Livermore Pleasanton San Ramon Pediatrics

Stanford Children's Health

NEW PATIENT INFORMATION

(LIST *ALL* **MINOR** CHILDREN ATTENDING PRACTICE)

	CHILD'S FIRST AND LAST NAME	DOB	Gender
1			M / F / O
2			M / F / O
3			M / F / O
4			M / F / O

Race (circle one): *American Indian or Alaska Native * Asian * Black or African American * Native Hawaiian or Other Pacific Islander * White * Other: _____ *Decline

Ethnicity (circle one): *NOT Hispanic/Latino *Hispanic/Latino *Decline

Legal Guardian #1

Name: _____

DOB_____ Relationship_____

Mailing Address: _____

City: _____ Zip_____

Primary Phone: _____

Secondary Phone: _____

Additional Phone: _____

Marital Status:

(Circle) Single *Married * Divorced * Widowed

Email Address: _____

Legal Guardian #2

Name: _____

DOB_____ Relationship_____

Mailing Address: _____

City: _____ Zip_____

Primary Phone: _____

Secondary Phone: _____

Additional Phone: _____

Marital Status:

(Circle) Single *Married * Divorced * Widowed

Email Address: _____

Who will be the primary contact *(Circle)*

Mother * Father * Grandparent * Nanny * Other_____

*If a non-legal guardian will need access to health information i.e. immunization records, school forms etc. please fill out an "Authorization for Use and Disclosure of Health Information" form allowing them access for a designated period of time.

Emergency Contact/Nanny/Caretaker (*other* than parent):

Name:_____Relationship:_____

Home Phone: _____Cell Phone: _____Phone:_____

How would you like to receive appointment reminders? Text/ Email/ Phone call/Decline (circle one)

Today's Date:_____

(We will request updated information annually)

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HEALTH COVERAGE INFORMATION

1. Patient Name _____ DOB _____
2. Patient Name _____ DOB _____
3. Patient Name _____ DOB _____
4. Patient Name _____ DOB _____
5. Patient Name _____ DOB _____
6. Patient Name _____ DOB _____

What address should we send mail to?

Full Name: _____

Relationship To Patient: _____

Street Address: _____

City _____ State _____ Zip _____

Primary Insurance

Insurance Company: _____

Insurance ID #: _____

Group #_____

Insurance Effective Date:_____

Employee's/ parent's Name: _____

Employee DOB: _____ Employer: _____

Secondary Insurance

Insurance Company: _____

Insurance ID #: _____

Group #_____

Insurance Effective Date:_____

Employee's/ parent's Name: _____

Employee DOB: _____ Employer: _____

THIS FORM SHOULD TO BE UPDATED WHEN YOUR INSURANCE CHANGES

Patient Name: _____ **DOB:** _____

FAMILY HISTORY: Please check all that apply for each relative (√). * M - indicates Maternal - P - indicates Paternal

Relationship	Alcohol Abuse	Arthritis	Asthma	Birth Defects	Cancer	COPD	Depression	Diabetes	Drug Abuse	Early Death	Hearing Loss	Heart Disease	Hyperlipidemia	Hypertension	Kidney Disease	Learning Disabilities	Mental Illness	Mental Retardation	Miscarriages	Stroke	Vision Loss
Mother																					
Father																					
Sister																					
Brother																					
Daughter																					
Son																					
Mat Aunt																					
Mat Uncle																					
Pat Aunt																					
Pat Uncle																					
MGM																					
MGF																					
PGM																					
PGF																					

Please indicate other major family illnesses not listed above: _____

Please indicate here if the patient was adopted yes_____ no _____

Please indicate here if there is no family history available _____

How many siblings does the patient have?_____ Are they healthy?_____

Has the patient had any surgeries or hospitalizations?_____

If so, please explain_____

Stanford Children's Health | Lucile Packard Children's Hospital Stanford

Lucile Packard Children's Hospital
STANFORD UNIVERSITY MEDICAL CENTER
725 Welch Road Palo Alto, CA 94304

CONSENT • MYCHART PROXY ACCESS REQUEST

Medical Record Number

Patient Name

Addressograph or Label

MyChart Proxy Access Request Form- *Request for Online Access to Medical Records*

I hereby request Lucille Packard Children's Hospital Stanford/Stanford Children's Health provide access to health information in MyChart allowable by law, of the minor patient named below to the following proxy representative.

