12409 W Indian School Rd, Avondale, AZ 85392--Ph: (866) 207-3882--Fax: (480) 562-6253

Dear Parent/Guardian,

Thank you for choosing Touchstone Integrated Care for your child's care. Our physicians and staff appreciate the trust you have placed in us and look forward to developing a long and healthy relationship with you and your child(ren).

The main goal with integrated medicine is to improve the physical and behavioral health and wellness of our members by providing access to whole health person centered care under highly qualified professionals in a shared safe, comfortable, welcoming and unique environment for children. At Touchstone Integrated Care, we know that when we treat a child, we treat a family as well. We believe that in every visit, phone call or procedure we partner with our families in the care of each child. Parent and patient education is always a priority in our dedication to promoting the health and well-being of children and their families. Our team's goal is to treat your child well, make your child well and help your child stay well. We accomplish this by teaching children at a young age the importance of healthy habits.

All of our providers are board-certified, with many years of experience. The providers and the rest of our staff that make up Touchstone Integrated Care all share a common mission. They desire to make a difference in the lives of children and feel very fortunate to have the opportunity to do work they love.

For your convenience, we've included a patient registration form, a medical history form, HIPAA privacy form and age appropriate screenings for you to complete before your child's appointment, along with information about our office procedures. These forms are available in the office if you are unable to access them via email.

Our office is open Monday through Friday, 8 a.m. to 5 p.m., except for holidays.

We welcome both parents/guardians at your child's appointment. If one of the parents is unable to attend the child's appointment, we ask that the parent who was at the visit convey the contents of the child's visit to the other parent**. If for any reason neither parent can attend the child's appointment, we require a hand written signed letter authorizing said person to bring the child in the parent's place. Please give the letter to the receptionist at the time of the visit. This letter is ONLY good for that one visit, unless the letter is notarized it will be good for one year. Guardians, a notice to provider or custody/court documents are required.**

Please **CALL** for an appointment early in the morning if your child is sick. We are committed to honor same day appointments upon an early morning call as much as our schedule will permit. If you cannot keep an appointment or you will be late, please give us the courtesy of a call. If you arrive late, your child will have to wait until on-time children are seen. **If you arrive 10 minutes late for your appointment without notifying us, the appointment will be re-scheduled.**

touchstone health services
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Within our scope, some of the services we will provide include:

- Preventative Care
- Care for Common Illnesses
- Well Child Visits
- Vaccinations/Immunizations
- Sports/Camp Physicals

The integrated health care model is built on the concept that members will have highly motivated teams of providers across both physical and behavioral health domains designed to offer whole health person centered care by working together on shared goals and communicating actively and openly on a regular basis.

Our team members will use screenings, strong communication, and therapeutic interactions to assist members and families in identifying personalized, meaningful and attainable treatment goals.

Please remember to bring with you to your appointment:

- ***Completed Forms or Arrive 15 Min Early to complete forms***
- ***Child's Birth Certificate/ Court Custody Documents***
- ***Parent/Guardian Identification***
- ***Insurance Card (Contact Insurance Company to be sure we are assigned as Primary Care Provider (PCP)***
- ***Medication List***

We look forward to greeting your family and working together to achieve your child's optimal health. If you have any questions now – or after you've become a part of our practice, please do not hesitate to call. Touchstone Integrated Care remains…… with you, for your child…for years to come.

Member Demographics

Touchstone
Integrated Care

Member Information

Date: _____ Gender:_____ Primary Language:_____

DOB:___/___/____ AHCCCS #:_____

Member's full name:

_____

School attending:

_____

School District:

_____

Primary Guardian/Placement

Name: Relationship:

_____

Address: City: Zip Code:

_____ _____ _____

Phone: Guardian/Placement Preferred Language:

Secondary Guardian/Placement

Name: Relationship:

_____ _____

Address:

_____

City: Zip Code: Phone:

_____ _____ _____

Member Demographics

Emergency contact name: _____ Relationship: _____

Emergency Contact Phone: _____

Complete bottom portion if DCS/SRP-MIC are involved:

Case Manager Name: _____ Phone number: _____

PCP Name: (Primary care Physician) _____

Phone number: _____

How did you hear about Touchstone Health Services?

