BLUE SPARK HEALTH
NATUROPATHIC MEDICINE

5224 Olympic Drive NW Suite 108
Gig Harbor, WA 98335
P: 253-525-108 F: 253-525-4130

info@bluesparkhealth.com
www.bluesparkhealth.com

PATIENT INFORMATION

Legal Name:_____ Preferred Name: _____

Date of Birth:_____Age:_____ Gender or Orientation: _____

Address:_____City_____State:_____Zip: _____

Occupation:_____Name of Employer: _____

Marital Status:_____If married, Name of Spouse: _____

I Authorize Blue Spark Health, PLLC to contact me at the following:

Home phone:_____Leave message at home: Yes:____No: _____

Mobile: _____ Leave message on mobile: Yes: _____ No: _____

Work Phone:_____Leave message at office: Yes:____No: _____

Email address: _____Initials _____

Pediatrician:_____ / _____

Specialists: _____

Whom may we thank for referring you to Blue Spark Health? _____

INSURANCE INFORMATION

Name of Insurance Company: _____

ID#:_____Group #: _____

IT IS UNDERSTOOD AND AGREED THAT I AM FINANCIALLY RESPONSIBLE FOR THE BALANCE ON THIS ACCOUNT, REGARDLESS OF MY INSURANCE STATUS, FOR ANY SERVICES OR LABORATORY WORK PERFORMED AND MEDICATIONS SUPPLIED BY BLUE SPARK HEALTH.

PEDIATRIC INTAKE FORM

Patient's Name:_____ Date: _____

Parent(s) or Legal Guardian(s) Name: _____
Reason for visit:_____

_____

_____

Current Medications: _____

_____

_____

Any Previous Medications: _____

Please check any of the following needed by your child on a regular or frequent basis:

Aspirin	Tylenol	Ibuprofen	Decongestant	Antihistamine	Antibiotics

Medical History: _____
Childhood Illness: Has your child had any of the following illnesses?

Chicken Pox:	Measles	Mumps	Rubella

Has your child had any of the following tests?

Scarlet Fever	Pneumonia	Frequent Colds	Rheumatic Fever
Yes No	Yes No	Yes No	Yes No

Has he/she ever had:

Tonsillitis Yes No	Number of Times?	Ear Infections Yes No	Number of Times?

Allergies to medication: List drug and type of reaction:

Medication	Reaction

Other known allergies: Foods or Environmental	

Electroencephalogram Psychological Evaluation:
Hearing _____ Speech_____ Language_____ Vision _____

Vaccinations:

Check for Yes	Polio	DPT(Tdap)	MMR	Hep A	Hep B	RV
Dates of vaccinations						
Hib	DtaP	Influenza	PCV	IPV	HPV	MCV

Any Adverse Reactions to Vaccinations?
_____
_____
_____
_____

Family History ____ Heart Disease _____Hypoglycemia _____Tuberculosis _____Allergies

_____Diabetes ____ Hypertension ____ Mental Illness ____ Arthritis____ Cancer

Mother's History	Mother's age at childbirth _____ Number of pregnancies by birth mother_____
Mother's health during pregnancy:	Bleeding Nausea Illness Hypertension
Consumption during pregnancy?	Alcohol Cigarettes Drugs Other
Please list any medications taken during pregnancy	
Gestational Health Conditions?	Ie. Diabetes, preeclampsia:
Injuries/Surgeries/Hospitalizations:	

Child's Birth History	Check if Yes	Explain
Physical or emotional trauma		
Birth injuries		
Birth defects		
Term: Preemie: _____ Full:	Late:	Length of Labor:
Weight at birth	Complications:	

Has your child had any of the following problems: Check if Yes

Jaundice: _____ Colic: _____ Blue Baby: _____

Any injuries, Traumas, Surgeries, Hospitalizations:
_____
_____
_____

Child's sleep patterns (First year): _____

Feedings:

_____ Breast Fed How long? _____ Age began eating solid food _____

_____Formula Milk_____ Soy _____ Other_____

Rashes _____ Allergies _____ Other _____

Developmental:
Any developmental delays? _____
Age began walking _____
Age began crawling _____
Age he/she spoke first word _____

Diet: Please describe your child's typical daily diet
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Beverages: _____
Favorite Foods/Snacks: _____

SYMPTOMS	NOW	PAST
Hives		
Eczema		
Acne		
Chronic rash		
Jaundice		
Bleeding gums		
Canker sores		
Teeth problems		
Nose bleeds		
Frequent colds		
Sore throats		
Hay fever		
Night sweats		
Easy bruising		
Motion sickness		
Fever		
Seizures		
Cough		
Hearing loss		
Stomach aches		
Diarrhea		
Constipation		
Excessive fatigue		
Bleeding tendency		

