Dr. Rudy Byron, Jr. M.D.
6232 Bankers Road
Mt. Pleasant, WI 53403
262-672-6393

Pediatric/Adolescent Medical Intake Form

Patient Name: _____ Date: _____

Age: _____ DOB: _____

Gender: ☐ Female ☐ Male

Mother's Name: _____ Father's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: (_____)_____ Cell phone: (_____)_____

Work phone: (_____)_____ Fax number: (_____)_____

Email: _____

Parent(s) Occupation(s):

_____

_____

In case of emergency, contact: _____ Relationship: _____

Home Phone: (_____)_____ Cell phone: (_____)_____

How did you hear about Byron Health and Healing? _____

Reason for visit: _____

Present Health Concerns: Please list concerns in their order of significance

1. _____
2. _____
3. _____
4. _____
5. _____

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Medications:

	Current	Past		Current	Past
Aspirin	_____	_____	Antibiotics	_____	_____
Tylenol	_____	_____	Anti-histamine	_____	_____
Ibuprofen	_____	_____	Decongestants	_____	_____

Please list other previous medications taken:

_____

_____

Please list all medications, supplements, and homeopathic remedies your child is currently taking:

1. _____ Dosage: _____
2. _____ Dosage: _____
3. _____ Dosage: _____
4. _____ Dosage: _____
5. _____ Dosage: _____
6. _____ Dosage: _____
7. _____ Dosage: _____
8. _____ Dosage: _____
9. _____ Dosage: _____
10. _____ Dosage: _____

Allergies:

Please include mild to severe or life-threatening allergies (medication, food, environment, etc.)

1. _____ Reaction: _____
2. _____ Reaction: _____
3. _____ Reaction: _____
4. _____ Reaction: _____
5. _____ Reaction: _____
6. _____ Reaction: _____
7. _____ Reaction: _____
8. _____ Reaction: _____
9. _____ Reaction: _____
10. _____ Reaction: _____

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Medical History:

☐ Chicken Pox ☐ Bronchitis ☐ Tonsillitis (approximate #_____)

☐ Measles ☐ Asthma ☐ Ear infections (approximate #_____)

☐ Mumps ☐ Pneumonia ☐ Other (please list: _____)

☐ Frequent colds ☐ Thrush

Injuries/ Surgeries/ Hospitalizations:

_____

_____

_____

Immunizations:

☐ Measles ☐ Polio ☐ MMR ☐ Smallpox ☐ Diphtheria ☐ Mumps ☐ DPT
☐ Tetanus ☐ Influenza ☐ Other: _____

Any adverse reactions? ☐ Yes ☐ No If yes, please explain:_____

Family History:

☐ Heart disease ☐ Diabetes ☐ Birth defects ☐ Tuberculosis ☐ Mental illness

☐ Hypertension ☐ Arthritis ☐ Cancer ☐ Allergies ☐ Other: _____

Prenatal History:

Maternal age at delivery: _____ Paternal age at delivery: _____

Mother's health during pregnancy:
☐ Bleeding ☐ Nausea ☐ Illnesses ☐ Hypertension ☐ Physical or emotional trauma
☐ Cigarettes, alcohol, drug consumption ☐ Medications ☐ Thyroid problems ☐ Diabetes
☐ Other: _____

Term: ☐ Full ☐ Premature ☐ Late

Weight at birth: _____ Length of labor: _____

Complications during labor and delivery:

_____

_____

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Medication(s) during labor and delivery:

_____

_____

Did your child have any of the following shortly after birth?

☐ Birth defects ☐ Cerebral palsy ☐ Colic ☐ Birth injuries ☐ Seizures ☐ Fever
☐ "Blue baby" syndrome ☐ Jaundice ☐ Rashes ☐ Other: _____

Medications given to child during hospital stay (if any):

_____

_____

Child's sleep patterns: _____
Food Intolerance: _____

Feeding: ☐ Breast-fed – how long? _____ ☐ Formula – type? _____
Age began solid food: _____ Foods: _____
Age began: Sitting: _____ Crawling: _____ Walking: _____ Talking: _____

Child/Adolescent Symptoms: (Please mark "C" for current, and "P" for past symptoms)

