LaFollette Family Clinic & Pediatrics
Pediatric Demographic Sheet

IDENTIFICATION

Last Name:	First Name:	☐Male ☐Female

Mailing Address	City	State	Zip

Home Phone	Cell Phone

Date of Birth	Social Security #	Pharmacy

Guarantor's Name	Relationship

Guarantor's DOB	Guarantor's Soc Sec #	Guarantor's Email

EMERGENCY CONTACT

LAST NAME	FIRST NAME	RELATIONSHIP

ADDRESS	CITY	STATE	ZIP

HOME PHONE	CELL PHONE	

INSURANCE INFORMATION

INSURANCE	SUBSCRIBER #	GROUP #

POLICY HOLDER (If different from above)	Policy Holder DOB	Policy Holder Soc Sec#

I verify that all the information above is correct to the best of my knowledge.

Guarantor Signature: _____

Date Signed: _____/_____/_____

PEDIATRIC PATIENT MEDICAL HISTORY FORM

Date	Child's Name	Nickname	DOB	☐Male ☐Female
Previous Physician		Request for Records Transfer Complete? Yes No		Date of Last Well Child Exam:
Mother's Full Name:		Father's Full Name:		
Step-Mother's Full Name (If Applicable)		Step-Father's Full Name (If Applicable)		
Custodial Provider's Full Name (If different from above)		Relationship to Patient		

Birth History

Birth Weight _____ Preg# _____ Mom's age _____ Was the birth ☐Vaginal? ☐Cesarean? ☐Early? ☐Late?
If birth was early, how many weeks early? _____ If Cesarean, why? _____
Did mother have any illnesses/problems with her pregnancy? ☐Yes ☐No Explain: _____
Did baby have any problems right after birth? ☐Yes ☐No Explain: _____

Before mother knew she was pregnant or at any time during her pregnancy did she:
☐Smoke Cigarettes (amount) _____ ☐Drink Alcohol (amount)_____
☐Use "street" drugs (type) _____ ☐Use Prescription Drugs (type)_____

Was initial feeding ☐ Breast milk? ☐ Formula?

Current and Past History

Is your patient currently on any medication?	☐Y ☐N	Explain _____
Does your child have any serious or chronic illnesses?	☐Y ☐N	Explain _____
Has your child had serious injuries or accidents?	☐Y ☐N	Explain _____
Has your child had any surgeries?	☐Y ☐N	Explain _____
Has your child ever been hospitalized?	☐Y ☐N	Explain _____
Is your child allergic to any medications?	☐Y ☐N	Explain _____
Has your child ever reacted to immunizations?	☐Y ☐N	Explain _____

Does Your Child Have or Has Your Child Ever Had:

Asthma, recurrent cough, bronchitis, or pneumonia	☐Y ☐N	Explain _____
Nasal allergies or eczema	☐Y ☐N	Explain _____
Frequent ear infections or sore throat	☐Y ☐N	Explain _____
Problems with ears or hearing	☐Y ☐N	Explain _____
Problems with eyes, vision or teeth	☐Y ☐N	Explain _____
Frequent headaches or other neurologic problems	☐Y ☐N	Explain _____
Frequent abdominal pain	☐Y ☐N	Explain _____
Constipation requiring doctor visits	☐Y ☐N	Explain _____
Bladder/kidney problems or bedwetting	☐Y ☐N	Explain _____
Any heart problems/murmur	☐Y ☐N	Explain _____
Anemia or bleeding problem	☐Y ☐N	Explain _____
Thyroid or other gland problem	☐Y ☐N	Explain _____
Diabetes	☐Y ☐N	Explain _____
ADD/ADHD	☐Y ☐N	Explain _____
Mental Health Issues	☐Y ☐N	Explain _____
Use of drugs or alcohol	☐Y ☐N	Explain _____

Household Information

Please List All Those Living in the Child's Home		
NAME	**Relationship to Child**	**DOB**

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

_____

_____

Child Care: _____

Smokers in household? ☐ Y ☐ N

Family Medical History (Parents, Siblings, Grandparents, Aunts and Uncles

Have Any Family Members Had the Following:

Alcohol/Drug Abuse	☐Y ☐N	Who_____	Comment_____	
Allergies	☐Y ☐N	Who_____	Comment_____	
Asthma	☐Y ☐N	Who_____	Comment_____	
Birth Defects	☐Y ☐N	Who_____	Comment_____	
Blood Disorders	☐Y ☐N	Who_____	Comment_____	
Bone Disorders	☐Y ☐N	Who_____	Comment_____	
Cancer	☐Y ☐N	Who_____	Comment_____	
Diabetes	☐Y ☐N	Who_____	Comment_____	
Endocrine Disease	☐Y ☐N	Who_____	Comment_____	
Ear/Nose/Throat Disorders	☐Y ☐N	Who_____	Comment_____	
Eye Disorders	☐Y ☐N	Who_____	Comment_____	
Gastrointestinal Disorders	☐Y ☐N	Who_____	Comment_____	
Heart Disease	☐Y ☐N	Who_____	Comment_____	
High Blood Pressure	☐Y ☐N	Who_____	Comment_____	
High Cholesterol	☐Y ☐N	Who_____	Comment_____	
Immune Disorders	☐Y ☐N	Who_____	Comment_____	
Joint Problems	☐Y ☐N	Who_____	Comment_____	
Kidney Disease	☐Y ☐N	Who_____	Comment_____	
Liver Disease	☐Y ☐N	Who_____	Comment_____	
Lung Disease	☐Y ☐N	Who_____	Comment_____	
Migraine Headaches	☐Y ☐N	Who_____	Comment_____	
Metabolic Disorders	☐Y ☐N	Who_____	Comment_____	
Obesity	☐Y ☐N	Who_____	Comment_____	
Seizure Disorders	☐Y ☐N	Who_____	Comment_____	
Skin Disorders	☐Y ☐N	Who_____	Comment_____	
Stroke History	☐Y ☐N	Who_____	Comment_____	
Thyroid Disorders	☐Y ