

PCP _____ Malinda Manzo, APRN _____ Heather Vandiver, APRN _____ 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/deductible 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: _____

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:

Flu: _____ Last tetanus: _____ Shingles: _____
 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 HeartDisease
 Heart Problems Hepatitis Hernia _____ High Cholesterol Hypertension Jaundice KidneyDisorders
 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 Sickel Cell Disease (Hbg SS/SC) Sickel Cell Trait Sleep Apnea Smoking (activeorpassive)
 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	
Caffeine 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		
P(lievtess: wYeitsh ...N)o	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: _____

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 hearing 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: