Creekmore Clinic FAMILY PRACTICE

PEDIATRIC DEMOGRAPHICS

Parent/Guardian Information

1. Legal Name: _____ Relationship to Patient: _____

Single (_____) Married (_____) Divorced/Single (_____) Divorced/Remarried (_____) Widowed (_____)

Previous Name: _____ Date of Birth: _____

Email Address: _____ D.L. # and State: _____

Home #: (____) _____ Cell #: (____) _____ Work #: (____) _____

Address: _____

Employer's Name: _____ Occupation: _____

2. Legal Name: _____ Relationship to Patient: _____

Single (_____) Married (_____) Divorced/Single (_____) Divorced/Remarried (_____) Widowed (_____)

Previous Name: _____ Date of Birth: _____

Email Address: _____ D.L. # and State: _____

Home #: (____) _____ Cell #: (____) _____ Work #: (____) _____

Address: _____

Employer's Name: _____ Occupation: _____

Children (Full Legal Names/Nickname) (Please check the box next to the children that are here for an appointment today)

- ☐ Name _____/_____ Sex _____ DOB _____
- ☐ Name _____/_____ Sex _____ DOB _____
- ☐ Name _____/_____ Sex _____ DOB _____
- ☐ Name _____/_____ Sex _____ DOB _____
- ☐ Name _____/_____ Sex _____ DOB _____

Type of Home: House _____ Apartment _____ Year built _____

Previous physician name _____ Practice Name _____ office #_____

Preferred pharmacy _____address_____

phone # _____

Creekmore Family Practice Clinic

Patient Name:_____

DOB:_____

Date:_____

Pediatric Health History Form

Allergies: (Include Drug, Reaction, and Age of Onset):

*please note if allergies were tested by blood or skin testing

Medication/Drug Allergies (list type of reaction) _____

Food Allergies (Do you carry a current epipen?) _____

Seasonal Allergies: _____

Current Problems:

_____

_____

History:

Birth History:

Age of Mom:_____ Birth Weight: _____
Discharge Weight: _____ Gestational Age at Birth (weeks): _____ Delivery Method: Vaginal C-Section
Duration of Labor: _____ If C-Section why?_____

Complications during pregnancy (diabetes, infections, high blood pressure, breech presentation) _____

Alcohol/Drug/Cigarette/Medications during pregnancy_____

Problems with baby in the nursery?_____

Did baby go home with mom?_____

APGAR 1m: _____ APGAR 5m: _____ APGAR 10m: _____
Infant Feeding : Breast Bottle Both Formula Name? _____

Comments: Newborn Hearing Screening: Pass Fail , Other Comments: _____

_____

Medical History: (Check Appropriate Box and Comment in Margins)

ADD/ADHD_____	Yes	No
Anemia _____	Yes	No
Congenital Heart Disease_____	Yes	No
Developmental delay _____	Yes	No
Eczema _____	Yes	No
GE Reflux _____	Yes	No
Murmur _____	Yes	No
Recurrent Otitis (ear infections) ___	Yes	No
Seizures _____	Yes	No
UTI _____	Yes	No
Vesicoureteral Reflux _____	Yes	No
Autism/Asperger's Disorder_____	Yes	No
Learning Problems_____	Yes	No
Chronic abdominal pain_____	Yes	No

Allergic Rhinitis _____	Yes	No
Asthma _____	Yes	No
Constipation _____	Yes	No
Diabetes _____	Yes	No
Mental Illness _____	Yes	No
Recurrent Strep Throat _____	Yes	No
Vision Problems _____	Yes	No
Wheezing/ RSV/Bronchiolitis _____	Yes	No
	Yes	No
	Yes	No
	Yes	No
	Yes	No
Concussion_____	Yes	No
Failure to thrive/poor growth_____	Yes	No
Headache_____	Yes	No

*Please list any specialists who your child sees and reason if not listed above*_____

_____

Other Medical History:

_____

Creekmore Clinic FAMILY PRACTICE

Patient Name:_____

DOB:_____

Date:_____

Surgical History: Check Appropriate Box	Yes	No	Date	Surgeon
Adenoidectomy (adenoids removal)				
Appendectomy (appendix removal)				
Ear Tubes				
Heart Surgery				
Hernia Repair				
Orthopedic Surgery				
Tonsillectomy				
Urologic Surgery				

*Other Surgical History:*_____

Please list any hospitalizations and approximate date if not listed above _____

Any previous adverse reaction to vaccines? _____

Immunizations up to date? _____

Please list current prescriptions and over the counter medication and dosage _____

List below any of child's relatives (mother, father, siblings, grandparents, aunts, uncles) who have had the following illnesses.

