Lafayette Pediatric Clinic

(Office use only) MRN: _____

Name: _____ Date of Birth: _____
Last First MI

Address: _____
Street City State Zip Code

Primary Phone: _____ Cell Phone: _____ SSN: _____

Email: _____

Sex: M/F Race: _____ Hispanic: Y/N Preferred Language: _____

Parent/ Guardian or Person Responsible for Paying Bill

Relationship to Patient: □ Mother □ Father Other :_____

Name: _____ Date of Birth: _____
Last First MI

Address: _____
Street City State Zip Code

Primary Phone: _____ Cell Phone: _____ SSN: _____

Insurance Information: please give insurance card to receptionist for copying.

Primary Insurance: _____

Policyholder's Name: _____ DOB: _____

ID #: _____ Group #: _____

Secondary Insurance: _____

Policyholder's Name: _____ DOB: _____

ID #: _____ Group #: _____

Emergency Contact

Name: _____ Relationship to Patient: _____

Primary Phone: _____ Cell Phone: _____

Siblings

Name: _____ DOB: _____ Brother/Sister

Name: _____ DOB: _____ Brother/Sister

Name: _____ DOB: _____ Brother/Sister

Name: _____ DOB: _____ Brother/Sister

I acknowledge I have read and received a copy of the Notice of Privacy Practice, No-Show Policy, Consent to Treat and Release of Medical Information and agree to all terms stated in agreements. Signature: _____

Relationship of Parent/Legal Guardian: _____ 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

Lafayette
Pediatric Clinic

Patient's Name: _____ DOB: _____

Consent for Medical Treatment of a Minor

I (we) the undersigned legal guardians of stated child(ren), a minor(s), do hereby authorize and consent to any medical exam or treatment rendered under the general or special supervision of any Lafayette Pediatric Clinic or Nurse Practitioner, a duly licensed physician or nurse practitioner, licensed under the provisions of the laws in the State of Mississippi.

It is understood that this authorization is given in advance of a specific diagnosis, recommended treatment or recommended medical care being required but is given to provide authority and power to render care, which the physician or nurse practitioner in the exercise of his or her best judgement may deem advisable.

Release Form for Individuals Involved in Patient Care

In the event I am unable to be with my child(ren) during a medical visit, I authorize the following person(s) to act as my child(ren)'s personal representative in my absence. I understand that this representative includes, but is not limited to, allowing the designated representative to schedule and cancel appointments, obtain medical advise from clinical staff, accompany my child(ren) to appointments, signing consent for immunizations, and payment for health services rendered.

Lafayette Pediatric Clinic, LLC may speak with:

Name: _____ DOB: _____
Address: _____
Phone: _____ Relationship to Patient: _____

Name: _____ DOB: _____
Address: _____
Phone: _____ Relationship to Patient: _____

Name: _____ DOB: _____
Address: _____
Phone: _____ Relationship to Patient: _____

I acknowledge that I was provided with the Notice of Privacy Practices of Lafayette Pediatric Clinic.

Signature of Parent/Legal Guardian: _____

Relationship of Parent/Legal Guardian to Patient: _____ Date: _____

Lafayette Pediatric Clinic

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Introduction: We maintain protocols to ensure the security and confidentiality of your personal information. We have physical security in the building, passwords to protect databases, compliance audits, and virus/intrusion detection software. Within our practice, access to your information is limited to those who need it to perform their jobs. At Lafayette Pediatric Clinic, we are committed to treating and using protected health information about you responsibly. This Notice of Privacy Policies describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice is effective November 1, 2007 and applies to all protected health information and defined by federal regulations.

Understanding Your Health Record: Each time you visit Lafayette Pediatric Clinic, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment. This information often referred to as your health or medical record, serves as a:

- Basis for planning you care of treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were provided,
- Tools in educating health professionals,
- Source of data for medical research,
- Source of information for public health officials charged to improve the health of state of nation,
- Source of data for our planning and marketing, and
- Tools by which we can assess and continually work to improve the care we render and outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy; better understand who, what, when, where, and why others may access your health information; and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights: Although your health record is the physical property of Lafayette Pediatric Clinic, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of privacy policies upon request,
- Inspect and obtain a copy of your health record (reasonable copy fees apply in accordance w state law),
- Amend your health record,
- Obtain an accounting of disclosure of your health information,
- Request confidential communications of your health information, and
- Request a restriction on certain uses and disclosures of your information (however, we are not required by law to agree to a requested restriction.)

