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Dear Parent or Guardian:

Thank you for bringing your child for a well visit today. We recommend regular well visits (also known as preventive exams or physicals) based on the American Academy of Pediatrics guidelines. We are providing this document to help you understand the difference between what is covered within a well visit versus a problem-oriented visit.

Screening – During well visits we perform recommended screenings appropriate to your child's age and seek to uncover any conditions that may lead to suboptimal health in the years to come. These screenings are also required for school, sports, camp, scouts and other activities. In our experience, some insurance plans cover these screenings and some do not. Because there are so many different insurance companies and plans, we do not know in advance what will and will not be covered. It is your responsibility to understand what screening services are covered by your insurance plan.

Insurance Coverage for Well Visits vs. Problem-Oriented Visits - Well visits may uncover or revisit problem-oriented issues that require evaluation or management (ex. ear infection, allergies, warts). When possible, we strive to address such problem-oriented issues at the same office visit. This is also an additional convenience so that families do not have to return to the office for another appointment. In compliance with insurance company billing policies, these issues then prompt charges for both categories. While preventive services may not require a co-pay/deductible, problem-oriented services do prompt a co-pay/co-insurance/deductible.

If you need further explanation about incurring additional fees for services provided during your visit today, please ask to speak with our biller.

Acknowledgement of Wellness Services Billing Procedures
I acknowledge that during my well visit, there may be a problem-oriented service performed in addition to the wellness services. In this case, I understand that two separate charges may be submitted to my insurance company and that, when applicable, a co-pay/deductible/co-insurance may be required for charges generated pertaining to problem-oriented services. Alternatively, I understand I may choose to return for a separate visit to address problem-oriented issues, at which time, my co-pay/deductible would still apply.

Patient name: _____ DOB: _____

Parent/guardian signature: _____ Date: _____

Tuberculosis and Lead Screening Questions

Casa Verde Pediatrics, Inc.

Name of Child _____ DOB _____ Date _____

Tuberculosis (TB) is an infection of the lungs and many other parts of the body that can cause death if undetected and untreated. It is contagious. California wants to treat and protect children who have been exposed to TB and are at risk of the infection.

The following questions help determine testing for tuberculosis. These questions and TB testing are required for childcare, school, and many jobs. These questions are used only to decide who needs TB testing.

Ask the doctor or nurse practitioner if you need more information to answer the questions.

Where was the child born? ***Please circle one***

United States
Africa
Asia
Middle East
Northern/Western Europe
Eastern Europe
New Zealand/Australia
Latin American: Central or South America

Please answer the following questions by circling **yes** or **no**

1. **Has the child traveled to or lived in a country with a high rate of TB and stayed for *one month* or more? YES/NO**

   Where did they travel or live? ***Please circle all areas below***

   Africa
   Asia
   Middle East
   Northern/Western Europe
   Eastern Europe
   New Zealand/Australia
   Latin American: Central or South America

2. **Has the child even been around anyone who has ever had TB or a positive TB test? YES/NO**

This includes anyone with a positive TB test or was treated for TB at any time in the past including family, friends, nannies, babysitters and childcare providers, especially if they were born outside of the United States.

3. **Is your child being treated for a condition that suppresses the immune system? YES/NO**
   This includes: oral steroids for more than a month, infection with HIV, an organ transplant or other medications that suppress the immune system.

For **children under 5**, please continue to the following lead screening questions:

5. Does your child live in or regularly visit a house that was built before 1950? YES NO
Is there chipped, peeling or damaged paint? YES NO
6. Does your child live in or regularly visit a house built before 1978 with recent or ongoing renovations or remodeling (within the past 6 months?) YES NO
7. Does your child have a sibling or playmate who has or did have lead poisoning? YES NO

Reviewed on: _____ _____ _____ _____ _____

SWYC™: 12 months

12 months, 0 days to 14 months, 31 days
V1.08, 9/1/19

Child's Name:

Birth Date:

Today's Date:

DEVELOPMENTAL MILESTONES

Most children at this age will be able to do some (but not all) of the developmental tasks listed below. Please tell us how much your child is doing each of these things. PLEASE BE SURE TO ANSWER ALL THE QUESTIONS.