_____Asthma	_____Blood in urine	_____Bedwetting
_____Hives	_____Burning of urine	_____Sleep problems
_____Eczema	_____Frequent urination	_____Night sweats
_____Bleeding gums	_____Heart murmur	_____Nervous
_____Nose bleeds	_____Vomiting spells	_____Obesity/Overweight
_____Acne	_____Anemia	_____Eating Disorders
_____High fevers	_____Stomachaches	_____Behavioral Problems
_____Chronic rash	_____Jaundice	_____Body/breath odor
_____Hearing loss	_____Easy bruising	_____Motion/car sickness
_____Diarrhea	_____Flat feet	_____Depression
_____Sore throats	_____Constipation	_____Nightmares
_____Headaches	_____Gas	_____Canker sores
_____Frequent colds	_____No appetite	_____Unusual fear
_____Wheezing	_____Joint pains	_____Excessive fatigue
_____Cough	_____Dizzy spells	_____Hair loss

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Diet: (please describe your child's typical daily diet)

Breakfast:

_____

_____

Lunch:

_____

_____

Dinner:

_____

_____

Snacks:

_____

_____

Beverages:

_____

_____

Daily water intake (glasses): _____
Special dietary restrictions: _____

Additional Comments:

_____

_____

_____

_____

.

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Medical Information Release and Health Information Privacy Notice Form

(*HIPPA RELEASE FORM*)

Patient Name: _____ Date of Birth: _____

Release of Information

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:
[ ] Spouse: _____
[ ] Child(ren): _____
[ ] Other: _____
[ ] Information is not to be released to anyone.

This notice is effective as of the date signed. This authorization will expire seven years after the date on which you last received services from the clinic.

Messages

Our office does like to confirm your reserved time prior to your appointment day. We may occasionally need to leave a voicemail message or leave a message with a family member for you to call our office. Our office also uses an online communication portal called Hello Health for secure messaging.

Please indicate your communication preference below:
Please call: ☐ Home ☐ Work ☐ Cell Contact #_____

☐ Email: _____

If you are unable to reach me:

☐ You may leave a detailed message

☐ Please leave a message asking me to return your call

☐ Other: _____

The best time of day to reach me is *(day)*_____ between *(time)*_____

Signed: _____ Date: _____

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Acknowledgment of Receipt of Privacy Practices

I, _____ have
(Please print patient's full name)

received a copy of this office's Notice of Privacy Practices (available in our office or on our website on the New Patient Page).

_____ _____
Signature of Patient or Parent/Guardian (if patient is a minor) Date

_____ _____
Witness Date

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Appointment Cancellation Policy Agreement

Patient name: _____

Please call us at (262) 672-6393 by 2:00pm two days (48 hours) **prior to your scheduled appointment** to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 2:00pm on Wednesday. **If the 48-hour prior notification is not given, we must apply a $200.00 charge for the missed appointment.**

Byron Health and Healing is committed to providing all patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen.

Please sign below to consent to these terms.

X_____

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Receipt of Patient Guide

By signing below, I acknowledge that I have received, reviewed, understand, and will comply with the policies and procedures explained in the Byron Health and Healing Center Office Policies & Procedures for Patients form.

Printed Name: _____

Signed: _____ Date: _____

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Pediatric/Adolescent Integrative Medical Treatment Consent Form

I understand that the evaluation, diagnosis and treatment at Byron Health and Healing includes but is not limited to history visits, physical examinations, common diagnostic procedures, dietary advice, over the counter medications, prescriptions to be filled at a pharmacy, and supplements.

In presenting my son/daughter for diagnosis and treatment by Dr. Rudy Byron, Jr. M.D., we/I hereby voluntarily consent to the rendering of such care, including diagnostic examinations, tests or procedures, or treatments as they may consider advisable to maintain my child's health and to assess, evaluate and treat his/her injury or illness.

Patient Name: _____ DOB: _____

Parent or Legal Guardian
Name: _____
(print name here)

By signing below, I, _____, parent or legal guardian
(print name here)
of_____, born _____, have received,
(print patient name here) (enter DOB here)

reviewed, understand, and accept this course of treatment, and acknowledge there is no guarantee regarding this course of treatment for my present condition or any future condition.

Signature of Parent or Legal Guardian _____ Date: _____

Thank you! We look forward to assisting you on your journey to health and wellness!