Patient Information: **(Please fill out every field completely. Circle Items in blue.)**

Child's first Name:		I II III IV V	
Last Name:		Jr Sr	
Mailing Address:		Date of Birth:	
Address line 2:		SSN:	
City, State:		Phone Number:	
Zip Code:			
Sex: M F		Who does the child live with?	
Email Address:		Father Mother Both Parents Other	

Parent/Legal Guardian Information

Father's Name:		I II III IV V	
Last Name:		Jr Sr	
Mailing Address:		Date of Birth:	
Address line 2:		SSN:	
City, State:		Phone Number:	
Zip Code:			
Sex: M F		Relationship to patient:	
Email Address:			

Mother's firstName:		I II III IV V	
Last Name:		Jr Sr	
Mailing Address:		Date of Birth:	
Address line 2:		SSN:	
City, State:		Phone Number:	
Zip Code:			
Sex: M F		Relationship to patient:	
Email Address:			

Insurance information: (Please provide current insurance card to the clinic.)

Insurance Name:	Insurance Phone:
Subscriber name:	Subscriber DOB:
Member ID:	
Group Name/Employer:	Group ID Number:
Relationship to Subscriber: Self Spouse Child Other:	
Reason For Visit:	

I authorize release of my information in the event of an emergency to the following person: (If none, leave blank.)

Emergency Contact Name:	
Emergency Contact Phone:	
Any Restrictions:	
Relationship:	

**If the patient is unable to sign this agreement or is a minor, I am entering into the agreement on behalf of and as the legally authorized representative of the patient. The appropriate paperwork has been given by the patient to the clinic.*

HIPPA PROTECTED HEALTH INFORMATION

I understand that state and federal laws permit HALLSVILLE MEDICAL CLINIC to share Protected Health Information with the persons involved in my care or the payment of my health care services. I further understand that I have (I) the right to grant certain persons access to my PHI and (II) the opportunity to restrict access to my PHI from certain persons who might otherwise have access. I understand that granting access DOES NOT give the person access to copies of my medical records.

I grant permission for the following persons to have access to my Protected Health Information.

NAME:	DOB:	PHONE NUMBER:

I understand that I may change or revoke this form at any time by contacting the Business Office Manager at the Hallsville Medical Clinic. I understand that such changes or revocation will not be effective for disclosures that have already been made or access which has already occurred based on this form.

YES or NO You may leave confidential clinical information on my answering machine/voicemail.

CONSENTS AND AGREEMENTS SIGNATURE

I UNDERSTAND THAT THE FOLLOWING PACKETS OF PAPERWORK WERE MADE AVAILABLE TO ME TO REVIEW BEFORE AND AT MY INITIAL NEW PATIENT VISIT. MY SIGNATURE BELOW INDICATES MY AUTHORIZATION OF THESE POLICIES IN REGARD TO MY MEDICAL TREATMENT. I CAN REQUEST A COPY OF ANY/ALL OF THESE DOCUMENTS AT ANY TIME, AND I AM AWARE THEY ARE ALSO AVAILABLE FOR REVIEW ON WWW.HALLSVILLEMEDICALCLINIC.COM

- PATIENT CONSENT – (GIVING CONSENT TO RECEIVE TREATMENT AT THE CLINIC LOCATION, RELEASE/ACQUISITION OF INFORMATION, HEALTH INFORMATION EXCHANGE, HIPPA NOTICE OF PRIVACY PRACTICES)
- PATIENT AUTHORIZATION – (ASSIGNMENT OF BENEFITS, FINANCIAL RESPONSIBILITY, AUTOMATED COMMUNICATIONS, OUTPATIENT DEPARTMENT)
- FINANCIAL POLICY – (AGREEMENT OF FINANCIAL RESPONSIBILITY, THE CLINIC'S RIGHT TO COLLECT PAYMENT FOR SERVICES, AND TO BILL INSURANCE IF ALLOWABLE)
- CLINIC CARE CONSENT – (GENERAL CONSENT, PERSONAL PROPERTY, RIGHTS AND ADVANCE DIRECTIVES, FINANCIAL ASSISTANCE, RELEASE OF INFORMATION, MEDICARE/MEDICAID BENEFITS, COMMUNICATIONS, ACCIDENTAL EXPOSURE AND STATE REPORTING, OWNERSHIP, PHOTOGRAPHY, ETHICS, TEACHING AND OBSERVATION, NOTICE OF PRIVACY PRACTICES, DIRECTORY, ASSIGNMENT OF BENEFITS, INSURANCE NETWORK, BALANCE BILLING DISCLOSURES)

(Requests for these documents can be made by email to hmc@hallsvillemedicalclinic.com or in person.)

