Children's Orthotics and Prosthetics

810 S. Durango Dr., Ste 100, Las Vegas, NV 89145 • Phone 702.932.1300 • Fax 702.848.4990 • childrensop.com

Insurance Information

Does the patient have Medicaid? *Yes* ◯ *No* ◯

If yes, please provide the medicaid number: _____

Primary Insurance Name: _____

Policy Number: _____

Group Number: _____

Policy Holder Date of Birth: _____ Policy Holder SSN#: _____

Policy Holder relationship to patient: _____

Secondary Insurance Name: _____

Policy Number: _____

Group Number: _____

Policy Holder Date of Birth: _____ Policy Holder SSN#: _____

Policy Holder relationship to patient: _____

I hereby authorize release of information necessary to file a claim with my insurance company/companies. I assign benefits to be paid to *Children's Orthotics and Prosthetics* and I understand that I am financially responsible for charges for medical devices provided by *Children's Orthotics and Prosthetics* to the above-named patient, regardless of insurance coverage.

Signature of patient's parent or authorized guardian: _____

Print Name: _____

Relationship to Patient: _____ Date: _____

How did you find us:

◯ *Google*

◯ *Friend*

◯ *Referred from physician*

◯ *Referred from therapist*

◯ *Family*

◯ *Other*

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General Information

Patient/Child's Name: *First* _____ *Middle* _____ *Last* _____

Preferred Name: _____

Gender: *Female* ◯ *Male* ◯ *Other* ◯ Date of Birth: _____ Age: _____

Preferred Language: ◯ *English* ◯ *Spanish* ◯ *ASL* ◯ *Other*: _____

Parent A Name: _____ Occupation: _____

Relationship to Patient: _____ Email: _____

Primary Address:

Street: _____ Apt. No: _____

City: _____ State: _____ Zip: _____

Parent's Work Phone: _____ Cell: _____

Parent B Name: _____ Occupation: _____

Relationship to Patient: _____ Email: _____

Primary Address:

Street: _____ Apt. No: _____

City: _____ State: _____ Zip: _____

Parent's Work Phone: _____ Cell: _____

Emergency Contact (other than child's parents):

Name: _____ Phone: _____

Street: _____ Apt. No: _____

City: _____ State: _____ Zip: _____

Physician Name: _____ Phone: _____

Therapist Name: _____ Phone: _____

Divorced or Separated Parents - please fill out this section

Who has custody? _____

Are there any legal restrictions that restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? *Yes* ◯ *No* ◯

If yes, you must provide a copy of any legal paperwork that supports this restriction.

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Cranial Remolding Patient and Family History

Patient History

Patient/Baby's Name: *First* _____ *Middle* _____ *Last* _____

Gestation at birth (how far along were you?) _____

Baby is a: *Singlet* ◯ *Twin* ◯ *Triplet* ◯ *Baby is :* *Male* ◯ *Female* ◯

Is this your first baby? *Yes* ◯ *No* ◯ *If no, how many children do you have (including this baby)?* _____

Race

White ◯ *Asian* ◯ *Black/African American* ◯ *Native Hawaiian/ Other Pacific Islander* ◯
American Indian or Alaska Native ◯ *Prefer not to answer* ◯

Ethnicity

Hispanic or Latino ◯ *Not Hispanic or Latino* ◯ *Prefer not to answer* ◯

Birth History

OBGYN/Perinatologist _____

Hospital/Location of Delivery _____

Type of Birth *Vaginal* ◯ *C-Section* ◯ *Breech* ◯ *Forceps* ◯ *Suction* ◯ *Prolonged* ◯

Describe any complications during labor and delivery _____

_____

_____

Was the baby hospitalized for any reason? _____

Was the baby in the NICU? If yes, for how long? _____

Baby's Weight at birth: _____ *Baby's Length at birth:* _____

Mother's age at birth: _____ *Father's age at birth:* _____

General Health

Check all that apply

Torticollis ◯ *Hearing Issues* ◯ *Vision Issues* ◯ *Feeding Issues (G or J tube)* ◯ *Blocked Tear Duct* ◯

Eczema ◯ *Cradle Cap* ◯ *Sensitive Skin* ◯ *Known Allergies* _____

Plagiocephaly/Brachycephaly

How do you feel your baby's head shape looks? Please place an X above the line where you feel it's appropriate.

