Welcome

(Please print)

Marina Burstein, MD

-Patient Information-

Name_____ Date of Birth_____ Age_____
Last Name First Initial

Address_____ City_____

State_____ Zip _____ Home Phone_____ Cell Phone:_____

Sex___M___F Soc.Sec.#_____ Parents E-mail:_____

Race:_____ Primary Language:_____ Pharmacy Information:_____

-Parent or Guardian Information-

Mother:

_____
Last Name First Name Date of Birth

_____
Soc.Sec# Driver's Lic#

_____
Address

_____

_____
Home Phone Cell Phone

_____
Employer

_____
Work Phone

Father:

_____
Last Name First Name Date of Birth

_____
Soc.Sec # Driver's Lic#

_____
Address

_____

_____
Home Phone Cell Phone

_____
Employer

_____
Work Phone

-Emergency Contact-

_____ _____ _____
Name Relationship Phone

-Referral Information-

Whom may we thank for referring you?_____

-Authorization, Assignment, Release, Financial policy-

I authorize Dr.Marina Burstein and the office staff to provide evaluation and necessary treatment to my child whether or not I am present. I hereby assign to Dr.Marina Burstein all payments for medical services rendered and authorize payments made directly to her. I also authorize my doctor to furnish insurance carriers with all necessary information. All professional services rendered are charged to the patient and payments due at the time services are rendered. As a courtesy, we complete the necessary forms to expedite your insurance claim. The patient is responsible for all fees, regardless of insurance coverage. Returned checks and balances older than 30 days are subject to additional fees and interest charges of 1.5% per month. Charges may also be made for broken appointments and appointments cancelled without 24 hours advance notice.

_____
Signature of Patient or Guardian

Rev,08/06/2014

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 and ages and where they live. _____

_____

If mother and father are not living together or if child does not live with parents, what is the child's custody status? _____

_____

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home? _____

_____

Birth History

Birth weight _____

Was the baby born at term? _____ Early? _____ Late? _____

If early, how many weeks' gestation? _____

Did mother have any illness or problem with her pregnancy?
☐ Yes ☐ No Explain _____

_____

During pregnancy, did mother
Smoke ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No
Use drugs or medications ☐ Yes ☐ No
What _____ When _____

Was the delivery ☐ Vaginal? ☐ Cesarean?

If cesarean, why? _____

Did your baby have any problems right after birth?
☐ Yes ☐ No Explain _____

_____

Was initial feeding ☐ Breast? ☐ Bottle?

Did your baby go home with mother from the hospital?
☐ Yes ☐ No Explain _____

_____

General

Do you consider your child to be in good health? ☐ Yes ☐ No Explain _____

Does your child have any serious illness or medical condition? ☐ Yes ☐ No Explain _____

Has your child had serious injuries or accidents? ☐ Yes ☐ No Explain _____

Has your child had any surgery? ☐ Yes ☐ No Explain _____

Has your child ever been hospitalized? ☐ Yes ☐ No Explain _____

Is your child allergic to any medicines or drugs? ☐ Yes ☐ No Explain _____

Development

Are you concerned about your child's physical development? ☐ Yes ☐ No Explain _____

Are you concerned about your child's mental or emotional development? ☐ Yes ☐ No Explain _____

Are you concerned about your child's attention span? ☐ Yes ☐ No Explain _____

If your child is in school:

How is his/her behavior in school? _____

Has he/she failed or repeated a grade in school? _____

How is he/she doing in academic subjects? _____

Is he/she in special or resource classes? _____

Family History

Have any family members had the following:

