The PEDIATRIC CLINIC
KIDS are at the heart of everything we do

✓ Lisa Powell, APRN

Pediatric Patient Registration

To be completed by parent – Parent(s) must be present for initial visit to our clinic.

Last Name: _____ **First Name:** _____
Sex: Male Female **DOB:** _____ **SSN:** _____
Address: _____
City: _____ **State:** _____ **ZIP** _____
Home Phone: _____ **Mobile Phone:** _____
Do you give us consent to send SMS messages to mobile phone? Yes No
Do you give us consent for automated calls to mobile number? Yes No
email address: _____
Language: _____ **Race:** _____ **Ethnicity:** _____
Patient care summary and patient letter delivery preference: Portal or Paper

Guarantor	Relationship: _____	**Other parent - relationship:**	_____
Name:	_____	**Name:**	_____
DOB:	_____	**DOB:**	_____
Address:	_____	**Address:**	_____
City, State, ZIP	_____	**City, State, ZIP**	_____
Home Phone:	_____	**Home Phone:**	_____
Mobile Phone:	_____	**Mobile Phone:**	_____
Employer:	_____	**Employer:**	_____
Work Phone:	_____	**Work Phone:**	
SSN	_____		

Emergency Contact

Name: _____ **Relationship:** _____
Home Phone: _____ **Mobile Phone:** _____
You are giving permission for us to discuss patient information with this contact.

Insurance Information

You are required to list all medical coverage.

	Primary		**Secondary**
Insurance Co:	_____	Insurance Co:	_____
Policy or ID No:	_____	Policy or ID No:	_____
Policy Holder Name:	_____	Policy Holder Name:	_____
Policy Holder DOB:	_____	Policy Holder DOB:	_____

Siblings:			
First/Last Name:		DOB	
First/Last Name:		DOB	
First/Last Name:		DOB	
First/Last Name:		DOB	

Authorization

* I consent to and authorize The Pediatric Clinic,PLLC, its providers including physicians, nurse practitioners, technicians, nurses, and other qualified personnel to perform evaluation and treatment services and procedures as may be necessary in accordance with their professional judgment. I acknowledge that there are some risks with all medical treatments and procedures and I understand that no one can guarantee how well treatments or procedures will work.

* I acknowledge review of and offered copy of the Health Information Privacy Notice for The Pediatric Clinic.

* I understand that The Pediatric Clinic is a teaching clinic. In addition to my provider and other support staff, I may receive care from people who are in training. They are supervised by licensed health care providers.

* I authorize the release of all medical records to referring physicians, my insurance company, and billing company, if applicable. I allow fax transmittal of medical records if necessary.

* I understand the payment of charges incurred or my co-payment/deductable as per my insurance contract is due at the time of services, unless prior financial arrangements have been made prior to treatment. I agree and understand to applicable finance charges on any balance over 30 days.

* I acknowledge full financial responsibility for *covered and non-covered services* rendered by The Pediatric Clinic. I further authorize and request that insurance payments be made directly to The Pediatric Clinic.

* I understand that The Pediatric Clinic uses an electronic prescription system which allows prescriptions and related information to be electronically sent between The Pediatric Clinic provider(s) and my pharmacy. I have been informed and understand that The Pediatric Clinic providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my Pediatric Clinic providers to see this health information.

* I understand The Pediatric Clinic charges $25 for copying or faxing medical records, $5 for replacement Blue Immunization cards, and $50 for FMLA paperwork. Please allow 2-3 business days for completion.
* I understand that not showing up for a scheduled appointment or failure to cancel an appointment with appropriate 24-hour notice will result in a no-show fee charged to my account of $25.

I have read and fully understand the above consent for treatment, financial responsibility, release of information, insurance authorization, privacy and cancellation policies.

