PATIENT REGISTRATION

Please Print Today's Date _____

Patient's First Name _____ MI ____ Last Name _____

SEX: □ M □ F □ Unknown □ Decline

DATE OF BIRTH ____/____/____ AGE _____ PATIENT'S SS# _____-_____-_____

MAILING ADDRESS_____

CITY_____STATE_____ZIP_____EMAIL_____

PHYSICAL ADDRESS IF DIFFERENT THAN MAILING

_____

CITY _____ STATE _____ ZIP _____

IF YOU ARE A PART TIME RESIDENT PLEASE PROVIDE YOUR PERMENATE MAILING ADDRESS

_____

CITY _____ STATE _____ ZIP _____

PREFERRED CONTACT METHOD FOR APPOINTMENT REMINDERS

□Home phone □Cell phone □Work phone

HOME PH _____ CELL PH _____ WORK PH _____

Emergency Contact Name _____ Ph. (___) _____

Relationship _____

****

RACE

□ American Indian or Alaska Native
□ Asian
□ White
□ Native Hawaiian or Other Pacific Islander
□ Black or African American
□ Decline

ETHNICITY - □ Hispanic or Latino □ Non-Hispanic or Latino □ Decline

PREFERRED LANGUAGE _____ □ Decline

****

If Patient is under 18 years please complete for Parent or Guardian:

Name - _____

Address (if different) - _____

City: _____ State: _____ Zip: _____

Relationship to minor child: _____

Home Ph (_____) _____ Work Ph (_____) _____

INSURANCE INFORMATION

Today's Date: _____

Primary of Insurance Plan: _____

ID #: _____ Effective Date: _____

Policy Holder Name: _____

Policy Holder Address: _____

_____, _____ _____

City State Zip

Policy Holders Date of Birth: _____

Policy Holders Home Phone: _____

Policy Holders Social Security Number: _____

Secondary Insurance Plan: _____

ID #: _____ Effective Date: _____

Policy Holder Name: _____

Policy Holder Address: _____

_____, _____ _____

City State Zip

Policy Holders Date of Birth: _____

Policy Holders Home Phone: _____

Policy Holders Social Security Number: _____

As the patient or parent/guardian I understand that it is my responsibility to provide any updates and changes in my insurance coverage to the receptionist **PRIOR** to receiving services from Chiefland Medical Center, LLC. I also understand employees of Chiefland Medical Center cannot guarantee any coverage of my benefits for services provided. I understand that any services provided by Cheifland Medical Center, LLC that are not a covered benefit under my plan are my responsibility and I will be bill for these uncovered services. I understand that any laboratory services drawn at Chiefland Medical Center, LLC are sent to outside laboratory's (ex: LabCorp/Quest) and those services are billed separately by those companies. It is my responsibility to know my insurance companies preferred lab and insure that I request these services be used.

Patient Signature: _____ Date: _____

Initial History Questionnaire

Name

ID NUMBER

FORM COMPLETED BY · DATE COMPLETED

BIRTH DATE | AGE

☐ M ☐ F

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names, ages, and where they live. _____

What is the child's living situation if not with both biological parents?
☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody
☐ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

Birth History ■ Don't know birth history

Birth weight _____ Was the baby born at term? _____ OR _____ weeks

Were there any prenatal or neonatal complications?
☐ Yes ☐ No Explain _____

Was a NICU stay required? ☐ Yes ☐ No Explain _____

During pregnancy, did mother
Use tobacco ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No
Use drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins
What _____ When _____

Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, why?

Was initial feeding ☐ Formula ☐ Breast milk How long breastfed? _____

Did your baby go home with mother from the hospital?
☐ Yes ☐ No Explain _____

General DK = don't know

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ DK Explain _____

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ DK Explain _____

Has your child had any surgery? ☐ Yes ☐ No ☐ DK Explain _____

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ DK Explain _____

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ DK Explain _____

Do you feel your family has enough to eat? ☐ Yes ☐ No ☐ DK Explain _____

Biological Family History DK = don't know

Have any family members had the following?

Childhood hearing loss	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Asthma	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tuberculosis	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Heart disease (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
High cholesterol/takes cholesterol medication	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Anemia	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bleeding disorder	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Dental decay	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Cancer (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

(Biological Family History continued on back side.)

