NEW CHILD PATIENT INFORMATION (AGES 0-11)

COUNTRY MEADOWS CLINIC

Date: _____

Patient Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Employer:_____ Work Phone: _____

E-Mail: _____

Would you like access to our patient portal via email? ❑ Yes ❑ No, I decline
Country Meadows Clinic will not share your contact or email info with any third parties.

Preferred Language: ❑ English ❑ Spanish ❑ Other_____

Gender: ❑ Male ❑ Female

Primary Race: ❑ White ❑ Black/African American ❑ Hispanic ❑ American Indian or Alaskan Native
❑ Asian ❑ Native Hawaiian or Other Pacific Islander ❑ Declined to Specify

Ethnicity: ❑ not Hispanic or Latino ❑ Hispanic or Latino ❑ Prefer not to answer ❑ Unknown

Student Status: ❑ Full time ❑ Part Time ❑ N/A School Name: _____

Parent(s)/Guardian(s):

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Emergency Contact

Name:_____ Relationship:_____ Phone:_____

Primary Care Physician

Doctor Name: _____ Office Phone: _____

Pharmacy

Name: _____ City: _____ Phone: _____
Referral Source: ❑ Facebook ❑ Radio ❑ Newspaper ❑ Google ❑ Insurance List ❑ Other:

COUNTRY MEADOWS CLINIC

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Patient Name: _____ DOB: _____

DRUG ALLERGIES ☐ *NO DRUG ALLERGIES*

ALLERGY	ALLERGIC REACTION

☐ *Additional allergies attached or listed on the back*

MEDICATIONS

PLEASE INCLUDE ALL VITAMINS, SUPPLEMENTS AND OVER THE COUNTER MEDICATIONS

MEDICATIONS	DOSE	TIMES PER DAY

☐ *Additional medications/supplements attached or listed on the back*

FEMALES ONLY

Age of first period _____ LMP _____ Regular cycle? YES or NO

MALES ONLY

Any missing testicles? YES or NO History of hernia? YES or NO

SURGICAL HISTORY

HAS YOUR CHILD HAD ANY SURGERY IN THE PAST? ____ YES ____ NO

IF YES, PLEASE LIST WHAT TYPE AND THE DATE PERFORMED:

_____

COUNTRY MEADOWS CLINIC

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SOCIAL HISTORY

Is child cared for by anyone other than parent(s) or guardian(s)? YES NO
If yes, by whom and how often?_____

Who lives at home?

Name	**Relationship**	**DOB**

Level of Education: _____ Religious Preference: _____

Does anyone in your home smoke or use alcohol or drugs? YES NO
If yes, which one(s)? _____

PAST MEDICAL HISTORY

PLEASE CHECK ANY PROBLEMS YOUR CHILD HAS NOW OR IN THE PAST:

☐ ADD/ADHD	☐ Chicken pox	☐ Headaches	☐ Liver disease/Hepatitis
☐ Allergies	☐ Concussion	☐ Hearing problems	☐ Recurrent Ear Infections
☐ Anemia	☐ Diabetes	☐ Heart murmur	☐ Seizures
☐ Asthma	☐ Eczema	☐ Congenital heart disease	☐ UTI(s)
☐ Bleeding Disorder	☐ Fracture	☐ High blood pressure	☐ Vesicoureteral reflux
☐ Bronchiolitis	☐ Disabilities	☐ Kidney disease	☐ Vision problems

OTHER:_____

Name of the hospital where the infant/child was born: _____
List any health problems for mother during pregnancy (ie. Diabetes, high blood pressure):
_____
List any prescription or over the counter medications used during pregnancy:
_____
Any drug or alcohol use during pregnancy? YES or NO If yes, what: _____
Delivered by (circle one): 1) VAGINAL 2) C-SECTION 3) EMERGENT C-SECTION
During delivery was there any trauma (ie. Use of forceps or vacuum)? YES or NO If yes:_____
Any medical problems for the patient during the newborn period? YES or NO If yes: _____