Deafness	☐ Yes	☐ No	Who _____	Comments _____
Nasal allergies	☐ Yes	☐ No	Who _____	Comments _____
Asthma	☐ Yes	☐ No	Who _____	Comments _____
Tuberculosis	☐ Yes	☐ No	Who _____	Comments _____
Heart disease (before 50 years old)	☐ Yes	☐ No	Who _____	Comments _____
High blood pressure (before 50 years old)	☐ Yes	☐ No	Who _____	Comments _____
High cholesterol	☐ Yes	☐ No	Who _____	Comments _____
Anemia	☐ Yes	☐ No	Who _____	Comments _____
Bleeding disorder	☐ Yes	☐ No	Who _____	Comments _____
Liver disease	☐ Yes	☐ No	Who _____	Comments _____
Kidney disease	☐ Yes	☐ No	Who _____	Comments _____
Diabetes (before 50 years old)	☐ Yes	☐ No	Who _____	Comments _____
Bed-wetting (after 10 years old)	☐ Yes	☐ No	Who _____	Comments _____
Epilepsy or convulsions	☐ Yes	☐ No	Who _____	Comments _____
Alcohol abuse	☐ Yes	☐ No	Who _____	Comments _____
Drug abuse	☐ Yes	☐ No	Who _____	Comments _____
Mental illness	☐ Yes	☐ No	Who _____	Comments _____
Mental retardation	☐ Yes	☐ No	Who _____	Comments _____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	Who _____	Comments _____

Additional family history _____

Past History

Does your child have, or has he/she ever had:

Chickenpox	☐ Yes	☐ No	When	_____
Frequent ear infections	☐ Yes	☐ No	Explain	_____
Problems with ears or hearing	☐ Yes	☐ No	Explain	_____
Nasal allergies	☐ Yes	☐ No	Explain	_____
Problems with eyes or vision	☐ Yes	☐ No	Explain	_____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	Explain	_____
Any heart problem or heart murmur	☐ Yes	☐ No	Explain	_____
Anemia or bleeding problem	☐ Yes	☐ No	Explain	_____
Blood transfusion	☐ Yes	☐ No	Explain	_____
Frequent abdominal pain	☐ Yes	☐ No	Explain	_____
Constipation requiring doctor visits	☐ Yes	☐ No	Explain	_____
Bladder or kidney infection	☐ Yes	☐ No	Explain	_____
Bed-wetting (after 5 years old)	☐ Yes	☐ No	Explain	_____
(For girls) Has she started her menstrual periods?	☐ Yes	☐ No	When	_____
(For girls) Are there problems with her periods?	☐ Yes	☐ No	Explain	_____
Any chronic or recurrent skin problem (acne, eczema, etc)	☐ Yes	☐ No	Explain	_____
Frequent headaches	☐ Yes	☐ No	Explain	_____
Convulsions or other neurologic problem	☐ Yes	☐ No	Explain	_____
Diabetes	☐ Yes	☐ No	Explain	_____
Thyroid or other endocrine problem	☐ Yes	☐ No	Explain	_____
Any other significant problem	☐ Yes	☐ No	Explain	_____
Use of alcohol or drugs	☐ Yes	☐ No	Explain	_____

HE0328

Important Information- Please Read

Burstein M.D. Professional Corporation **cancellation** and **no show** policy:

Our office has set aside time for you in our busy schedule, please give our doctor and staff the courtesy of cancelling your appointment 24 hours prior to your set appointment time. We always try to do our best to accommodate our patients, and our office strives to treat patients in a timely manner- we expect the courtesy to be returned. There is now a fee for any appointment canceled less than 24 hours prior to a scheduled appointment or for a "no show".

Fee schedule is as follows:

(A) Office Visit Sick: $100
(B) Physical/Preventive Visit: $120
(C) **$15 FEE FOR RETURNED CHECKS**

As a courtesy to our patients we will call the day before to confirm your appointment, but it is your responsibility to keep track. It is not our responsibility if you do not get a call and forget your appointment- you will still be charged for an appointment as a "no show".

I have read and understand the above policies.

_____
Patient Name

_____ _____
Patient or Authorized Signature if patient is a Minor Date

_____
Parent Name (If applicable)

Marina Burstein M.D.

Burstein,MD A Prof Corporation
6325 Topanga Cyn Blvd
#224
Woodland Hills, CA 91367

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPPA) provides safeguards to protect your privacy. Implementation of HIPPA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporary, in administrative areas such as the front office, examination room, etc. those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient's records, PHI and other documents or information.

It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

You agree to bring any concerns or complains regarding privacy to the attention of the office manager or the doctor.

Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

We agree to provide patients with access to their records in accordance with state and federal laws.

We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to confirm to your request.

I, _____ date _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.