Our Responsibilities-Our practice is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the term of this notice,
- Notify you if we are unable to agree to requested restriction, and
- Accommodate reasonable requests you may have to communicate your health information.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. We will keep a posted copy of the most current notice in our facility containing the effective date. In addition, each time you visit our facility for treatment, you may obtain a copy of the current notice in effect upon request. We will not use or disclose your health information in a manner other than described in the section regarding Examples of Disclosure for Treatment, Payment, and Health Operations, without your written authorization, which you may revoke, except to the extent that action has already been taken.
For More Information or to Report a Problem- If you have questions and would like additional information, you may contact our practice's Privacy Officer, Pat Nelson 615-236-3939.
If you believe your rights have been violated, you can either file a complaint with Pat Nelson, or with the Office of Civil Rights, U.S. Department of Health and Human Services (OCR). There will be no retaliation for filing a complaint with either parties.

Examples of Disclosures for Treatment, Payment, and Health Operations- We will use your health information for treatment.
For example:
Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your medical information will be shared among health care professionals involved in your care.
We will also provide your other physician(s) or subsequent health care provider(s) (when applicable) with copies of various reports that should assist with them treating you.
We will use your information for payment.
We may disclose your information so that we can collect or make payment for the healthcare services you receive.
For example:
If you participate in a health insurance plan, we will disclose necessary information to that plan to obtain payment for you care.
We will use your health information for regular health operations.
We may disclose your health information for our routine operations. These uses are necessary for certain administrative, financial, legal, and quality improvement activities that are necessary to our practice and support the core functions.
For example:
Members of the quality improvement team may use information in your health record to access the care and outcomes in your case and others like it. This information will then be used to continually improve the quality and effectiveness of the healthcare and service we provide and to reduce health care costs.

- **Appointment reminders-** We may disclose medical information to provide appointment reminders (e.g. contacting you at the phone number you have provided for us and leaving a message as an appointment reminder.)
- **Decedents-** Consistent with applicable law, we may disclose health information to a coroner, medical examiner, or funeral direction.
- **Workers Compensation-** We may disclose health information to the extent authorized by and necessary to comply with laws relating to worker compensation or other similar programs established by law.
- **Public Health-** As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.
- **Research-** We may disclose information to researchers when their research has been approved and the researcher has obtained a required waiver from the Institutional Review Board/Privacy Board, who has reviewed the research proposal.
- **Organ Procurement Organization-** Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for donation and transplant.
- **As Required by Law-** We may disclose health information as required by law. This may include reporting a crime, responding to a court order.
- **Specialized Government Functions-** We may disclose information for military and veterans' affairs or national security and intelligence activities.
- **Business Associates-** There are some services provided in our organization through contacts with business associates. Some examples are billing or transcription services we may use. Due to the nature of business associates' services, they must receive your health information in order to perform the jobs we've asked them to do. To protect your health information, however, when these services are contracted we require the business associates to appropriately safe guard your information.
- **Practice Marketing-** We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you (for example: to notify you of any new tests or services we may be offering.)
- **Food and Drug Administration (FDA)-** We may disclose the FDA health information relative to adverse events with respect to food, supplements, product and product defect, or post marketing surveillance information to enable product recalls, repairs, and replacement.
- **Personal Representative-** We may use or disclose information to your personal representative (person legally responsible for your care and authorized to act on your behalf in making decisions related to your health care.
- **To Advert A Serious Threat to Health/Safety-** We may disclose your information when we believe in good faith, that this is necessary to prevent a serious threat to your safety or that of another person. This may include cases of abuse, neglect, or domestic violence.
- **Communication with Family-** Unless you object, we may disclose health information about you to an organization assisting in a disaster relief effort.
- **Disaster Relief-** Unless you object, we may disclose health information about you to an organization assisting in a disaster relief effort.

For all non-routine operations, we will obtain your written authorization before disclosing your personal information. In addition, we take great care to safeguard your information in every way that we can.