_____

Normal	*Slightly Abnormal*	*Moderately Abnormal/ Acceptable*	*Moderately Abnormal/ Unacceptable*	*Severely Abnormal*

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Cranial Remolding Patient and Family History

Plagiocephaly/Brachycephaly

Has your baby ever been evaluated for cranial helmet before today? Yes ◯ No ◯

If yes, please provide name of clinic and date of evaluation: _____

_____

Did your baby's head shape appear normal at birth? Yes ◯ No ◯ Not Sure ◯

When did you first notice flattening or asymmetry of your baby's head? _____

Who first noticed the asymmetry

Doctor ◯ Therapist ◯ Mother ◯ Father ◯ Family Member ◯ Friend/Other ◯

Has your baby had an MRI , Ultrasound or CT scan? Yes ◯ No ◯

If yes, please specify which one and when _____

Has your baby been evaluated by a Neurosurgeon? Yes ◯ No ◯

If yes, please specify who and when _____

Has any physician or therapist suspected Craniosynostosis? Yes ◯ No ◯

Does your baby favor one side of their head over the other? Yes ◯ No ◯

If yes, which side? _____

Has your baby had any physical or occupational therapy? Yes ◯ No ◯

If yes, who is the therapist? _____

How often? _____

Developmental Milestones

Roll from stomach to back? Yes ◯ No ◯

Roll from back to stomach? Yes ◯ No ◯

Sit Independently? Yes ◯ No ◯

Pulling up to stand? Yes ◯ No ◯

Crawling? Yes ◯ No ◯

Walking? Yes ◯ No ◯

Anything else you would like to tell the practitioner?

Signature

Signature of Parent or Authorized Guardian: _____

Print Name: _____ *Date:* _____

Photo/Video Waiver (OPTIONAL) I understand that *Children's Orthotics and Prosthetics* may take and/or use photos of me and my family/friends during evaluations and follow-ups. I give *Children's Orthotics and Prosthetics* permission to use these images/photos for before and after education of new patients as well as their public relations/marketing (including but not limited to use on Facebook, Linked In and Twitter accounts, in their e-news and/or printed newsletter).

Parent Signature _____ Date _____

AUTHORIZATION TO RELEASE MEDICAL RECORDS

(This authorization complies with HIPAA)

Printed Name of Patient (first, middle, last name)	Birthdate (mm/dd/yyyy)
Address (Street Address, City, State, Zip Code)	
Phone Number	E-mail

Printed Name of Guardian or Legal Representative (first, middle, last name)	
Address (Street Address, City, State, Zip Code)	
Phone Number	E-mail

The following person/organization is hereby authorized to receive my entire medical record, treatment record and diagnostic record.

Person/Organization to Receive Information Children's Orthotics and Prosthetics		
Street Address 810 South Durango Drive, STE 100		
City Las Vegas	State NV	Zip Code 89145
Phone Number 702-932-1300	Fax Number 702-848-4990	

By my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization.

I understand and agree that health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by law.

This authorization is valid for 24 months following the date of my signature shown below. A copy, electronic copy, image, or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing at any time. I acknowledge that such a revocation is not effective to the extent the above person/organization has relied on the use or disclosure of my health information.

I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization.

Signature of Patient or Personal Representative:	Date Signed:

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ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I am a parent or legal guardian of (patient name): _____
I have received a copy of Children's Orthotics and Prosthetics Notice of Privacy Practices effective September 1st, 2017.

Name (please print): _____
Relationship to Patient: ☐ Parent ☐ Legal Guardian
Signature: _____
Date: _____