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

✓ Lisa Powell, APRN

Adult Patient Registration

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:	_____

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 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: Last tetanus: _____ Shingles: _____
Flu: _____ Pneumonia: _____ Other: _____

Past Medical History: *Please circle all that apply*

Acne ADD/ADHD AIDS/HIV Abuse/Domestic Violence Alcohol/Drug Use Allergies/Hayfever Anemia Asthma Bladder/Kidney Problems Blood Diseases Breast Cancer Breast Problems 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 Psoriasis Recurrent Strep Throat Reflux/GERD Seizures/Convulsions STD/STI Skin Problems Sickle Cell Disease (Hbg SS/SC) Sickle Cell Trait Sleep Apnea Smoking (active or passive) Thyroid Problems Hyper/Hypo Tuberculosis Weight Gain (unexplained) Weight Loss (unexplained)
Other:

Surgical History:			
Procedure:		Date:	
Procedure:		Date:	
Procedure:		Date:	
Procedure:		Date:	
Procedure:		Date:	

Social History:

Smokers in home: Yes No

Pool Exposure: 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?**

Marital Status: Married Unmarried Separated Divorced Widowed

Home Situation: Lives alone Lives with spouse Lives with roommates Lives in group home

Pets: Yes No

Smoke Detectors: Yes No

Seat belt used routinely: Yes No

Sunscreen used routinely: Yes No

Sexually active: Yes No Same sex or Opposite Sex

Safe Sex: Yes No

History of STD/STI: Same Partner or Multiple Partners

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

Signature: _____ **Date:** _____

Provider Signature: _____ **Date:** _____

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Patient Name: **DOB**

FAMILY MEDICAL HISTORY									
Please indicate with an (X) or a check mark family members (child's parents, grandparents, aunts, uncles, brothers, sister) who have had any of the following conditions:									
Illness/Disease	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other Please specify
Anemia/Bleeding Problems									
Asthma									
Allergies									
Alcohol use problems									
Bed-wetting (after age 10 yr)									
Cancer: Type									
Childhood hearling loss									
Dental Decay/multiple cavities									
Depression or Anxiety									
Developmental disability									
Diabetes									
Heart Attack									
Heart Disease (before age 55 yr)									
High Cholesterol									
High Blood Pressure									
Kidney Disease									
Liver Disease									
Mental Health Conditions									
Obesity									
Seizures or Epilepsy									
Stroke									
Substance Use Problems									
Sudden Death (before age 50 yr)									
Thyroid Disorder									
Tuberculosis									
Vision or eye problems									
Provider Reviewed: **Date:**									