Signature: _____ Date: _____

Printed Name: _____

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11870 Cranston Drive Suite 104
Arlington, Tennessee 38002

CONFIDENTIAL MEDICAL HISTORY

Name: _____ **DOB** _____

Allergies and Medications

Allergy to Nuts? Yes No **Allergy to Latex?** Yes No

Allergies: ◯ **No Known Drug Allergies**

Allergic to:	_____	Reaction:	_____	Mild Mod Severe
Allergic to:	_____	Reaction:	_____	Mild Mod Severe
Allergic to:	_____	Reaction:	_____	Mild Mod Severe
Allergic to:	_____	Reaction:	_____	Mild Mod Severe

Pharmacy Name _____
Address: _____
Phone number: _____

Current Medications: ◯ **No medications**

Medication name	_____	Dose:	_____	Freq:	_____
Medication name	_____	Dose:	_____	Freq:	_____
Medication name	_____	Dose:	_____	Freq:	_____
Medication name	_____	Dose:	_____	Freq:	_____
Medication name	_____	Dose:	_____	Freq:	_____

Vaccines: UTD on vaccines? Yes No
Vaccination Record Provided: Yes No

Past Medical History: *Please circle all that apply* No Previous History _____

Acne ADD/ADHD AIDS/HIV Abuse/Domestic Violence Alcohol/Drug Use Allergies/Hayfever Anemia Asthma Autism Bedwetting Birth Defects Bladder/Kidney Problems Blood Diseases Breast Cancer Breast Problems Bronchiolitis/RSV Bronchitis Cancer _____ Chicken Pox Chronic Ear Infections Chronic Strep Throat Congenital Anomalies Cerebral Palsy Depression Developmental/Behavioral Disorders Diabetes Difficulty Swallowing/Eating Probs Ear or Hearing Problems Eczema Eye Problems Glasses/Contacts GI Problems Head Injury/Concussion Headaches Heart Disease Heart Problems Hepatitis Hernia _____ High Cholesterol Hypertension Jaundice Kidney Disorders Learning Disability Leukemia Liver Disease Lupus Menses <11 yrs of age Muscle/Joint/Bone Problems Overweight/Obesity Pneumonia Prematurity <37 wks Psoriasis Recurrent Strep Throat Reflux/GERD Seizures/Convulsions Seizures/Febrile Skin Problems Sickle Cell Disease (Hbg SS/SC) Sickle Cell Trait Sleep Apnea Smoking (active or passive) Speech Delay Speech Disturbance/Stutter Thyroid Problems Hyper/Hypo Tuberculosis Weight Gain (unexplained) Weight Loss (unexplained) Other:

Surgical History:

Procedure: _____ Date: _____
Procedure: _____ Date: _____
Procedure: _____ Date: _____
Procedure: _____ Date: _____

Social History:

Smokers in home: Yes No
Diet Type: Regular Vegan Vegetarian Gluten Free Other **Guns in home:** Yes No
Caffiene Intake: None Occasional Moderate Heavy **Locked away in safe:** Yes No
Exercise Level: None Occasional Moderate Heavy **Daily time exercising:** None under 1 hour over
Sporting Activities: **City water?** Or **Well Water?**
Parents' Marital Status: Married Unmarried Separated Divorced Widowed
Home Situation: Both Parents Mother Father Relatives Adoptive Parents Foster Parents Other
Siblings: # _____ **Hours of TV/Screen time daily:** _____
Childcare: None Relative Private Sitter Daycare/Preschool
Pets: Yes No **Smoke Detectors:** Yes No
Seat belt used routinely: Yes No **Sunscreen used routinely:** Yes No
Bike Helmets: Yes No **Bullied:** Yes No
Pool Exposure: Yes No **School:** Traditional Virtual Hybrid Homeschooled
Grades: A's A/B's B's B/C's C's C/D's D's D/F's F's **Grade in school?**

Gynecologic History *(Female Patients)*

Not applicable - too young **LMP:** _____ **Regular/Monthly:** Yes No
Flow: Light Moderate Heavy **Age of First Period:** _____ **HPV Vaccine:** Yes No

Birth History *(For patients less than 1 years old)*

Hospital of Birth _____ **Weeks Gestation at Birth** _____
Prenatal/Birth Problems: No Yes _____
Delivery Type: Vaginal C-Section Use of Forceps/Vacuum **Birth Weight:** _____ lbs _____ oz
Hearing Test: Pass Fail Not performed **Birth Length:** _____ inches
Complications with pregnancy/delivery? No Yes _____
Group B strep HIV Herpes Syphilis Diabetes Hypertension Fever
Male circumcision? Yes No **Days in Nursery** _____ **Hep B vaccine at Birth?** Yes No
Days in NICU: _____ Reason: _____
Feeding: Breast Formula Both **Amount** _____ **Frequency** _____

Signature: _____ **Date:** _____

Provider Signature: _____ **Date:** _____