SYMPTOMS	NOW	PAST
Sensitive to light		
Joint pains		
Flat feet		
Muscle/bone pain		
Dizzy spells		
Hair loss		
Body/breath odor		
Cries easily		
Unusual fears		
Nervousness		
Sleep problems		
Anemia		
Nightmares		
Frequent headaches		
Runny nose		
Heart murmur		
Bloody urine		
Burning urination		
Vomiting spells		
Lack of appetite		
Diarrhea		
Gas / colic		
Wheezing		

Any other concerns not listed:

_____

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HIPAA Notice of Privacy Practices and Consent/Written Acknowledgment

I hereby consent to the use and disclosure of my protected health information by Blue Spark Health for the purposes of **treatment, payment and health care operations, or as otherwise required by law.**

* I acknowledge that I have a right to review or receive a printed copy of the Notice of Privacy Practices provided by Blue Spark Health prior to signing this consent. The Notice of Privacy Practices describes how medical information about me may be used and disclosed, and how I can access this information.

* I have the right to request restrictions to the usage and disclosure of my protected health information.

*I have the right to request an alternative to the standard method of communication of my protected health information.

* I understand that if I wish to revoke this consent at any time I will do so in writing and submit to the address listed below. I understand that while Blue Spark Health may honor these requests, they are not required by law to do so. I also understand that revocations will be honored as of the date they are received by Blue Spark Health at the following address: **5224 Olympic Dr. NW Gig Harbor, WA 98335**

* I understand that if I have any questions or complaints, I may submit them in writing to the address above or contact Blue Spark Health by phone at: **(253) 525-1080**

* I am aware that Blue Spark Health reserves the right to change the terms of their Notice of Privacy Practices and to make new notice of Privacy Practices provisions effective for all protected health information that they maintain. In the event of amendments, Blue Spark Health will make available a revised Notice of Privacy Practice for my review.

PERSONAL IDENTIFICATION INFORMATION

Please be aware that you do NOT have to provide your social security number as a form of personal identification to receive health care. However, in compliance with state and federal guidelines, Blue Spark Health does require a front and back copy of your state drivers' license. Additionally, Blue Spark Health may require your social security number in order to extend certain financial options to you.
Your social security number or parent/guarantor's social security number may be required when:
* Payment for any balance due is being billed to/made by another third-party payer, including but not limited to the following:
A) Your health, motor vehicle accident, or workers' compensation insurance
B) Parent/guarantor, relative, attorney or any other payer agreeing to be financially responsible for charges you incur
*Payment arrangement is requested/made for any balance due not paid at the time of service
*Standard discounts are given for services, supplements, herbs, lab fees, and supplies.

I have fully read and understand the above terms for personal identification information.
NON-COVERED SERVICES WAIVER/ACKNOWLEDGEMENT
SERVICES/SUPPLEMENTS/SUPPLIES I understand and agree to the following:

* Any and all supplements, supplies, herbs, formulas, etc. prescribed by my provider and/or purchased by me at Blue Spark Health are my full financial responsibility with payment to be made at the time of service/purchase. No open products can be returned to the clinic for refund under any circumstances.

*Blue Spark Health does not bill insurance carriers, health saving plans or any other like entities for any supplements, herbs, formulas, or supplies. It is my full responsibility to submit the required information to these entities for reimbursement.

*Treatment/services such as acupuncture, hydrotherapy, cranial therapy, energy work, injections, IV therapy, etc. are generally not covered by insurance carriers and are my full financial responsibility.

* It is my full financial responsibility to pay for any charges to the provider and/or Blue Spark Health.

I have fully read and understand the above agreements and information.

STATEMENT OF FINANCIAL RESPONSIBILITY I understand and agree to the following general responsibilities:

* Financial options extended to me are based on the personal identification information and documentation I have provided.

* I am responsible as the patient or patient's guarantor for full payment of services rendered at the time of service, including all supplements, herbal formulas, supplies, lab work and tests, and physician ordered add-on lab work and tests, as well as any additional expenses incurred in connection to my health care, such as: postage and delivery, shipping and handling, and phone calls to the provider or clinic wherein medical advice is provided.

*I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, I agree to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize Blue Spark Health to release information necessary to secure payment.

* I understand that there will be a minimum $50 fee for any appointment not canceled within 24 hours of the scheduled appointment.

*Fees and rates are adjusted periodically and therefore may increase during the term of our engagement. While we will do our best to avoid unknown adjustments, on occasion such changes may occur without written notice.

_____ _____

Client Signature Date