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Biological Family History *(Continued from front side.)* DK = don't know

Liver disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Kidney disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Diabetes (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bed-wetting (after 10 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Obesity	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Epilepsy or convulsions	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Alcohol abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Drug abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Mental illness/depression	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Developmental disability	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tobacco use	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

Additional family history _____

Past History DK = don't know

Does your child have, or has your child ever had,

Chickenpox	☐ Yes	☐ No	☐ DK	When _____
Frequent ear infections	☐ Yes	☐ No	☐ DK	Explain _____
Problems with ears or hearing	☐ Yes	☐ No	☐ DK	Explain _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Explain _____
Problems with eyes or vision	☐ Yes	☐ No	☐ DK	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	☐ DK	Explain _____
Any heart problem or heart murmur	☐ Yes	☐ No	☐ DK	Explain _____
Anemia or bleeding problem	☐ Yes	☐ No	☐ DK	Explain _____
Blood transfusion	☐ Yes	☐ No	☐ DK	Explain _____
HIV	☐ Yes	☐ No	☐ DK	Explain _____
Organ transplant	☐ Yes	☐ No	☐ DK	Explain _____
Malignancy/bone marrow transplant	☐ Yes	☐ No	☐ DK	Explain _____
Chemotherapy	☐ Yes	☐ No	☐ DK	Explain _____
Frequent abdominal pain	☐ Yes	☐ No	☐ DK	Explain _____
Constipation requiring doctor visits	☐ Yes	☐ No	☐ DK	Explain _____
Recurrent urinary tract infections and problems	☐ Yes	☐ No	☐ DK	Explain _____
Congenital cataracts/retinoblastoma	☐ Yes	☐ No	☐ DK	Explain _____
Metabolic/Genetic disorders	☐ Yes	☐ No	☐ DK	Explain _____
Cancer	☐ Yes	☐ No	☐ DK	Explain _____
Kidney disease or urologic malformations	☐ Yes	☐ No	☐ DK	Explain _____
Bed-wetting (after 5 years old)	☐ Yes	☐ No	☐ DK	Explain _____
Sleep problems; snoring	☐ Yes	☐ No	☐ DK	Explain _____
Chronic or recurrent skin problems (eg, acne, eczema)	☐ Yes	☐ No	☐ DK	Explain _____
Frequent headaches	☐ Yes	☐ No	☐ DK	Explain _____
Convulsions or other neurologic problems	☐ Yes	☐ No	☐ DK	Explain _____
Obesity	☐ Yes	☐ No	☐ DK	Explain _____
Diabetes	☐ Yes	☐ No	☐ DK	Explain _____
Thyroid or other endocrine problems	☐ Yes	☐ No	☐ DK	Explain _____
High blood pressure	☐ Yes	☐ No	☐ DK	Explain _____
History of serious injuries/fractures/concussions	☐ Yes	☐ No	☐ DK	Explain _____
Use of alcohol or drugs	☐ Yes	☐ No	☐ DK	Explain _____
Tobacco use	☐ Yes	☐ No	☐ DK	Explain _____
ADHD/anxiety/mood problems/depression	☐ Yes	☐ No	☐ DK	Explain _____
Developmental delay	☐ Yes	☐ No	☐ DK	Explain _____
Dental decay	☐ Yes	☐ No	☐ DK	Explain _____
History of family violence	☐ Yes	☐ No	☐ DK	Explain _____
Sexually transmitted infections	☐ Yes	☐ No	☐ DK	Explain _____
Pregnancy	☐ Yes	☐ No	☐ DK	Explain _____
(For girls) Problems with her periods	☐ Yes	☐ No	☐ DK	Explain _____

Has had first period ☐ Yes ☐ No Age of first period _____

Any other significant problem _____

This American Academy of Pediatrics Initial History Questionnaire is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 3rd Edition.

HE0328

9-223/0109

CONSENTS

Patient Name: _____ DOB: _____

CONSENT TO TREAT AND COMMUNICATION WITH FAMILY OR OTHERS INVOLVED IN MINORS CARE

Please list anyone who may be involved in coordinating your child's care. You may update this in writing at any time.

Name	Relationship	Phone Number

_____ ____/____/____

Parent/Guardian Signature Date

****

PRESCRIPTION HISTORY CONSENT

Preferred Pharmacy: _____

I agree that Chiefland Medical Center may request and use my prescription medication history from other healthcare providers or third party pharmacy benefits payors for treatment purposes.

