SOUTHSIDE PEDIATRICS A PROFESSIONAL MEDICAL CORP.

Patient Information

Patient Name: ____ **Sex**: **M** ☐ **F** ☐
(Please Print)
Address: ______________________________ **City, St, Zip**______________________

Home Phone: _________________________ **Cell Phone**: _______________________

SSN: __________________ **Date of Birth**: ______________ **Lives with:** ____________

School or daycare that child attends: ________________________Year/Grad: _______

Responsible Party Information

Mothers Name: ______________________________ **Date of Birth:** ______________

Address: _____________________________ **City, St, Zip** _______________________

Email address: _________________________________ **SSN**: ____________________

Employer: ______________________________________ **Work Phone:** __________

Fathers Name: ______________________________ **Date of Birth:** ______________

SSN: ___________**Employer:** ______________________ **Work Phone:** ___________

List Siblings: ____

Emergency Contact Information

Name: ________________________ **Phone:** _________________ **Relationship:** ___________________

Notice of Privacy Practices (HIPPA)

By signing below you are acknowledging that you have read the Notice of our Privacy Practices:

Print Name: ____________________________ Date: ___________________________

Signature: ______________________________ Relationship to child: ______________

Please return all completed forms to receptionist and present your insurance card and picture ID for verification.
Thank You!

Appointment Policy

There is a twenty minute grace period for all scheduled appointments. If check in is after the twenty minutes, the appointment will be rescheduled for the next available time. If you fail to call and cancel an appointment there will be a **$20.00** non cancellation fee due before another appointment will be scheduled. If the patient misses three appointments he/she will be dismissed from the practice. You will have 30 days to find another Primary Care Physician.

Additional Fees and Policies

There will be a $5.00 fee for any forms and letters needed to be filled out by the physician. There will be a $1.00 charge for copies of shot records. Please remember to obtain any school or work excuses needed while at check out. Excuses or shot records will not be faxed or mailed; they will have to be picked from the office.

We accept cash or checks and major credit cards only; please note there will be a $30.00 NSF fee for any checks returned unpaid from your bank. This will have to be paid before another appointment will be scheduled.

Persons Permitted to Bring Patient to Appointment

Name: ______________________________ Relationship________________________

Name: ______________________________ Relationship________________________

Name: ______________________________ Relationship________________________

Insurance Information

Private **Medicaid** **Self Pay**
(Circle All That Apply)

Name: ____________________ **Policy**: ____________________ **Group:** ______________

Policy Holder: __________________________ **Relationship**: ______________________

Date of Birth: ___________________ **SSN**: _________________________

Effective date: _______________ **Termination Date:** _________________

Mail Claims to (address): ____
____

I authorize the release of any medical or other information necessary to process this claim. I also authorize payment of medical benefits to the physician or supplier for services described.

office use: _________ ___________ _____________ _________ ________

1/3/2010

patientprivacyrights

Health Privacy Rights

Health Privacy "Rights" Under HIPAA

- Receive **notice** of how providers ***use and share*** *your information* with over 4 million "covered entities", **without asking you** ("Privacy Notice" or "Notice of Privacy Policies").
- The right to a copy of your health records. The provider may charge a "reasonable fee" for such copies.
- You can **request changes** to your health records. *The provider does NOT have to make the changes requested.* Your changes must be added to your records and the provider has to state reasons s/he disagrees with changes.
- You can **request an accounting of disclosures** of your health information. *Most disclosures do not require consent and have no audit trails.* Audit trails are required only for disclosures for "non-routine" uses.
- Health establishments and "covered entities" are required to **secure information** to the best of their ability, and a **privacy official** must be designated by each "covered entity."
- The ADA prohibits an employer from asking about health information or requiring a physical prior to an offer if they have more than 15 employees. After the offer is made, the employer may require a medical exam if it is required by all employees with similar positions. Employers may also ask employees to authorize disclosure of their medical records. ***But, if the employer is self-insured they can access their employees' medical information without consent.***

  Job discrimination is the most common complaint sent in to Patient Privacy Rights.

Health Privacy Rights You Should Have

These rights are based on thousands of years of medical ethics, our own Constitution and state laws.

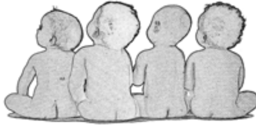
<u>None of these rights are provided by HIPAA</u>.

- Right to **control** who can see, use, share and sell your health information.
- Right to **feel safe talking truthfully** to your doctors.
- Right to privacy and control of health information unless otherwise stated or required by law.
- Right to be **notified of any breach** or possible breach of information**.**
- Right to **audit trails** of <u>every</u> disclosure of health information. Health IT makes it easier than ever to know exactly who has your information.
- Right to EHR and PHR systems that have the highest standards for **security (keep hackers out).**
- Right to participate in **research** and have researchers access your records ONLY if you give informed consent
- Right to **segment sensitive information** such as mental health, addiction or STDs, in your health record.
- Right to obtain **prescriptions** with privacy; no one should be able to use or sell your prescriptions without your consent.
- Right to obtain **employment, insurance, credit, admission to schools**, etc. without being compelled to share health information unless required by statute.

