# WEST HILLS CHILDREN'S MEDICAL GROUP


## Scott Calig, M.D., F.A.A.P.
## Susanne Sager, M.D., F.A.A.P.

Phone: 818 593-KIDZ (5439)
Fax: 818 593-3460

7345 Medical Center Dr., Suite 500
West Hills, CA 91307


Welcome to our office,

We have enclosed forms for you to fill out at your convenience. Please bring them to your child's initial appointment as well as your child's insurance card and immunization record. Well child exams cannot be performed without immunization records.

We look forward to meeting you and your child(ren).

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**Please COMPLETELY print the following information**

Child's Name: _____ M____ F____ Date of Birth _____

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Child's Name: _____ M____ F____ Date of Birth _____

Mother's Name: _____ DOB: _____ Driver's License # _____

Home Address: _____
Street Address City State Zip Code

Home Phone: _____ Cell Phone: _____

Work Phone: _____ E-Mail: _____

Employer's Name and Address: _____

_____

Father's Name: _____ DOB: _____ Driver's License # _____

Home Address: _____
Street Address City State Zip Code

Home Phone: _____ Cell Phone: _____

Work Phone: _____ E-Mail: _____

Employer's Name and Address: _____

_____

Primary Contact Phone Number (where automated reminders and lab results will be sent) _____

Would you like us to leave a message on your voice mail if we can't reach you? Y____N___

Do we have permission to send you reminders via-e-mail? Y___N___

Language Spoken at Home: _____ Race: _____ Ethnicity: _____

Emergency Contact Name and Phone Number: _____
**(Emergency Contact must be a third party other than parents)**

Referred by: _____

**Financial Responsibility: Mother _____ Father _____ Other (please specify) _____**

Preferred Pharmacy Name: _____ Preferred Pharmacy Phone: _____

Insurance Company: _____ Insured's Name: _____

**As a courtesy, we will bill your insurance company, but please remember that payment is your obligation regardless of insurance or other third party involvement**

Additional Children Information:

Child's Name: _____ M ____ F ____ Date of Birth_____

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Child's Name: _____ M ____ F ____ Date of Birth_____

Child's Name: _____ M ____ F ____ Date of Birth_____

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7345 Medical Center Drive, Suite 410
West Hills, Ca. 91307
818-593-KIDZ (5439)

**Continuing Consent to Treatment**
(Minor or Child or Children)

I, the undersigned, parent or guardian of _____,
a minor child, does Hereby consent to any x-ray examination, anesthetic, medical or surgical diagnostic or treatment, and hospital service that may be rendered to said minor, under the general or specific instructions of Scott Calig, M.D., Susanne Sager, M.D., and/or Susan Salzwedel, PA-C, licensed to practice in the state of California, whether such diagnosis or treatment is rendered at the doctor's office or at a hospital licensed by the state of California.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required, but is given in order that said physician/physician assistant may have the opportunity to exercise their best judgment as to the action which may be necessary or required to protect the life and health of said minor child or children.

Signature of Parent or Guardian Date

Signature of Witness Date

This consent shall remain effective until revoked by a writing delivered to said physician.

Additional Child or children to be added to the above consent form:

Child's Name_____ DOB_____

Child's Name_____ DOB_____

Child's Name_____ DOB_____

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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY, THE PRIVACY OF YOUR MEDICAL INFORMATION IF IMPORTANT TO US.**

The undersigned Patient or legally authorized representative ("Agent") of the Patient acknowledges that he or she personally received a copy of the Scott Calig, M.D., Inc. Notice of Privacy Policies on the date indicated below:

Patient: _____

Signature: _____ Date: _____

Name of person signing: _____

Information about Agent (attach appropriate documentation):

Agent: _____

Title: _____

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# VERIFICATION OF MEDICAL INSURANCE

Name of Insurance Co: _____

Subscriber's Information:

_____

Name | Date of Birth | Social Security Number

_____

Employer | Policy Number | Group Number

**PATIENTS WHO CARRY MEDICAL INSURANCE SHOULD REMEMBER THAT PROFESSSIONAL SERVICES ARE RENDERED AND PAYMENT IS THE RESPONSIBILITY OF THE PATIENT/PARENT. INSURANCE BILLING AND ASSISTANCE WITH THE INSURANCE FORMS IS A COURTESY PROVIDED BY OUR OFFICE, HOWEVER, FULL RESPONSIBILITU FOR PAYENT REMAINS WITH THE PATIENT.**