_____ ____/____/____

Parent/Guardian Signature Date

****

CONSENT TO EXAMINATION / TREATMENT
INSURANCE ASSIGNMENT, RECORDS AUTHORIZATION AND INFORMATION ACKNOWLEDGEMENT

I HEREBY CONSENT TO EXAMINATION AND TREATMENT AS DEEMED NECESSARY BY CHIEFLAND MEDICAL CENTER AND ITS PHYSICIANS. I HEREBY AUTHORIZE CHIEFLAND MEDICAL CENTER AND ITS PHYSICIANS TO FURNISH PATIENT HEALTH INFORMATION CONCERNING MY RELEVANT MEDICAL HISTORY (INCLUDING BUT NOT LIMITED TO THE SUPERCONFIDENTIAL INFORMATION) TO ANY OF THE FOLLOWING: OTHER HEALTHCARE PROVIDERS INVOLVED IN MY CARE, INSURANCE CARRIERS, ATTORNEYS AND ADJUSTORS. I HEREBY CONSENT TO THE USE OF A PATIENT PORTAL. I HEREBY ASSIGN TO CHIEFLAND MEDICAL CENTER AND ITS PHYSICIANS ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNTS NOT COVERED BY INSURANCE. I ACKNOWLEDGE THAT TO THE BEST OF MY KNOWLEDGE THE INFORMATION IN THIS FORM IS ACCURATE AND COMPLETE.

SIGNATURE _____ DATE ___/___/___

PARENT/GUARDIAN NAME _____

****

Primary Insurance - _____

ID # - _____

Policy Holder - ___ Self ___ Spouse ___ Parent ___ Other

Name - _____

Address (if different) - _____

DOB - _____ Social Security # - _____

ACKNOWLEDGEMENT NOTICE & SHARE RECORD RELEASE

I understand that my health care provider creates and uses a record of my health history and related financial information that may be used for:
Continuing care and treatment:
*A way of communicating with other health care professionals and pharmacies who are involved in my care
*Deriving information used in billing for my care
*A means of responding to insurers requests for information about my care
*Review in quality assessment projects designed to help the clinic improve its ability to provide good health care.

My signature below acknowledges my awareness of the above potential uses of my records also signifies that I was given a "Notice of Privacy" that this notice provides a more complete description of the ways my medical record might be used or disclosed when I registered as a patient at Chiefland Medical Center, LLC (CMC). I understand that the clinic's policies about using information might change from time to time and that I can obtain another copy of the notice at the front desk at any time I want one.

I know that I can request restrictions on the way my health care information is used, but I also understand that CMC is not required to abide by my restrictions. I also understand that I can revoke this consent at any time, but that this revocation will not apply to uses of my records between the date of this consent and the date of revocation.

_____ _____

SIGNATURE DATE

_____

PRINT NAME

Permission to treat in the absence of Parent or Guardian

It is the practice of Chiefland Medical Center, LLC and Chiefland Pediatrics to treat patients under the age of 18 only with the parent or guardian present at our facility unless Florida Statutes dictate otherwise. However, if you would like to assign authority to another party to consent to treatment for your child in your absence you may do so by completing the document below.

PLESE UNDERSAND, UNLESS YOU HAVE COMPLETED THIS FORM WE WILL NOT BE ABLE TO SEE YOUR CHILD FOR HEALTH CARE THAT IS NOT LIFE THREATENING UNLESS YOU ARE PRESENT.

[ ] I DO NOT WISH FOR MY CHILD TO BE SEEN IN MY ABSENCE.

I, _____, parent or legal guardian of _____, hereby authorize the following persons the right to consent to medical treatment by the medical staff of Chiefland Medical Center, LLC for the child listed above.

The following persons may bring my child in for medical treatment.

_____

_____

_____

_____

_____

_____

SIGNATURE DATE

Patient Name: _____

Date of Birth: _____/_____/_____ Sex: _____ SS# _____-_____-_____

Address: _____

Parent/Guardian: _____

I authorize: _____

Address: _____

Phone: _____ Fax: _____

To Release the following protected healthcare information:

Entire Medical Chart
Immunization Record
Medication List
Specific Record: _____
Labs: _____
Diagnostic Tests: _____
Consults from: _____
Demographic Information
Other: _____

Please send to: CHIEFLAND PEDIATRICS

Address: 1113 NW 23RD AVE CHIEFLAND FL 32626

Phone: (352)490-5005 Fax: (866)895-8359

This information is to be used for (circle one):

Continuation of Medical Care Transfer of Primary Care

I understand that I have the right to revoke this authorization at any time through written notice and that the written notice must include (1) my child's name, date of birth, address and phone number if applicable, (2) effective date of this authorization and the names of those authorized by this form to receive the information, (3) a statement that the parent/guardian wants to revoke this authorization, signature of parent or legal guardian, and the date revocations signed. I am aware this authorization is valid for 90 days from the date signed.

_____ _____ _____

Signature of Parent/Guardian Relationship Date

1113 NW 23RD AVE CHIEFLAND, FL 32626 PHONE 352-490-5005 FAX 352-490-9450