Patient Privacy Rights is working to ensure **<u>these rights</u>** are guaranteed by Congress.

Southside Pediatrics,APMC

Date:



Name: ______________________________

Date of birth:

PEDIATRIC HISTORY

Note: Please complete all items, marking "no" or "none" for each section or item if it does NOT apply to you.

ILLNESS AND INJURIES

Have you ever had:

Yes	No	
☐	☐	Mumps
☐	☐	Measles
☐	☐	German measles
☐	☐	Chickenpox
☐	☐	Seizures
☐	☐	Asthma
☐	☐	Allergies
☐	☐	Poison ingestion
☐	☐	Broken bone(s)
☐	☐	Knocked unconscious
☐	☐	Tonsillitis
☐	☐	Urinary tract infection
☐	☐	Ear infection(s)
☐	☐	Pneumonia
☐	☐	Meningitis
☐	☐	Feeding problems
☐	☐	Hearing problems
☐	☐	Vision problems
☐	☐	Heart murmur

HOSPITAL, SURGERY, OTHER MAJOR ILLNESS OR INJURY

Date	Describe why hospitalized, nature of surgery, what illness

DRUG ALLERGIES OR REACTIONS ☐ NONE

Drug	Date of Reaction	What happened?

DRUGS CURRENTLY TAKEN (Once/month or more) ☐ NONE

Drug	How Often	What for?

PREVENTION

Yes	No	
☐	☐	Child in car seat or seat belt at all times when riding in car
☐	☐	Poisons kept in a lock place
☐	☐	Pools, lakes, streams properly fenced or supervised
☐	☐	Knives and guns properly stored
☐	☐	Fireplace screened
☐	☐	Nutritious diet (your opinion)
☐	☐	Brush teeth daily

TUBERCULOSIS SKIN TEST

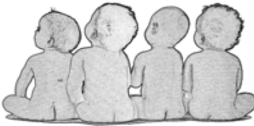
Yes	No	
☐	☐	Never had one
☐	☐	Negative test (year ____________, _____________)
☐	☐	Positive test (year _____________, _____________)

Family History: Is there any of the following conditions that run in the family?(Either side of the Family)

Yes	No		Yes	No	
☐	☐	Diabetes/who?____________	☐	☐	High Cholesterol/who?__________
☐	☐	Hypertension/who?_________	☐	☐	Acid Reflux/who?______________
☐	☐	Asthma/who?_________	☐	☐	Penicillin Allergy/who?___________
☐	☐	Seizures/who?__________	☐	☐	Any other illnesses that run in the family?_____________________
☐	☐	Bleeding Problems/who?_________			

Southside Pediatrics,APMC

Date:



PEDIATRIC HISTORY

Name: ______________________________

Date of birth:

MATERNAL HISTORY

Mother's age when this child born ________________

Number of pregnancies prior to this child __________

Medical problems during this pregnancy:
(Illnesses, infections, anemia, blood pressure, etc.)

Medications taken during pregnancy: (list all):

Prenatal care was provided by:__________________

Number of days mother in hospital after birth: ________

BIRTH HISTORY

Where born: ________________________________

Who delivered baby: ___________________________

Apgar score? (if known): 1 min _______ 5 min ________

Was baby born within 2 wks of expected day?
Yes ☐ No ☐ Early ☐ Late ☐

Hours of labor ____________

Labor was ☐ Spontaneous ☐ Induced

Was medication given during labor? ☐ Yes ☐ No

Delivery was: ☐ Spontaneous vaginal delivery
☐ Forceps
☐ Cesarean section

Baby position: ☐ Head first
☐ Feet/bottom first

Problems or complications of delivery:

NEWBORN HISTORY (First few days of life)

Baby cried or breathed spontaneously within 1 or 2 min?
☐ Yes ☐ No

Was baby jaundiced (yellow)?
☐ Yes ☐ No

How many days in hospital? ________________

Baby's problems or complications:

Was child breast fed?
☐ Yes How long?_________________ ☐ No

DEVELOPMENTAL HISTORY (Leave blank if not done currently)

Give age at which child accomplished the following skills

Roll stomach to back	____________
Laugh out loud	____________
Reach out for objects	____________
Sit without support	____________
Feed self crackers	____________
Say dada, mama to right parent	____________
Drink from a cup	____________
Walk well	____________
Toilet trained (daytime)	____________
Combine 2 words	____________
Give first and last name	____________
Dress self	____________

SOCIAL HISTORY

Give your brief assessment in 2-3 words of **your child's** :
Personality
Ways of comforting self
Expression of anger/frustration
Cooperation/obedience
Fears
Self-satisfaction/degree of happiness
Reaction to change
Relationship to other children
Number of close friends
School performance
Child's opinion of school
What do you like best about this child?
What concerns you most about this child?