COUNTRY MEADOWS CLINIC

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FAMILY HISTORY

PLEASE CIRCLE THE DISEASE AND WHO IT AFFECTED IN YOUR FAMILY

ASTHMA	MOTHER FATHER SISTER BROTHER GRANDMOTHER GRANDFATHER	ALZEHIEMER'S	MOTHER FATHER SISTER BROTHER GRANDMOTHER GRANDFATHER	CANCER*	MOTHER FATHER SISTER BROTHER GRANDMOTHER GRANDFATHER
ARTHRITIS	MOTHER FATHER SISTER BROTHER GRANDMOTHER GRANDFATHER	ALCOHOLISM	MOTHER FATHER SISTER BROTHER GRANDMOTHER GRANDFATHER	DIABETES (TYPE 1)	MOTHER FATHER SISTER BROTHER GRANDMOTHER GRANDFATHER
AUTOIMMUNE DISEASE*	MOTHER FATHER SISTER BROTHER GRANDMOTHER GRANDFATHER	ANXIETY	MOTHER FATHER SISTER BROTHER GRANDMOTHER GRANDFATHER	DIABETES (TYPE 2)	MOTHER FATHER SISTER BROTHER GRANDMOTHER GRANDFATHER
HEART DISEASE	MOTHER FATHER SISTER BROTHER GRANDMOTHER GRANDFATHER	MIGRAINES	MOTHER FATHER SISTER BROTHER GRANDMOTHER GRANDFATHER	THYROID DISEASE	MOTHER FATHER SISTER BROTHER GRANDMOTHER GRANDFATHER
HIGH BLOOD PRESSURE	MOTHER FATHER SISTER BROTHER GRANDMOTHER GRANDFATHER	OSTEOPOROSIS	MOTHER FATHER SISTER BROTHER GRANDMOTHER GRANDFATHER	OTHER:	MOTHER FATHER SISTER BROTHER GRANDMOTHER GRANDFATHER
HIGH CHOLESTEROL	MOTHER FATHER SISTER BROTHER GRANDMOTHER GRANDFATHER	STROKE	MOTHER FATHER SISTER BROTHER GRANDMOTHER GRANDFATHER	OTHER:	MOTHER FATHER SISTER BROTHER GRANDMOTHER GRANDFATHER

*TYPE OF CANCER(S): _____

*TYPE OF AUTOIMMUNE DISEASE(S):_____

Date: _____

Patient Name: _____ DOB: _____

NUTRITION & EXERCISE

Typical Breakfast: _____

Typical Lunch: _____

Typical Dinner: _____

Snacks? If so, what?: _____

Type of Exercise: _____

PROVIDER LIST

PLEASE LIST ANY OTHER PROVIDERS YOUR CHILD SEES ON A REGULAR BASIS

PROVIDER NAME	SPECIALTY	LOCATION OR PHONE NUMBER

HEALTH MAINTENANCE SCREENING

TEST	DATE	FACILITY	RESULT (NORMAL?)
WELLNESS EXAM			
VISION EXAM			
CHEST X-RAY			

VACCINATION HISTORY

Is your child up to date on their immunizations? YES NO
If no, why?_____

Did your child receive a COVID-19 shot? YES NO
If yes, what brand and how many (list dates): _____

Has your child had a natural COVID-19 infection? YES NO
If yes, when? _____

COUNTRY MEADOWS CLINIC

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PERSON RESPONSIBLE FOR BILL *(complete only if different from patient)* ❑ Same as above

Name:_____ Relationship: _____

Mailing Address: _____ Apt # _____

City_____ State:_____ Zip: _____

DOB: _____ Phone (home): _____ (cell): _____

PRIMARY MEDICAL INSURANCE

Insurance Company : _____

Policy Number:_____ Group Number: _____

Policy Holder's Name (if different from patient): _____

DOB (*Required) : _____ SSN: _____

Relationship to Patient ❑ Self ❑ Spouse ❑ Child ❑ Other_____

SECONDARY MEDICAL INSURANCE

Insurance Company : _____

Policy Number:_____ Group Number: _____

Policy Holder's Name (if different from patient): _____

DOB (*Required) : _____ SSN: _____

Relationship to Patient ❑ Self ❑ Spouse ❑ Child ❑ Other_____

The above information is accurate and complete to the best of my knowledge.
**WILL NEED COPIES OF INSURANCE CARD(S) & GOVERNMENT ISSUED PICTURE ID*

_____

Signature of Patient/Responsible Party Date Signed

Date: _____

Patient Name: _____ DOB: _____

CONSENT TO CONTACT

Please initial next to each paragraph as well as sign at the bottom of this page to acknowledge that you have read, understand, and agree to comply with each of our office's policies.

____ CONTACT PERMISSION
In the event that Country Meadows Clinic needs to contact you (patient) regarding an appointment, lab result, medication, or any other reason, it is permissible to:
(check all that apply)

- ❑ Leave a message on an answering machine or voice mail. Phone # _____
- ❑ Speak with spouse/significant other. Name: _____
- ❑ Speak with other family members. Name: _____

____ CONSENT TO TELEPHONE/EMAIL COMMUNICATION
I understand that any phone or email communication will be part of my medical record. I also understand that all email communication is not secure, not to be used for any emergent matters, and response will be given back within three to five business days.

_____ _____
Signature Date Signed

_____ _____
Patient Printed Name/Legal Guardian Relationship to patient

OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained due to the following:

- ❑ Individual waived signature
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other:

_____ _____
Practice Representative Date

Date: _____

Patient Name: _____ DOB: _____

FINANCIAL POLICY

Please initial next to each paragraph as well as sign at the bottom of this page

____ **Insurance claims**. If we participate with your managed care or commercial insurance plan under which you are covered, we will bill the carrier for all charges for services rendered. We will bill both your primary and secondary insurance plans. You will be responsible at the time of service for the payment of the copayments and annual deductibles.