ACKNOWLEDGEMENT: By signing below, I certify that I have read this document, understand its contents and agree to the terms. I acknowledge that I am the patient, or I am the patient's legally authorized representative and/or Guarantor. A photocopy or a faxed copy of this consent shall be deemed as valid as the original.

Signature: _____ Date: _____

(Signature of parent/guardian/responsible party.)

Printed Name: _____ Relationship to Patient: _____

Pediatric Medical Questionnaire

Name (last, first, middle initial):_____
Birth date: ____/____/____ Age: _____ Sex: M F

Medical History: Please list any medical problems your child has, take medications for, or has had in the past.

_____

_____

_____

Pregnancy: Was the child full term? Y N How many weeks?_____
Did your child come home from the hospital with Mom? Y N If not, why?_____
Complications during pregnancy: _____
Problems during the first week of life: _____
Birth weight:_____Birth Head Circumference:_____ Birth Length:_____
Immunizations: Please give us copy of your child's immunizations
Current Medications:

Medication Name	*Dosage (mg)*	*# times per day*	*Medication Name*	*Dosage (mg)*	*# times per day*

Surgical History:

Surgery	*Date*	*Surgery*	*Date*

Hospitalizations:

Reason for Hospitalization	*Date*	*Reason For Hospitalization*	*Date*

Allergies: Please list any drug, food, or contact allergies _____

_____

Social History:
[ ] Exposure to Tobacco
Does your child eat a balanced diet? Y N [ ] Breast Fed [ ] Bottle fed. Type of Formula: _____
Appetite [ ] good [ ] poor. What types of food does your child eat? _____

Family History:
Mother: Age _____ Living [ ] Medical problems: _____
Deceased [ ] Cause of Death: _____
Father: Age _____ Living [ ] Medical Problems: _____
Deceased [ ] Cause of Death: _____
Number of siblings_____Medical Problems: _____
Do any members of your family have? (Parents, siblings, children, grandparents)

[ ] Allergies	[ ] Diabetes	[ ] High Blood Pressure	[ ] Seizures
[ ] Anemia	[ ] Glaucoma	[ ] High Cholesterol	[ ] Bleeding disorders
[ ] Cancer	[ ] Heart Problems	[ ] Kidney Problems	[ ] other inherited diseases

Review of Systems: Has your child had any of the following problems in the past month?

[ ] Skin Problems	[ ] Frequent Ear Infections	[ ] Abdominal Pain	[ ] Foot or Leg Problems
[ ] Headaches	[ ] Frequent Colds	[ ] Excessive Colic	[ ] Joint/bone pain
[ ] Head Injuries	[ ] Neck Lumps	[ ] Nausea/Vomiting	[ ] Weakness
[ ] Loss of Consciousness	[ ] Cough	[ ] Diarrhea	[ ] Seizures
[ ] Visual Problems	[ ] Wheezing	[ ] Constipation	[ ] Sleeping Problems
[ ] Sinus Problems	[ ] Shortness of Breath	[ ] Change in Bowels	[ ] Nervousness/anxiety
[ ] Nose Bleeds	[ ] Chest Pain	[ ] Burning with Urination	[ ] Depression
[ ] Seasonal Allergies	[ ] Heart Murmurs	[ ] Blood In urine	[ ] Problems in School
[ ] Hearing Problems	[ ] Feeding Problems	[ ] Skin rashes	

Development/Behavior:
As far as you know is your child's development normal? Y N
At what age did you child do the following: Hold head steady_____Sit Up_____Crawl_____Talk_____
Walk_____Potty Train_____

Do you have any other concerns about your child?_____