PRIORITY
FAMILY MEDICAL CLINIC

Pediatric Patient Information

Patient Name:	Date of Birth:	Gender:	Todays Date:
Address:	City:	State:	Zip:
Mothers Name:	Mobile Phone:	Fathers Name:	Mobile Phone:
☐ Hispanic or Latino □ Non-Hispanic or Latino	Race:	Primary Care Physician:	
Who does the child live with?	Is the child adopted?		
Emergency Contact: Relationship to patient: Phone:	Secondary Emergency Contact: Relationship to patient: Phone:		

Guarantor's Information (Only required for patients less than 18 years of age)

Guarantor Information (Adult residing with child):	Date of Birth:	Relationship to Patient:
Social Security Number:	Employer:	Employment Status: □ Full Time □ Part Time □ Retired

Guarantor's Insurance Information

Primary Insurance Company:	ID#:	Group No./ Name:	Insurance Phone:
Address:		City, State, Zip:	
Subscriber's Name (Policy Holder):	Date of Birth:	Gender:	Relationship to Patient:
Social Security Number:	Employer:	Employment Status: □ Full Time □ Part Time □Retired	

Secondary Insurance Company:	ID#:	Group No./ Name:	Insurance Phone:
Address:		City, State, Zip:	
Subscriber's Name (Policy Holder):	Date of Birth:	Gender:	Relationship to Patient:
Social Security Number:	Employer:	Employment Status: □ Full Time □ Part Time □ Retired	

Name: Relationship:

Name: Relationship:

Signature: Date:

Preferred Local Pharmacy:

Mail Order Pharmacy:

PATIENT RIGHTS AND RESPONSIBILITIES

We respect your rights as a patient and recognize that you as an individual have unique healthcare needs. Therefore, we respect your personal dignity and want to provide care based upon your individual needs. Not only do you have rights and responsibilities, but these rights and responsibilities also apply to the people who are legally responsible for making your healthcare decisions. These people may include parents of patients under the age of 18, legal guardians, and those you have given decision-making responsibility in a Durable Power of Attorney for Health Care.

PATIENT RIGHTS

- Patients have the right to be treated with dignity and respect.
- Patients have the right to fair treatment, regardless of race, ethnicity, creed, religious belief, sexual orientation, gender, age, health status, or source of payment for care.
- Patients have the right to have their treatment and other patient information kept private. Only by law may records be released without patient permission.
- Patients have the right to access care easily and in a timely fashion.
- Patients have the right to a candid discussion about all their treatment choices, regardless of cost or coverage by their benefit plan.
- Patients have the right to share in developing their plan of care.
- Patients have the right to the delivery of services in a culturally competent manner.
- Patients have the right to information about the organization, its providers, services, and role in the treatment process.
- Patients have the right to information about provider work history and training.
- Patients have the right to information about clinical guidelines used in providing and managing their care.
- Patients have a right to know about advocacy and community groups and prevention services.
- Patients have a right to freely file a complaint, grievance, or appeal, and to learn how to do so.
- Patients have the right to know about laws that relate to their rights and responsibilities.
- Patients have the right to know of their rights and responsibilities in the treatment process, and to make recommendations regarding the organization's rights and responsibilities policy.

PATIENT RESPONSIBILITIES

- Patients have the responsibility to treat those giving them care with dignity and respect.
- Patients have the responsibility to give providers the information they need, in order to provide the best possible care.
- Patients have the responsibility to ask their providers questions about their care.
- Patients have the responsibility to help develop and follow the agreed-upon treatment plans for their care, including the agreed-upon medication plan.
- Patients have the responsibility to let their provider know when the treatment plan no longer works for them.
- Patients have the responsibility to tell their provider about medication changes, including medications given to them by others.
- Patients have the responsibility to keep their appointments. Patients should call their providers as soon as possible if they need to cancel visits.
- Patients have the responsibility to let their provider know about their insurance coverage, and any changes to it.
- Patients have the responsibility to let their provider know about problems with paying fees.
- Patients have the responsibility not to take actions that could harm others.
- Patients have the responsibility to report fraud and abuse.
- Patients have the responsibility to openly report concerns about quality of care.
- Patients have the responsibility to let their provider know about any changes to their contact information (name, address, phone, etc).
- Patients have the right and the responsibility to understand and help develop plans and goals to improve their health.

I HAVE READ AND UNDERSTAND MY RIGHTS AND RESPONSIBILITIES.

Patient Signature | Printed Name | Date

FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Priority Family Medical Clinic (PFMC) to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Priority Family Medical Clinic Notice of Privacy Practices provides a more complete description of such uses and disclosures). I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Additionally, I give my consent for Priority Family Medical Clinic to access information on my prescription history from pharmacy networks, if needed, to reconcile strengths, dosages, or medications I have taken.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Priority Family Medical Clinic reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Priority Family Medical Clinic, Attn: Privacy Officer at 3625 Crossings Dr. Ste B, Prescott, AZ 86305

I have the right to request that Priority Family Medical Clinic restrict how Priority Family Medical Clinic uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

ACKNOWLEDGEMENT OF RECEIPT OF PATIENT BILL OF RIGHTS

I have received a copy of the Priority Family Medical Clinic Patient Bill of Rights & Responsibilities.

PERMISSION TO RENDER SERVICES/ACKNOWLEDGEMENT OF FINANCIAL POLICY

By presenting for treatment, I hereby employ Priority Family Medical Clinic to provide medical services to me. I agree to pay for all services rendered on my behalf at the rates established by Priority Family Medical Clinic or those rates as established by Priority Family Medical Clinic and my insurance carrier if such a contractual relationship exists. I remain fully responsible for all treatments, services and out-of-pocket expenses incurred on my behalf. I have been given a copy of Priority Family Medical Clinic Financial Policy and Procedures and acknowledge my responsibility to notify Priority Family Medical Clinic of any changes in my insurance plan or status.