We will call your insurance company to verify eligibility and benefits. However, verification of benefits is not a guarantee of payment. You will be billed a balance if:

- Your insurance company pays less than what we expected (i.e. deductible plan)
- We obtain a denial from your insurance company
- We have not received payment from the insurance within 60 days of our filing the claim

____ **Authorization/Financial Responsibility**. I authorize the release of any medical information necessary to process an insurance claim on my behalf. I understand that I am financially responsible for all charges and responsible for obtaining referrals required by my insurance carrier. I request that my medical insurance carrier make any payment directly to CMC HEALTHCARE, PLLC for services rendered to me.

____ **Medicare**. We are Medicare participating providers, therefore we will bill Medicare directly. You will be responsible at the time of service for payment of:

- The copayments and annual deductibles
- Charges for non-covered services. You will be asked to sign a Waiver of Liability in the event a service is provided that is not covered by Medicare.

____ **Patients without insurance coverage or out-of-network coverage**. Payment is due for all services on the day they are rendered.

____ **Returned checks**. There will be a $25.00 service fee charged to your account if your check is returned for any reason. Upon notification from our office, payment of the entire balance is due immediately.

____ **Healthcare products**. If you purchase healthcare products/supplies from our office, please understand that these items are a non-refundable. If the product/supply is defective, we will gladly replace the item(s).

____ **No show policy**. We kindly request that you give us 24 hours' notice if you are unable to keep your appointment. Failure to give 24 hours' notice will result in a $35.00 missed appointment fee. This fee is not covered by your insurance plan.

Your signature below signifies that you understand our financial policy and policies listed above, your responsibility regarding charges incurred in this office, and have read and reviewed all of the above notices.

_____ _____

Signature Date

Date: _____

Patient Name: _____ DOB: _____

QUEST DIAGNOSTICS

If your provider performs a biopsy or orders a lab test during your appointment, it will be sent to an outside laboratory. The pathology or lab results will be communicated to your provider and your provider will notify you of these results.

The outside laboratory will submit a bill to your insurance company. You may receive a bill from them should you have deductibles*, co-insurance, or co-payments. If you are a self-pay patient, rates will be discussed with you during your visit. Medicare: You may be asked to sign a Waiver of Liability in the event a service is not covered by Medicare.

*Those with high deductible plans have the option to bill as self-pay, please discuss this with the front desk or your provider.

If you have any questions regarding this process, please do not hesitate to ask your provider or nurse.

By signing below, you understand that you may be billed by an outside laboratory in the event that you receive a biopsy or lab test during your examination.

_____ _____

Signature Date

Date: _____

Patient Name: _____ DOB: _____

VACCINATION POLICY

We provide all required childhood vaccinations here at Country Meadows Clinic. Giving children vaccines not only protects the child from preventable disease but it also protects everyone else who may have a compromised immune system. According Centers for Disease Control (CDC) and American Academy of Pediatrics (AAP), it is recommended that children receive the following vaccines at certain intervals:

- Hepatitis B
- Diphtheria,tetanus,acellular pertussis (DTaP or TdaP)
- Diphtheria tetanus (DT or Td)
- Haemophilus influenza type b (Hib)
- Pneumococcal conjugate or polysaccharide
- Inactivated poliovirus (IPV)
- Measles-mumps-rubella(MMR)
- Varicella(chickenpox)
- Influenza(flu)
- Meningococcal conjugate or polysaccharide
- Hepatitis A
- Rotavirus
- Human papillomavirus (HPV)

Why have your child(ren) vaccinated?

- Vaccines protect your child from diseases which can be fatal or have lasting health consequences
- Having a high vaccination percentage in a group of children protects children who have immune-deficiencies and those too young to receive vaccines
- Appropriately vaccinated children also protect adults, especially the elderly, from preventable disease outbreaks as elderly typically have age related decline in immune system function.
- Children who are unvaccinated or under vaccinated can spread preventable diseases to all children who are not old enough to be fully immunized. This can happen at the grocery store, the mall, office waiting rooms etc.

Please contact your primary care provider to discuss any issues or hesitations you may have with vaccinating your child. You can always refuse vaccination at any point in time. If you choose to decline 1 or more vaccinations for your child, you will need to sign the vaccine refusal form.

I authorize that the vaccines may be entered into/released from the ImmTrac system (Texas immunization registry) to track immunizations. I am an adult who **can legally** consent for the person receiving vaccines and freely/voluntarily give my signed permission for the vaccines to be administered if needed. I have received a VIS/explanation for vaccine(s) being administered, I know the risks/benefits of each vaccine being given and know that I can ask if I have any questions concerning vaccines.

Patient / Legal Guardian's name (print): _____

Patient / Legal Guardian's signature: _____ Date:_____