Covenant Pediatrics, PLLC

421 Old Riceville Rd. Ste. 2 Athens, TN 37303
(423) 744-8755 (844) 485-8911 fax
www.covpeds.com

Kim T. Breeden M.D. F.A.A.P.
Mia Matias M.D. F.A.A.P.
Kim Rucker M.D.
Mahefa Ratsimbason M.D. F.A.A.P.
Elizabeth Cruttenden NP-C
Regena Shelton, NP-C

Dear Parent,

Thank you for entrusting the care of your children to Covenant Pediatrics. Please fill out all the forms in this packet and bring them to the office on the date of your first appointment or mail them to the address above. When you come in for your first appointment, please bring all the insurance cards for your children. If you have any questions about filling out the forms, please call our office at 423-744-8755 and a member of our staff will gladly help you.

Sincerely,

Covenant Pediatrics, PLLC

PATIENT INFORMATION

Date _____

CHILDREN'S FULL NAME (list all children)	SEX	NICKNAME	BIRTHDAY	SOC. SER. #	RACE
1.					
2.					
3.					
4.					
5.					

RACE: (1) American Indian (2) African American (3) Asian (4) Hispanic/Latino (5) White [enter number]

Parent/Guardian: _____ Relationship _____
FIRST MI LAST

Address _____
STREET CITY STATE ZIP

Home Phone_____ Work Phone _____Cell_____

E-Mail _____ Sex M/F: _____

Birthdate _____Soc. Sec # _____ Employer_____

Insurance Co. _____Policy Number _____Group # _____

Parent/Guardian:_____ Relationship _____
FIRST MI LAST

Address _____
STREET CITY STATE ZIP

Home Phone_____ Work Phone_____ Cell _____

E-Mail _____ Sex M/F: _____

Birthday _____ Soc Sec # _____ Employer_____

Married ❑ Single ❑ Divorced ❑
Who Has Legal Custody: Mother ❑ Father ❑ Grandparents ❑ Other ❑ _____

WHO CAN WE CONTACT IN CASE OF AN EMERGENCY (RELATIVE OR FRIEND, NOT LIVING IN YOUR HOUSEHOLD)

Name: _____ Phone _____ Cell _____

Address: _____
CITY STATE ZIP

How did you find out about us _____

In my absence _____ is authorized to sign for medical care for my children.

BY SIGNING I AUTHORIZE COVENANT PEDIATRICS TO PROVIDE MEDICAL TREATMENT FOR MY CHILDREN AND I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY BILLS INCURRED FOR MEDICAL TREATMENT. I AUTHORIZE THE RELEASE OF INFORMATION BY PHONE, FAX, MAIL OR INTERNET AS REQUESTED BY MY INSURANCE COMPANY FOR THE PROCESSING OF INSURANCE CLAIMS. I HAVE RECEIVED AND READ THE HEALTH INFORMATION AND PORTABILITY AND ACCOUNTABILITY ACT NOTICE.

SIGNATURE _____ DATE _____ Rev. 6/21

Covenant Pediatrics, PLLC

Health Information Portability and Accountability Act
Provider notice on Information 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.

Uses and disclosures of health information.

We use health information about you for treatment (diagnostic testing, prescription, referral, etc.), to obtain payment (submit claims and/or encounters to billing services, and/or clearinghouses, and/or collection agencies, etc.), for administrative purposes (reporting, utilization management, quality improvement and surveys, etc.? and to evaluate the quality of care that you receive. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may use or disclose identifiable health information about you without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. We may apply a change to our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area and in each examining room. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Individual Rights

You have the right to look at, get a copy of or receive electronically protected health information about you that we use to make decisions about you. It you request copies; we will charge you $0.05 (5 cents) for each page. You also have the right to receive a list of instances where we have disclosed protected health information about you for reasons other than treatment, payment or related administrative purposes. If you believe that information in your record is incorrect or important information is missing, you have the right to request in writing that we amend the existing information. You may request in writing that we restrict and/or not use or disclose your information for treatment, payment and circumstances. We will consider your request but are not legally required to agree to it.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the business manager. You also may send a written complaint to the U.S. Department of Health and Human Services. The business manager can provide you with the appropriate address upon request.