**TO AVOID DELAYS AND MISUNDERSTANDINGS, IT IS IMPORTANT TO LEARN, BEFOREHAND, EXACTLY WHAT BENEFITS YOUR POLICY PROVIDERS AND WHAT TYPE OF COVERAGE YOU HAVE.**

**ALL DEDUCTIBES, COPAYMENTS AND COINSUANCE PAYMENTS ARE DUE AND PAYABLE AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE PRIOR TO THE MEDICAL SERVICES BEING RENDERED.**

**YOUR SIGNATURE BELOW INDICATES THAT YOU ARE IN AGREEMENT WITH OUR FINANCIAL RESPONSIBILTY STATEMENT.**

_____ _____

Signature | Date

# WEST HILLS CHILDREN'S MEDICAL GROUP

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## Pediatric Past Medical History

Child's Name:_____Date of Birth: _____Birth weight:_____

**Pregnancy:**

Prenatal Care ___ Y ___N Maternal Age _____
Problems During Pregnancy ___ Y ___ N (If yes, comment)
During pregnancy and of the following:

| | | |
|---|---|---|
| ___ Swelling of Extremities | ___ Rubella | ___ Smoking |
| ___ High Blood Pressure | ___ PPD Positive | ___ Alcohol use |
| ___ Convulsions | ___ X-Rays During Pregnancy | ___Vaginal Bleeding |
| ___Anemia | ___Surgery | ___Prescription drugs/OTC drugs |
| ___Diabetes | ___STD | ___Drug use |
| ___STD | ___Pos. hepatitis screen | ___Other |

**Birth Site:** ___Hospital ___Home ___Other _____
Gestation: (weeks) _____ ___Vaginal delivery ___C-Section

**Neonatal Problems** (First six weeks) ___Y ___N (If yes, comment)

| | |
|---|---|
| ___Congenital Abnormalities | ___Feeding |
| ___Breathing | ___Infection |
| ___Jaundice | ___Re-hospitalization |
| ___Anemia | ___Other _____ |

**Childhood Problems**: (7 weeks – 12 years old)

| | | | |
|---|---|---|---|
| ___Hospitalization | ___Eye | ___Muscular/Skeletal | ___Developmental |
| ___Operation(s) | ___Ear/Nose/Throat | ___Skin | ___Endocrine |
| ___Serious Injury | ___Heart | ___Allergies | ___Psychological |
| ___Drug Allergy | ___Respiratory | ___Anemia | ___Tuberculosis |
| ___Poisoning | ___Gastrointestinal | ___Asthma | ___Other: _____ |
| ___Gastro/urinary | ___Nervous System | ___Convulsions | |

**Adolescent**: (13 years – 18 years)
___Problem with school/family ___Smoking

**Adolescent Girls**:
___Sexually active ___ETO use Menarche: _____years old Pregnancies ___
___Any offspring ___Drug use Interval: _____Days Duration: ____

**Medical History:**
___ Allergies to food, environment, medications _____
___Hospitalizations _____
___Surgeries _____
___Injuries, Accidents, Significant Illnesses _____

**Family History**:
Mother Alive Y/N Father Alive Y/N Number of Siblings (living) _____
Family history of any serious illnesses/disease? Y/N
If yes, indicate relationship

| | | | |
|---|---|---|---|
| ___Alcohol/drugs | ___Birth defects | ___Cancer | ___Heart Disease |
| ___Developmental | ___Asthma | ___Hypertension | ___Thyroid |
| ___Blood diseases | ___Tuberculosis | | |

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I give permission for the following people to bring my child(ren) in to West Hills Children's Medical Group for treatment/physicals.

Child(ren) Name: DOB:

_____

_____

_____

_____

_____

_____

People allowed to bring my child(ren) to West Hills Children's Medical Group:

_____

_____

_____

_____

_____

Parent Signature: _____ Date: _____