The PEDIATRIC CLINIC

KIDS are at the heart of everything we do

Effective November 1, 2025, missed appointments without at least 24 hours' notice will incur a $50 no-show fee.

_____ MalindaManzo,APRN _____ HeatherVandiver,APRN _____ Lisa Powell, APRN

Pediatric Patient Registration

Tobecompletedbyparent–Parent(s)mustbepresentforinitialvisit to our clinic.

Last Name: _____ First Name: _____

Sex: Male Female DOB: _____ SSN: _____

Address: _____

City: _____ State: _____ ZIP _____

Primary Phone: _____ Mobile Phone: _____

email address: _____

Language: _____ Race: Black White Asian HawiianNative Indian Ethnicity: Not Hispanic/Latino

Primary Preferred Contact Methods: Youaregivingusconsenttocontact you via the options you select.

Recalls:	No Contact	Call Primary	Call Mobile	Text Mobile	Email
General:	No Contact	Call Primary	Call Mobile	Text Mobile	Email
Portal:	No Contact	Call Primary	Call Mobile	Text Mobile	Email
Reminders:	No Contact	Call Primary	Call Mobile	Text Mobile	Email

Guarantor		Other parent - relationship:	
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			

Siblings to Register Today:

First/Last Name: _____ DOB Sex: M F

First/Last Name: _____ DOB Sex: M F

First/Last Name: _____ DOB Sex: M F

First/Last Name: _____ DOB Sex: M F

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 requiredtolistallmedicalcoverage.

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, itsprovidersincluding 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 providers 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 4-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 *Arlington Apothecary - Kroger Arlington - Kroger Lakeland - Kroger Oakland - Walmart Oakland -*
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

PATIENT Past Medical History: Please circle all that apply No Previous History _____
(Family history is listed on a separate page)

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:

Hospitalization Admission and Surgical History:	
Reason/Procedure:	Date:
Reason/Procedure:	Date:
Reason/Procedure:	Date:
Reason/Procedure:	Date:

Social History:

Smokers in home: Yes No

If guns in home, they are locked away: Yes No

Diet Type: Regular Vegan Vegetarian Gluten Free Other

Has Dental Home: Yes No

Caffiene Intake: None Occasional Moderate Heavy

Last Dental Visit:

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

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

:

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Patient Name: **DOB**

FAMILY MEDICAL HISTORY									
Please indicate with an (X) or a check markfamily members(child'sparents, 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									
Alcohol use problems									
Anxiety									
Bed-wetting (after age 10 yr)									
Cancer: Type									
Childhood hearling loss									
Dental Decay/multiple cavities									
Depression									
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									
Sickle Cell Trait or Disease									
Stroke									
Substance Use Problems									
Sudden Death (before age 50 yr)									
Thyroid Disorder									
Tuberculosis									
Other: Specify									
Provider Reviewed:							**Date:**		

FH: July 2024

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11870 Cranston Drive Suite 104 Arlington,
Tennessee 38002

Vaccination Policy

The Pediatric Clinic strives to provide comprehensive, compassionate and high-quality healthcare to all of ourpatients andfamilies.

One of the most important services we can provide to our patients is vaccinations against life threatening diseases.

We strongly agree with the American Academy of Pediatrics (AAP) and Centers for Disease Control (CDC) that childhood vaccines are critical to maintaining healthy children and communities. As medical professionals, we feel that vaccinating children following the recommended schedule with currently available vaccines is absolutely the right thing to do for all children and young adults.

- *We firmly believe in the effectiveness of vaccines to prevent serious illness and save lives.*
- *We firmly believe in the safety of vaccines*
- *We firmly believe that all children and young adults should receive all of the recommended vaccines according to the AAP and the CDC.*
- *We firmly believe, based on all available literature, evidence, and current studies, that vaccines do not cause autism or other developmental disabilities.*
- *We firmly believe that vaccinating children and young adults may be the single most important health-promoting intervention we perform as healthcare providers, and that you can perform as parents/caregivers.*

Our policy is that:

- We adhere to the American Academy of Pediatrics (AAP) & CDC Immunization Guidelines.
- Because we are committed to protecting the health of your children, we require all of our patients to be vaccinated.
- We do not follow “alternative schedules”. Any parent who refuses to adhere to the AAP recommended vaccine schedule may be discharged from our practice following a 30 day written notice. New patients will not be seen at all.
- If you decline to vaccinate your child despite all our efforts, we will ask you to find another healthcare provider who shares your views. Please recognize that by not vaccinating, you are putting your child and others around you at unnecessary risk for life threatening illness and disability, and even death. **We do allow declination of influenza and covid vaccines.**
- We understand that the choice to vaccinate may be a very emotional decision for some parents. We will do everything we can to educate you that vaccinating according to the recommend schedule is the best thing you can do for your child. If you have doubts, please talk with your child’s provider.

Patient Name: _____

Parent Signature: _____ Date:_____

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Arlington, Tennessee 38002

Non-Parental Consent to Medical Care and Treatment

I, _____ parent/legal guardian of the child(ren) listed below do hereby give my authorization and consent for the below named authorized person(s) to consent to the medical care and treatment of my child(ren) at The Pediatric Clinic. I hereby authorize and grant that the below named person(s) has/have permission from the natural parent or legal guardian to sign for any medical procedures or treatments deemed necessary for the well-being of my child(ren).

I am, by this document, representing that I have the authority to consent for all medical care and treatment of said child(ren). This can be revoked in writing at any time.

_____ _____
Signature Date

Child(ren):

_____ _____
Patient Name DOB

_____ _____
Patient Name DOB

_____ _____
Patient Name DOB

Authorized person(s):

_____ _____
Name Relationship to patient

_____ _____
Name Relationship to patient

_____ _____
Name Relationship to patient

Witness (Staff):

_____ _____
Staff Signature Date

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11870 Cranston Drive Suite 104
Arlington, Tennessee 38002
Phone: 901-317-7958
Fax:901-201-4485

Medical Records Release

Name of Patient	*Birth Date*
Street Address	*City, State, ZIP*

Authorizes:	**Release of Records to:**
	Lisa Powell, APRN
Name of Provider/Clinic	*Name of Provider*
	The Pediatric Clinic, PLLC
Phone Number	*Name of Clinic*
	11870 Cranston Drive, Suite 104
Address	*Address*
	Arlington, TN 38002
City, State Zip Code	*City, State Zip Code*

Information to be Released:

All Clinic Records Visual Fields Lab Reports Office Notes Vaccine Records
Other (specify)

List other facilities' records to be included when releasing for the purpose of continuing medical care:

_____

For the following dates: _____

In compliance with state statutes which require special permission to release otherwise privileged information, please release records pertaining to:

Mental health AIDS test results Drug abuse Developmental disabilities
AIDS-released disease diagnosis Alcoholism STI/STD Pregancy Other

I understand that this authorization shall be valid for one (1) year unless otherwise stated below or revoked through written notice to Medical Records _____ (Alternate date if not (1) year)

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed.

Signature of Patient/Parent	*Date*

Relationship to patient: