send to your insurance company.

We do not provide insurance billing and I do not take Medicare/Medical/Worker's Comp.

Remedies

Remedies are not included in the cost of your office visit. After agreeing to your treatment plan, you will be responsible for the cost of your remedies. Please inform Dr. Baer when you are down to a quarter left of your remedy so she can order a refill, if necessary.

Appointments

Please give 48 hours' notice if you wish to cancel or reschedule.

There will be a 50% charge for the visit if cancelled with less than 24 hours' notice.

Fees:

New Patients

<u>Limited (30 Minutes)</u>	<u>\$140.00</u>
<u>Comprehensive (1 Hour)</u>	<u>\$280.00</u>
<u>Complex (2 hours)</u>	<u>\$340.00</u>
<u>Medical Exemption</u>	<u>\$280.00</u>

Follow Up Appointment

<u>Brief (15 Minutes)</u>	<u>\$70.00</u>
<u>Limited (30 Minutes)</u>	<u>\$140.00</u>
<u>Comprehensive (1 Hour)</u>	<u>\$280.00</u>

Phone consultations

The first 5-10 minutes of a phone consultation is without charge. After this time, you will be charged according to the above fee schedule.

Tiffany Baer, MD
Internal Medicine, Holistic Medicine
Anthroposophic Medicine

(510) 526-5256 • fax (510) 526-5547
902santafe@gmail.com

CONSENT FOR TREATMENT

I hereby consent to a comprehensive medical treatment. This means that I am seeking treatment beyond conventional therapy. Conventional or allopathic medicine is based on physical findings and diagnosis, and uses chemical substances (pharmaceutical drugs), surgery, and radiation therapy.

I am responsible for the choice to seek a therapeutic regimen that is individualized and may include physical, physiological, environmental, emotional, mental, and spiritual aspects.

I recognize that this treatment may not prove effective.

I am fully informed that this therapy differs from conventional medical standards. I recognize that this treatment – like any other medical treatment – can have side effects, such as homeopathic aggravations in sensitive patients.

I fully understand that this is given in advance of any specific diagnosis or treatment. I intend to consent to be continuing in nature even after a specific diagnosis had been made and treatment recommended. The consent will remain in full force until revoked in writing.

I am also aware that as a consulting physician specializing in Anthroposophical medicine, Tiffany Baer, M.D., is not available on nights, weekends, and/or specific holidays throughout the year and she does not admit patients to hospitals. In addition to being a patient of Dr. Baer's, I understand that it would be in my best interest to have a Primary Care Physician (PCP) with hospital and admitting privileges that could provide emergency care. I also understand that I may elect to use a hospital emergency room for emergency care, if needed, if I choose not to have another Primary Care Physician.

Patient Name: _____ Date: _____

Signature: _____

Parent/ Guardian name: _____

Parent/Guardian Signature: _____

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AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

AUTHORIZATION

I hereby authorize Dr. Tiffany Baer to release information on

_____ (Patient’s Name) _____ (Patient’s DOB) regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above named health care provider may hold, by means of mail, fax, or other electronic methods.

To: _____
 Name

 Address
_____ _____ _____
 City State Zip Code

The medical information/records will be used for the following purpose:

This authorization is:

- Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)
- Limited to the following medical information:

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse	_____ (initial)
Psychiatric/Mental Health	_____ (initial)
Tests for Antibodies to HIV	_____ (initial)
HIV Diagnosis/Treatment	_____ (initial)
Genetic Information	_____ (initial)

DURATION

This authorization shall be effective immediately and remain in effect until _____
Date

RESTRICTIONS

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

Signature of patient *or legal/personal representative patient*

Relationship *if other than representative*

Patient's Name (PRINT)

Date

Patient's Social Security Number

Patient's Date of Birth

Witness name

Witness signature

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HIPPA NOTICE OF PRIVACY PRACTICE - ACKNOWLEDGEMENT OF RECEIPT

I hereby acknowledge that a current copy of the medical practice's Notice of Privacy Practices is available online at www.hhs.gov/hipaa as well as in the reception area.

Today's Date: _____

Patient Name: _____

Patient/Guardian Signature: _____

_____ Date

(Print Name of Guardian if signing for patient)

If not signed by the patient, please indicate relationship:

- Parent or guardian of minor patient
- Guardian or conservator of an incompetent patient