

PCP _____ Malinda Manzo, APRN _____ Lisa Powell, APRN _____ Heather Vandiver, 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** _____
Primary Phone: _____ **Mobile Phone:** _____
email address: _____
Language: _____ **Race:** _____ Black White Asian Hawaiian Native Indian **Ethnicity:** _____ Not Hispanic/Latino

Primary Preferred Contact Methods: *You are giving us consent to contact 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	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 _____		

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 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 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 \$50.

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: _____

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					

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 Sick Cell Disease (Hbg SS/SC) Sick 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:

Vaccination Policy

The Pediatric Clinic strives to provide comprehensive, compassionate and high-quality healthcare to all of our patients and families.

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) 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) 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: _____

VP: January 2026

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The Pediatric Clinic Missed Appointment/No Show Policy

Repeated missed appointments and last-minute cancellations can adversely affect availability of parent appointments for other patients in need of care. To improve access to care for all our patients, we have established the following policy:

Appointment Confirmation: Please answer calls from our office to confirm your appointment. We typically call the day before your appointment to ensure no changes need to be made. A text message also is sent to confirm your appointment. Please also feel free to use your patient portal (once it is set up) to confirm appointments.

Cancellation Notice: If you need to reschedule or cancel your appointment, please notify our office at least one day in advance, so that we may offer this appointment slot to other patients in need of care. Appointments that are canceled or rescheduled with less than 24 hours' notice are considered "Late Cancellations" and may count toward Missed Appointments.

No Show/Missed Appointment: An appointment that is missed without any prior notification of cancellation or rescheduling. The below is based on a rolling 12-month time period.

- a. First missed appointment: Verbal reminder regarding our policy. We will contact you via phone numbers we have on file and will leave voicemail if available. A \$50 No Show fee will be charged to your account
- b. Second missed appointment: A phone call will be repeated, and a letter will be sent to the address on file. A \$50 No Show fee will be charged to your account.
- c. Third missed appointment: If a patient misses three appointments without providing proper advance notice, their eligibility to receive medical care at The Pediatric Clinic will be terminated and a dismissal letter from the practice will be sent certified mail. All family members will be dismissed from the practice.

Double and Triple Checkups: We accommodate double and triple checkups as a convenience to our families with multiple children. In addition to the policy above, if a family misses a double or triple checkup only single checkups will be scheduled for a period of 12 months after that date.

Exceptional Circumstances: We understand that unexpected situations arise, such as emergencies or other unpredictable events. If you encounter exceptional circumstances that prevent you from canceling or rescheduling an appointment with at least one day's notice, please contact our office as soon as possible. Our office management team will consider each case individually to determine the appropriate course of action.

Patient reinstatement: For patients who are dismissed from the practice due to repeated missed appointments, reinstatement will be considered on a case-by-case basis after 12 months. Any patient/family who is dismissed twice will not be considered for reinstatement under any circumstances.

I have read and understand the above Missed Appointment policy.

Parent/Guardian signature: _____ Date: _____

Patient Name: _____ DOB: _____

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
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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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Medical Records Release

<i>Name of Patient</i>	<i>Birth Date</i>
<i>Street Address</i>	<i>City, State, ZIP</i>
Authorizes:	Release of Records to:
<i>Name of Provider/Clinic</i>	<i>Name of Provider</i>
<i>Phone Number</i>	The Pediatric Clinic, PLLC
<i>Address</i>	<i>Name of Clinic</i>
<i>City, State Zip Code</i>	3161 Hwy 64, Suite 100
	<i>Address</i>
	Eads, TN 38028
	<i>City, State Zip Code</i>

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-related disease diagnosis
 ☐ Alcoholism
 ☐ STI/STD
 ☐ Pregnancy
 ☐ 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.

<i>Signature of Patient/Parent</i>	<i>Date</i>
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Relationship to patient:



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									
Alcohol use problems									
Anxiety									
Bed-wetting (after age 10 yr)									
Cancer: Type									
Childhood hearing 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: January 2026