CONDITION	NO	YES	FAMILY MEMBER
Allergies			
Anemia			
Arthritis			
Asthma, Emphysema, T.B.			
Birth Defects			
Blood Disease			
Bone/Muscle Disease			
Cancer (specify)			
Cystic Fibrosis			
Diabetes ( ) Adult ( ) Juvenile			
Drug / Alcohol Abuse			
Eye / Ear Disorders			
Heart Disease			
High Blood Pressure			
Infections (Frequent / Severe)			
Kidney / Liver Disease			
Learning Problems			
Mental Illness / Retardation			
Metabolic / Genetic Disease			
Nerve Disorder (Epilepsy, C.P.)			
Rheumatic Fever			
Sickle Cell Trait / Disease			
TB or Exposure			
Thyroid Disease			
Autoimmune Disease			
Skin Disease (eczema, psoriasis)			
Heart Attack < 50 years old			

Insurance Information:

Insurance Company Name: _____

Insurance ID #: _____ Group #: _____

Insurance Claim Address _____

Policy Holder (Last, First, Middle) _____ DOB _____

Address: SAME?

Street _____Apt # _____ City _____State _____ Zip Code _____

Phone #: _____Home Work Cell/Other

SSN _____ Employer _____

Payment is due at the time services are rendered. By signing below, you agree to and understand the following policies:

HIPPAA- Privacy Notice

I am aware that I may review Creekmore Clinic's HIPPAA privacy notice at any time and understand that I may request a copy.

Initials:_____

Creekmore Clinic Medical Care Agreement

I aurthorize the physicians of Creekmore Clinic to administer medical treatment as deemed necessary. I understand that there will be a $25.00 charge for appointments not cancelled 24 hours in advance. I understand that the primary insured is financially responsible for any balance not coverd by my insurance including co-pay, deductible/co-insurance, and any services excluded by my policy.. I also understand that Creekmore Clinic will not verify insurance coverage. I also understand the primar insured will be held held responsible for any and all charges incurred by myself or covered dependents should there be no coverage on the date of service. Furthermore, I hereby authorize release of medical information necessary to file a claim with my insurance company and assign benefits to otherwise payable to me to Creekmore Clinic.

Initials:_____

Medical Care Agreement

I authorize the physicians of Creekmore Clinic to instruct their Physician Assistant/Nurse Practitioner and Physical Medicine Providers to assist in certain aspects of my medical care. I understand that a Physician Assistant/ Nurse Practitoner is not a licensed physician and may not treat or diagnose any illness or medical condition except under the supervision/direction of a licensed physician. I understand that each timel make an appointment, if my physician is not available in a timely manner, I will be given the choice to be seen by the Physician Assistant/ Nurse Practitioner... I acknowledge that it is my responsibility to inform the staff of Creekmore Clinic that I wish not to see the Physician Assitant/ Nurse Practitioner and be scheduled with my assigned pysician accordingly. I understand that i may revoke this authorization at any time.

Signature:_____ Date: _____

Electronic Communication

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach & messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, **for the purpose of notifying me of a pending appointment, missed appointment, overdue wellness visit, or any other reasonable healthcare related communication**. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information regarding healthcare events, unpaid balances, missed appointments, and to leave a reminder message on my voice mail or answering system if I am unavailable at the number provided by me.

Signature:_____ Date:_____

How did you hear about us?

Word of Mouth☐ Yelp☐ Web Search☐ Facebook☐ Health Grades☐ Community Newsletter☐

Insurance Company☐ _____Other

Creekmore Family Practice Clinic

In order to help you clearly understand our policies and services, please read the following statements, and sign the bottom indicating you accept these rules:

- I understand there can be a fee for controlled substance prescriptions written without an appointment.
- I understand there may be a fee for missed appointments or appointments not cancelled within 24 hours. Please notify us as soon as possible if you cannot make your scheduled appointment.
- I understand there is a $35 fee for bounced checks and an additional $20 processing fee for balances that go in to collections.
- I understand a fee may be assessed for any paperwork or forms to be completed without an appointment and that it may take up to 10 days to be completed.
- I understand prescription renewals are to be processed through the requested pharmacy. If the prescription is mail order and requires a written prescription, it may take 3-4 business days to be processed.
- I understand that labs, x-ray reports, and other test results need to be reviewed and it may take between 3-4 business days to be reviewed by the physician/PA. A staff member will contact you sooner if the results are urgent; otherwise, you will be contacted by phone, mail or via our secure patient web portal with the results.

Fees for Services:

$12 Controlled substance prescriptions without an appointment
$35 Attending physician statement
$50 Physician dictated letter
$75 Physician narrative

Thank you for your cooperation.