Please note the following age range limitations for MyChart. These age range limitations do not affect any legal right you have to access your child's records by other means. To request a copy of your child's record, contact the medical records department.

- If your child is age 0-11: You will be granted full access to your child's MyChart record, a subset of complete medical records
- If your child is age 12-17: You will be granted partial access to your child's MyChart record. (e.g. immunizations, messaging)
- Once your child reaches age 18, you will no longer have access to your child's MyChart record.

Please print legibly and complete all fields to ensure timely processing.

MEDICAL RECORD ACCESS REQUEST

Patient Name:		My relationship to patient:	Are you the legal custodian*?
_____ First	_____ Last	☐Parent ☐Other	☐Yes ☐No
Date of Birth: _____	MRN: _____	_____	

*Legal documents may be required, such as a birth certificate, guardianship papers, adoption documents, etc.

REQUESTOR INFORMATION (Parent/Legal Guardian)

Your Name: _____ First _____ Last

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Date of Birth: _____

Email: _____

Your Signature: _____ Date: _____

FACILITY USE ONLY

Date Received:	Patient Relationship Verified By: _____ Name _____ Phone Number
Proxy MRN:	**Proxy Access Approved:** ☐Yes ☐No **Letter Sent:** ☐Yes ☐No Date Sent: _____ ☐Form FAXED to HIMS for processing

CAIR California Immunization Registry

Immunization Registry Notice to Patients and Parents (TB)

Immunizations or 'shots' prevent serious diseases. Tuberculosis (TB) screening tests help to determine if you may have TB infection and can be required for school or work. Keeping track of shots/TB tests you have received can be hard. It's especially hard if more than one doctor gave them. Today, doctors use a secure computer system called an *immunization registry* to keep track of shots and TB tests. If you change doctors, your new doctor can use the registry to see the shot/TB test record. It's your right to choose if you want shot/TB test records shared in the *California Immunization Registry*.

How Does a Registry Help You?

- Keeps track of all shots and TB tests (skin tests/chest x-rays), so you don't miss any or get too many
- Sends reminders when you or your child need shots
- Gives you a copy of the shot/TB record from the doctor
- Can show proof about shots/TB tests needed to start child care, school, or a new job

How Does a Registry Help Your Health Care Team?

Doctors, nurses, health plans, and public health agencies use the registry to:

- See which shots/TB tests are needed
- Remind you about shots needed
- Prevent disease in your community
- Help with record-keeping

Can Schools or Other Programs See the Registry?

Yes, but this is limited. Schools, child care, and other agencies allowed under California law may:

- See which shots/TB tests children in their programs need
- Make sure children have all shots/TB tests needed to start child care or school

What Information Can Be Shared in a Registry?

- patient's name, sex, and birth date
- parents' or guardians' names
- limited information to identify patients
- details about a patient's shots/TB tests

What's entered in the registry is treated like other private medical information. Misuse of the registry can be punished by law. Under California law, only your doctor's office, health plan, or public health department may see your address and phone number.

Patient and Parent Rights

It's your legal right to ask:

- not to share your (or your child's) registry shot/TB test records with others besides your doctor*
- not to get shot appointment reminders from your doctor's office
- to look at a copy of your or your child's shot/TB test records
- who has seen the records or to have the doctor change any mistakes

If you DO want your or your child's records in the registry, do nothing. You're all done.

If you DO NOT want your doctor's office to share your immunization/TB test information with other registry users, tell your doctor or download a "*Decline or Start Sharing/Information Request Form*" from the CAIR website (http://cairweb.org/cair-forms/) and FAX or email it to the CAIR Help Desk at **1-888-436-8320** or CAIRHelpDesk@cdph.ca.gov.

For more information, contact the CAIR Help Desk at 800-578-7889 or CAIRHelpDesk@cdph.ca.gov

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**By law, public health officials can also look at the registry in the case of a public health emergency.*