Our legal duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

If you have any questions or complaints, please contact the business manager.

Signature of Patient or Parent: _____ Date: _____

Covenant Pediatrics, PLLC - 421 Old Riceville Rd. Ste 2 - Athens, TN 37303
(423) 744-8755 -- (844) 485-8911 (fax)

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(All sections must be completed)

I hereby authorize_____and its physicians employees and agents to release or disclose to the below-named recipient all of my medical records including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection.

Physician/facility: _____

Patient Name: _____Date of Birth: _____

I hereby authorize the release of medical records to: _____

Purpose of disclosure: _____

The authorization will expire on: _____
Date or Event may not exceed one year

This request and authorization applies to:

_____ All medical records

_____ Health care information relating to the following treatment, condition, or dates of treatment:
_____
_____

_____ Specific records to be released (eg. Labs, imaging reports, other):
_____

If you DO NOT WANT certain portions of your medical records released, please initial the box for the information you do not want released.

_____Substance abuse _____ Psychological or psychiatric treatment ____HIV/AIDS/STD

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

_____ _____
Signature of Patient or Authorized Representative Date Signed

_____
Relationship to Patient

_____
Witness

Child's Health History Form · Please Give To Nurse When Called

Name: **Today's Date:**

Does child have allergies? ☐Yes - ☐No; If yes then specify: Date of Birth _____

Surgical History of Child (Please Check All That Apply)

☐ Eye Surgery	☐ Heart Surgery	☐ Ear Tube Insertion	☐ Abdominal Surgery	☐ Orthopedic Surgery
☐ Removal Of Adenoids	☐ Heart Valve Repair	☐ Ear Tube Removal	☐ Hernia Repair	☐ Appendix Removal
☐ Removal Of Tonsils	☐ Sinus Surgery	☐ Other:		☐ **No Prior Surgery**

Personal Medical History of Child

☐ Headache/Migraine	☐ Asthma	☐ Reflux	☐ Kidney Stones	☐ Anxiety
☐ Epilepsy	☐ Pneumonia	☐ Heart Disorders	☐ Arthritis	☐ Depression
☐ Allergies	☐ Tuberculosis	☐ Diabetes Mellitus	☐ Easy Bleeding	☐ HIV
☐ Chronic Sinusitis	☐ Sleep Apnea	☐ Hypertension	☐ Anemia	☐ High Cholesterol
☐ Thyroid Disorders	☐ Chicken Pox – Date:			

☐Yes - ☐No Have you had a blood transfusion? When? Where? Reaction?

☐Yes - ☐No Previous Hospitalizations	☐Yes - ☐No Previous Emergency Room Visits	☐ Previous EKG. Date:	☐ Previous EKG. Date:

Child's Social History (Check All That Apply)

☐ Alcohol Use	☐ Do You Smoke?	☐ Caffeine Use	☐ Recreational Drug Use
Drinks per day: _____	Cigarette packs per day: _____	Cups Of Coffee/Day: _____	☐ Regular Exercise
☐ Alcohol Use Disrupting Home	☐Yes - ☐No Exposed to second smoke?	Cups of Tea/Day: _____	
☐ Household includes: father, mother, stepfather, stepmother, # of sisters_____ # brothers ____, Others:	☐ Child Living in: Apartment, foster home, private residence, homeless shelter, other: _____	☐ Parents, step family, Relatives, Other _____ _____	☐ Home Environment: High Risk neighborhood, domestic violence, second hand smoke, guns in home, fear of occupants, other_____

Family History of Child

Condition	Father	Mother	Brothers	Sisters	Sons	Daughters	Maternal Grand Mother	Maternal Grand Father	Paternal Grand Mother	Paternal Grand Father
Deceased	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Birth Defects	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes Mellitus	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lung Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Infant Deaths	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychiatric Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mental Retardation	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐ **Other**							☐ **Adopted: Family History Unavailable**			

Girl's History

Pads used in 24hr:	☐ Light Bleeding	Flow Duration	☐ Regular Cycles	Last Pap Smear:
☐ Tampon use	☐ Heavy Bleeding	Age offi rst period:	☐ Irregular Cycles	☐ Past Abnormal Pap
Pregnancies (Gravid):	Deliveries (Para):			☐ Menopausal