

# The PEDIATRIC CLINIC

KIDS are at the heart of everything we do

Malinda Manzo, APRN

Lisa Powell, APRN

Heather Vandiver, 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

Insurance Co:

### Secondary

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 \$50.

***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**

<b>Allergy to Nuts?</b>	Yes	No	<b>Allergy to Latex?</b>	Yes	No
<b>Allergies:</b> <input checked="" type="radio"/> <b>No Known Drug Allergies</b>					
Allergic to:	Reaction:			Mild Mod Severe	
Allergic to:	Reaction:			Mild Mod Severe	
Allergic to:	Reaction:			Mild Mod Severe	
Allergic to:	Reaction:			Mild Mod Severe	

<b>Pharmacy Name</b>					
Address:					
Phone number:					

<b>Current Medications:</b>	<input checked="" type="radio"/> <b>No medications</b>				
Medication name	Dose:	Freq:			
Medication name	Dose:	Freq:			
Medication name	Dose:	Freq:			
Medication name	Dose:	Freq:			
Medication name	Dose:	Freq:			
<b>Vaccines:</b>	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 (Hgb 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:

**Social History:**

<b>Smokers in home:</b> Yes No	<b>Pool Exposure:</b> Yes No
<b>Diet Type:</b> Regular Vegan Vegetarian Gluten Free Other	<b>Guns in home:</b> Yes No
<b>Caffeine Intake:</b> None Occasional Moderate Heavy	<b>Locked away in safe:</b> Yes No
<b>Exercise Level:</b> None Occasional Moderate Heavy	<b>Daily time exercising:</b> None under 1 hour over
<b>Sporting Activities:</b>	
<b>Marital Status:</b> Married Unmarried Separated Divorced Widowed	
<b>Home Situation:</b> Lives alone Lives with spouse Lives with roommates Lives in group home	
<b>Pets:</b> Yes No	<b>Smoke Detectors:</b> Yes No
<b>Seat belt used routinely:</b> Yes No	<b>Sunscreen used routinely:</b> Yes No
<b>Sexually active:</b> Yes No	<b>Safe Sex:</b> Yes No
<b>History of STD/STI:</b>	

**Gynecologic History (Female Patients)**

<b>Flow:</b> Light Moderate Heavy	<b>LMP:</b> _____	<b>Regular/Monthly:</b> Yes No
	<b>Age of First Period:</b> _____	<b>HPV Vaccine:</b> Yes No

<b>Signature:</b> _____	<b>Date:</b> _____
<b>Provider Signature:</b> _____	<b>Date:</b> _____