	Not Yet	Somewhat	Very Much
Picks up food and eats it	0	1	2
Pulls up to standing	0	1	2
Plays games like "peek-a-boo" or "pat-a-cake"	0	1	2
Calls you "mama" or "dada" or similar name	0	1	2
Looks around when you say things like "Where's your bottle?" or "Where's your blanket?"	0	1	2
Copies sounds that you make	0	1	2
Walks across a room without help	0	1	2
Follows directions - like "Come here" or "Give me the ball"	0	1	2
Runs	0	1	2
Walks up stairs with help	0	1	2

BABY PEDIATRIC SYMPTOM CHECKLIST (BPSC)

These questions are about your child's behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child.

	Not at all	Somewhat	Very Much
Does your child have a hard time being with new people?	0	1	2
Does your child have a hard time in new places?	0	1	2
Does your child have a hard time with change?	0	1	2
Does your child mind being held by other people?	0	1	2
Does your child cry a lot?	0	1	2
Does your child have a hard time calming down?	0	1	2
Is your child fussy or irritable?	0	1	2
Is it hard to comfort your child?	0	1	2
Is it hard to keep your child on a schedule or routine?	0	1	2
Is it hard to put your child to sleep?	0	1	2
Is it hard to get enough sleep because of your child?	0	1	2
Does your child have trouble staying asleep?	0	1	2

Floating Hospital for Children at Tufts Medical Center

********** Please continue on the back **********

PARENT'S CONCERNS

	Not At All	Somewhat	Very Much
Do you have any concerns about your child's learning or development?	○	○	○
Do you have any concerns about your child's behavior?	○	○	○

FAMILY QUESTIONS

Because family members can have a big impact on your child's development, please answer a few questions about your family below:

	Yes	No
1 Does anyone who lives with your child smoke tobacco?	Y	N
2 In the last year, have you ever drunk alcohol or used drugs more than you meant to?	Y	N
3 Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?	Y	N
4 Has a family member's drinking or drug use ever had a bad effect on your child?	Y	N

	Never true	Sometimes true	Often true
5 Within the past 12 months, we worried whether our food would run out before we got money to buy more.	○	○	○

Over the past two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
6 Having little interest or pleasure in doing things?	0	1	2	3
7 Feeling down, depressed, or hopeless?	0	1	2	3

8 In general, how would you describe your relationship with your spouse/partner?	**No tension** ○	**Some tension** ○	**A lot of tension** ○	**Not applicable** ○
9 Do you and your partner work out arguments with:	**No difficulty** ○	**Some difficulty** ○	**Great difficulty** ○	**Not applicable** ○

10 During the past week, how many days did you or other family members read to your child?	0	1	2	3	4	5	6	7

Casa Verde Pediatrics, Inc.

ORAL HEALTH and FLUORIDE VARNISH PROGRAM

Name of child: _____ Date of Birth: _____

Parent/Guardian's name: _____

(Please print)

Has your child seen the dentist? Yes _____ No _____

Do you brush your child's teeth at bedtime? Yes _____ No _____

Does your child nurse at night or have a bottle? Yes _____ No _____

Does your child drink juice? Yes _____ No _____

Does your child drink bottled water? Yes _____ No _____

If your family drinks bottled water, is it fluoridated? Yes _____ No _____ I don't know____

A preventive dental program is available for children with risk factors. A protective coating called fluoride varnish can be applied to your child's teeth to prevent tooth decay.

To receive these services you must provide consent.

___ Yes, I want my child to receive fluoride varnish (please fill in the bottom of this form)

___ No, I do not want my child to receive these preventive fluoride varnish services.

HEALTH HISTORY

Has your child ever had serious health problems? No: ___ Yes: ___ If yes, please explain:

_____

Does your child have any allergies? No: ___ Yes: ___ If yes, please list:

_____

Parent Signature: _____ Date: _____

*** This service does not replace a comprehensive evaluation.
We recommend that a dentist regularly examine your child. ***

FOR OFFICE USE ONLY

Comments _____

Varnish placed on: _____ by: _____

Varnish deferred on: _____ ☐ no risk factors