Patient Name (please print): _____ **DOB:** _____

Patient Signature: _____ **Date:** _____

Creekmore Clinic
FAMILY PRACTICE

CONSENT FOR RELEASE OF INFORMATION

Patient Name:_____Date of Birth:_____

Cell Phone#:_____Email:_____

Please check the sections that apply, then sign at the bottom of the page:

_____**I do not give Creekmore Clinic permission** to release my information to anyone other than myself.

or

_____**I give Creekmore Clinic permission** to release my information that includes:

_____Entire Medical Record

_____Blood Tests

_____X-rays

_____Cultures, including throat, urine and genital

_____Appointment Details

_____Billing Information

with

_____My spouse or significant other (Name _____)

_____Other family member (Name _____)

_____On home answering machine or cell phone # _____

_____On office/work voice mail # _____

I also give permission to receive all information by mail to address:

_____

_____

Signature:_____ Date:_____

(A signature is required for this form to be considered valid

Creekmore Clinic FAMILY PRACTICE

Patient Auto-Payment Agreement

For your convenience we are offering a patient balance payment option. This option is designed to help you pay your bill on time every time. You are not required to fill this form out if you do not wish to participate in our Auto-Payment program.

If after a claim has been submitted to my insurance company:

1) the claim is denied as a non-covered service; or
2) the charges deemed a patient responsibility by your insurance company Creekmore Clinic has my permission to charge my credit card/ debit card on file for services provided to me or my dependent.

I understand that in the event my credit card or debit card has been charged for medical services, and then my insurance company makes payment to Creekmore Clinic for those charges, the office will issue a refund or credit to my credit or debit card in the amount received from my insurance company.

I hereby authorize Creekmore Clinic and its designated payment system to charge my credit or debit card the full amount of charges for medical services provided. The amount charged will be reflected on my credit / debit card statement

If payment is denied by my payment card company or bank, I agree to pay the entire amount promptly via another form of payment

Patient Name: _____

Patient Date of Birth: _____

Dependent Name:

Dependent Date of Birth:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Signature: _____ Date: _____

(you will receive an electronic receipt via text or email for any transactions processed, provided we have your contact information)

Your Family. Our Team. Good Health.

Creekmore Family Practice Clinic

Consent to Treat Minor Patient-Without Parent/Legal Guardian Present

By law, any child under the age of 18 years old cannot be seen by a doctor without consent from a parent or legal guardian. If the minor arrives with someone other than a parent or legal guardian, we must have written permission from the parent or legal guardian that this person has been appointed by you to act on your behalf.

Minor's name: _____ **DOB:**_____

For those occasions when you may not be with your child, **please list those individuals who may give us consent to see your child:**

_____ _____

Name Relationship to Patient

_____ _____

Name Relationship to Patient

LIMITATIONS:

Identify any specific limitations on the kinds of medical services for which this authorization is given. (If none, state "none")

_____

☐ Check here if you wish to give consent for the minor to receive medical care **without an accompanying adult**. This consent may only apply to **minors age 16 and older**.

This consent shall be in effect for: ☐ Date_____ **(only)**

☐ Indefinitely, until revoked by written communication

AUTHORIZATION:

I (parent/guardian name)_____request and authorize Creekmore Clinic and its personnel to deliver routine medical care to my child listed above as may be deemed necessary or advisable in the diagnosis and treatment of the minor child. I am also aware that the adult presenting the child is responsible for payment of the patient portion at the time of service.

I have the legal right to preauthorize Creekmore Clinic and its personnel to deliver routine medical treatment and services to my child. Routine medical care and interventions may include, but are not limited to: medical evaluation, physical exam, routine immunizations, injections, x-rays, lab work (examples: throat or nasal swabs, blood draws, wart treatment with liquid nitrogen, minor burns, minor suturing of lacerations)

I have read, understand, and give my consent as stipulated above. My signature means that I have read this form and/or have had it read to me and explained in the language that I can understand.

_____

Parent or Legal Guardian (please print) **Relationship**

_____

Parent or Legal Guardian Signature **Date**

PATIENT AGREEMENT

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_____

Initials

PFP Medical Care Agreement

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_____

Initials

Medical Care Agreement

I authorize the physicians of Creekmore Clinic to instruct their Physician Assistant/ Nurse Practitioner and Physical Medicine Providers to assist in certain aspects of my medical care.
I understand that a Physician Assistant/ Nurse Practitioner is not a licensed physician and may not treat or diagnose any illness or medical condition except under the supervision/direction of a licensed physician. I understand that each time I make an appointment, if my physician is not available in a timely manner, I will be given the choice to be seen by the Physician Assistant/Nurse Practitioner. I acknowledge it is my responsibility to inform the staff of Creekmore Clinic if I wish not to see the Physician Assistant/ Nurse Practitioner and be scheduler with my assigned physician accordingly. I understand that i may revoke this authorization at any time.

_____

Initials

Electronic Communication

By supplying my home/mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach & messaging system to use my personal information., the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, **for the purpose of notifying me of a pending appointment, missed appointment, overdue wellness visit, or any other reasonable healthcare related communication.** I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information regarding healthcare events, unpaid balances, missed appointments, and to leave a reminder message on my voice mail or answering system if I am unavailable at the number provided by me.

_____

Initials

Signature: _____ **Date:** _____