- ☐ Community event
- ☐ Google
- ☐ LinkedIn
- ☐ Twitter
- ☐ Facebook
- ☐ Instagram
- ☐ Yelp
- ☐ School
- ☐ Referral Agency- Other
- ☐ Touchstone Health Services Website

Revised 9/6/17

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PEDIATRIC PATIENT HISTORY FORM

Patient Name _____ **Date of Birth:** _____

BIRTH HISTORY	
Delivery: Vaginal Cesarean - due to:	Birth Weight:
Was this child premature? Yes No If yes, how many weeks? _____	Were there problems with this child's delivery? Yes No If yes, list:
Did this child have any unusual problems in the hospital such as trouble breathing, blue spells, yellow jaundice, trouble feeding, etc.? If yes, please list:	
Did this child need special treatment while in the hospital such as oxygen, transfusions, and lights?	
Was (is) this child breast fed? No Yes	
Did (does) this child have any problems with breast feeding or formula feeding?	
SOCIAL HISTORY (Circle the appropriate answers)	
Parents: Married Divorced Separated Single	
Siblings - please list:	
How many people live in your home? _____Adults _____Children	
Is your child currently enrolled in daycare or school? No Yes	
Does your child participate in regular exercise? No Yes explain:	
Does your child drink caffeine? No Yes	
Is there a swimming pool at home? No Yes	Any smokers at home? No Yes
Are there smoke detectors at home? No Yes	Carbon Monoxide detectors? No Yes
Any pets at home? No Yes If yes, please list:	
What is your water source?	Are guns kept in your home No Yes
Do all family members use Seat belts/care safety sets? No Yes	Do all family members use Helmets when biking? No Yes
Any issues we should be aware of? No Yes Please list:	

Parents Initials: _____ Date: _____

Medical Provider's Initials:_____ Date: _____

Patient Name _____ **Date of Birth:** _____

MEDICAL HISTORY	
Hospitalizations? None Yes - list:	
Surgeries? None Yes - list:	
Drug Allergies? None Yes - list:	
Did you bring a copy of child's immunization record? No Yes If no, please provide as soon as possible.	Hepatitis B Vaccine? No Yes
Has your child had chicken pox? No Yes If yes, when?	Has your child had chicken pox vaccine? No Yes
Any Chronic Illnesses: none yes - list:	Has your child seen a sub-specialist? No Yes If yes, when?

REVIEW OF SYSTEMS		
Any lung problems?	None	Yes - list:
Any heart problems?	None	Yes - list:
Any kidney/urinary problems?	None	Yes - list:
Any bone/muscle problems?	None	Yes - list:
Any gastro-intestinal problems?	None	Yes - list:
Any brain/nervous system problems?	None	Yes - list:
Any genital problems?	None	Yes - list:
Any skin problems?	None	Yes - list:
Any eye/ear/nose/throat problems?	None	Yes - list:
Any developmental concerns or learining problems?	None	Yes - list:
Any behavioral problems or eating disorders?	None	Yes - list:
Any regular medications (over the counter or prescription)? Include does and frequency.		
Any medical issues we should be aware of? None Yes - list:		

Parents Initials: _____ Date: _____

Medical Provider's Initials:_____ Date: _____

Patient Name _____ **Date of Birth:** _____

FAMILY MEDICAL HISTORY						
	Child's Father	**Child's Mother**	**Sibling**	**Sibling**	**Grandparent**	**Other**
Year of Birth (if known)						
Year of Death (if known)						
Cause of Death (if known)						
Heart Disease						
High Blood Pressure						
Stroke						
High Cholesterol						
Anemia						
Diabetes (note if onset as Adult or Child)						
Asthma						
Tuberculosis						
Cystic Fibrosis						
Alcohol Abuse						
Drug Abuse						
Mental Problems						
Social Problems						
Psychiatric Problems						
Cancer (type)						
Kidney Disease						
Migraines						
Seizures						
Congenital Birth Defects						
Eating Disorder						
Other:						
Other:						

COMMUNICATION NEEDS:

Language if other than English: Child_____Parent(s)_____
Any special communication needs? No Yes
If yes, explain:_____

PATIENT EDUCATION ASSESSMENT:

Would you prefer patient education be provided to you or your child by:
Demonstration
Written Materials
Other Explain:_____

PATIENT RIGHTS:

Is there anything we need to know about your religion or culture in order to care for your child?_____Y_____N
If YES, explain:_____

Parents Initials: _____ Date: _____

Medical Provider's Initials:_____ Date: _____