

Date	Account Number

Montebello East Los Angeles Pasadena

Patient Account Information:	
Phone:	
D.O.B.	

Patient Insurance Information:	
Name	
Policy #:	
Group #:	
Phone:	
Co-Pay Due:	

Appointment Information

Insurance Verification Notes
Is Patient Eligible ? <input type="radio"/> Yes <input type="radio"/> No
Verification Number:

Responsible Person Name:				Ethnic Code:	
Patient county of Residence:	Code:	Date of Next Visit:	Notes:	1-Amer Indian	5-Mex/Hispanic
NEW VISIT? YES NO If NO, is it a: Partial Screen <i>Prev. PM-166 Dated:</i>				2-Asian	6-White
Proc. Recheck				3-Black	7-Other
				4-Filipino	8-Pacific Islander

CHDP ASSESSMENT	No Problem Suspected A	Refused or Contra-indicated B	PROBLEM SUSPECTED		DATE OF SERVICE:	FOLLOW UP CODES			
			NEW C	KNOWN D		1. No DX/RX indicated or under care	4. Dx Pending, F/U visit sched.		
Indicate outcome for each screening procedure			Enter follow-up Code:			2. Questionable results, recheck	5. Referred to another doctor		
						3. Dx made and RX started	6. Referral Refused		
01 HISTORY and PHYSICAL EXAM					01	REFERRED TO:			
02 DENTAL ASSESSMENT						Phone #:			
03 NUTRITIONAL ASSESSMENT						REFERRED TO:			
04 Anticipatory Guidance / Health						Phone #:			
05 DEVELOPMENT ASSESS						COMMENTS / PROBLEMS			
06 SNELLEN					06				
07 AUDIOMETRY					07				
08 HEMOGLOBIN or HEMATOCRIT					08				
09 URINE DIPSTICK					09				
10 COMPLETE U/A (lab)					10				
11 TB MULTIPUNCTURE					11				
12 TB MANTOUOX					12				
CODE	TEST							PPD: <i>pos</i> <i>neg</i>	Blood Lead: _____
15	Blood Lead Level				15			SNELLEN:	
16	VDRL				16	Head Circumference			
Height in Inches:		Weight		Blood Pressure		OD			
		Lbs Oz				OS			
Hemoglobin		Hematocrit		Birth Weight:		OU			
%		.0 %		Lbs Oz		ROUTINE REFERRAL (S)			
						FOSTER CHILD ?			
IMMUNIZATION		GIVEN TODAY		NOT GIVEN		BLOOD LEAD DENTAL			
		Now up to date for age	Still not up to date	Already up to date	Refused / Contra-indicated	ANSWER THE QUESTIONS BELOW			
		A	B	C	D	1. Patient exposed to Passive tobacco smoke YES NO			
31 Polio - ORAL or IPV						2. Tobacco used by the patient YES NO			
32 DPT						3. Counseled about Tobacco use / Prevention / Cessation. YES NO			
33 MMR									
38 HIB									
40 Hepatitis B									

Nurse / Lab Orders:

Follow-Up:
<input type="radio"/> 1 week
<input type="radio"/> 2 week
<input type="radio"/> 4 week
<input type="radio"/> 3 month
<input type="radio"/> _____

Charges	\$
Previous	\$
Payment	\$
Balance	\$

Superbill Number:	Physician Signature: