Stanford Children's Health
Pediatric Group of Monterey
1900 Garden Rd. Suite 110, Monterey, CA 93940

Pre-Visit Questionnaire

Medical Record Number

Patient Name

Patient Name (Last/First/M.I.) _____ DOB _____

Address: _____ City: _____ Zip Code: _____

Sex: F _____ M _____ Birth Weight: _____ lbs. _____ oz Birth Length _____ in _____

Born Place (Hospital, Birth Center, ETC.) _____ Dr. who delivered: _____

FATHERS INFORMATION

Father's Name _____ DOB _____ SS# _____
Last First M.I.

Father's Employer _____ Phone (___) _____

Business Address _____

Email Address _____ Cell (___) _____

MOTHERS INFORMATION

Mother's Name _____ DOB _____ SS# _____
Last First M.I.

Mother's Employer _____ Phone (___) _____

Business Address _____

Email Address _____ Cell (___) _____

PATIENT SIBLINGS (list additional children on back if necessary)

Name _____ DOB _____ Name _____ DOB _____

Name _____ DOB _____ Name _____ DOB _____

Relative or friend we may contact in an emergency: _____ Phone (___) _____

Address: _____

Patient Insurance: _____

PLEASE PROVIDE A COPY OF INSURANCE CARD; SEE BOTTOM OF PAGE

I UNDERSTAND THAT IF I CANCEL AN APPOINTMENT WITHOUT AT LEAST 24 HOUR NOTICE OR MISS AN APPOINTMENT I AM SUBJECTED TO A $30.00 MISSED APPOINTMENT FEE.

PLEASE PRESENT THIS INFORMATION SHEET WHEN COMPLETED TO THE FRONT DESK WHERE A COPY WILL BE MADE OF YOUR INSURANCE CARD. IF YOU HAVE INSURANCE FOR WHICH WE ARE A PROVIDER OR WHICH WE MAY BILL. PLEASE REMEMBER THAT PAYMENT IS YOUR OBLIGATION REGARDLESS OF INSURANCE OR THIRD-PARTY INVOLVEMENT.

PARENT/GUARDIAN: _____ PARENT/GUARDIAN: _____
(PRINT NAME) (SIGNATURE)

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CONSENT • AUTHORIZATION TO TREAT A MINOR

I), We), the undersigned parents of _____a minor, do hereby authorize the following people to bring this child into this medical facility for the undersigned to consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon whether such diagnosis or treatment is rendered at the Pediatric Group of Monterey.

1._____

2._____

3._____

4._____

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority and power in the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which the aforementioned physician in the exercise of his (her) best judgment may deem advisable. It is also understood that every effort shall be made by the above named agent(s) to contact the undersigned prior to rendering emergency treatment to the patient.

This authorization shall remain effective for one year from the date of execution or unless sooner revoked in writing delivered to said agent(s).

Date of Authorization: _____

Parent(s) or Legal Guardian: _____ (Name)_____ (Signature)

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

FAMILY HISTORY FORM

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	High Cholesterol	High Blood Pressure	Kidney Disease	Learning Disabilities	Mental Illness	Mental Retardation	Miscarriages	Stroke	Vision Loss
Mother																					
Father																					
Sister																					
Brother																					
Daughter																					
Son																					
Maternal Aunt																					
Maternal Uncle																					
Paternal Aunt																					
Paternal 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? _____

If yes, please list names of siblings _____

Has the patient had any surgeries or hospitalizations?

If so, please explain _____

L15701

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**