I also understand and acknowledge that I am personally responsible to pay Priority Family Medical Clinic in full for services that my health insurer will not cover due to non-payment of my health insurance premiums.

I have received a copy of Priority Family Medical Clinic's Financial Policy and Procedures and understand that all bills are due and payable upon presentation. PFMC reserves the right to charge interest on any bills not paid when due from the date thereof at the rate of up to 18% per annum. If a check is not honored upon presentation to the bank for payment, I agree to pay a $30.00 handling fee, which may be charged to my account. If legal action is instituted to collect any amount due, I agree to pay all court costs and reasonable attorney’s fees. If my immediate family and I are discharged due to nonpayment on our account, I agree to pay all delinquent balances along with a $30.00 reinstatement fee before being seen again in the clinic.

I understand that Priority Family Medical Clinic requests 24 hours’ notice of cancellation, whenever possible. I agree to notify in advance of my scheduled appointment whenever I am unable to keep it.

INSURANCE ASSIGNMENT OF BENEFITS AUTHORIZATION

I request that payment of authorized insurance benefits be made on my behalf to Priority Family Medical Clinic at: 3625 Crossings Dr. Ste B, Prescott, AZ 86305 for any or all medical services furnished which were not paid by me in full at the time services were rendered. I further authorize the release of medical information about me or my insured dependents to my health insurance carrier (s), if applicable, as needed to determine this benefits payable for related services.

If I do not sign this consent, or later revoke it, Priority Family Medical Clinic reserves the right to deny medical treatment to me.

Patient Signature | Printed Name | Date

Circle Yes/No or fill in the blanks

1.Were there any problems, infections, or abnormal tests during pregnancy? Yes No
2.Was any treatment or medication required during pregnancy? Yes No
3.Mother's age at birth: _____
4.Delivery method: Vaginal __ Cesarean: __
5.Were there any difficulties during labor or delivery? Yes No
6.Were there any problems at birth, such as jaundice (yellow), breathing difficulty? Yes No
7.Was the baby premature? Yes No
If so, at how many weeks? _____
8. Weight at birth: _____ lbs., _____ oz., or _____ kgs.
9. Place of birth: _____
10. Were there any problems during the first month of life? Yes No
11. Do you have any concerns about your child's development? Yes No
12. If in school, current grade: _____
13.Has your child ever had chickenpox? Yes No
14.Has your child ever had to stay in the hospital? Yes No
If so, please list:
Date Name of Hospital Reason
_____
_____
_____
15.Is your child allergic to any medications? Yes No
If so, please list:
_____
16.Is your child allergic to any foods? Yes No
If so, please list:
_____
17.Does your child take fluoride? Yes No
18.Does your child take vitamins? Yes No

Surgical History:

Adenoidectomy	yes no	Fracture surgery	yes no	Strabismus surgery	yes no
Appendectomy	yes no	Gastrostomy	yes no	Tear duct surgery	yes no
Circumcision Cleft	yes no	Heart surgery	yes no	Tonsillectomy	yes no
lip	yes no	Inguinal hernia	yes no	Umbilical hernia	yes no
Cleft palate	yes no	Lymph node		VP Shunt	yes no
Ear tubes	yes no	Biopsy	yes no		
		Orchiopexy	yes no		

Other Surgical History:
_____
_____

List any medicine your child takes on a regular basis (include over the counter and herbals)

Medication	Dose	How often?

Please check any of the following that your child has ever had.

( ) Skin conditions, eczema
( ) Eye problems, glasses
( ) Frequent ear infections
( ) Difficulty hearing
( ) Frequent nose bleeds
( ) Pneumonia
( ) Asthma or lung problems
( ) Heart murmur
( ) Jaundice
( ) Frequent stomach aches
( ) Frequent diarrhea
( ) Constipation
( ) Stitches
( ) Other:

( ) Kidney or bladder infections
( ) Difficulty urinating
( ) Bed-wetting
( ) Problems with menstrual periods
( ) Anemia
( ) Head injuries
( ) Loss of consciousness
( ) Seizures
( ) Frequent headaches
( ) Migraines
( ) Trouble gaining weight
( ) Problems with muscles
( ) Broken bones

What interests, hobbies, or activities does your child do outside of school?

_____

_____

How many hours a day does your child watch TV? _____

Are there any financial, personal, or family problems you are worried about?

_____

_____

How does your child do in school?

_____

_____

Does s/he have good friends?

_____

Please check any of the following conditions which relatives have had (parents, grandparents, siblings).

( ) Asthma
( ) Eczema
( ) Hayfever
( ) Tuberculosis
( ) High blood pressure
( ) Stroke
( ) Heart attack under age 55
( ) High cholesterol
( ) Thyroid or Goiter
( ) Deafness other than elderly
( ) Cataracts, glaucoma
( ) Astigmatism, amblyopia (lazy eye)
( ) Seizures
( ) Diabetes
( ) Obesity
( ) Migraines
( ) Learning disabilities
( ) Attention deficit disorder

( ) Hyperactivity
( ) Intestinal diseases, colitis
( ) Anemia or blood diseases
( ) Kidney disease or stones
( ) Cystic fibrosis
( ) Mental retardation
( ) Birth defects
( ) Neurological diseases
( ) Muscles diseases
( ) Mental health conditions
( ) Depression
( ) Schizophrenia
( ) Smoking
( ) Alcoholism
( ) Drug use
( ) Death before age 50
( ) Cancer
( ) Inherited or genetic diseases

GYN History (females only)

At what age did you begin menstruation?_____

Date of your last menstrual period?_____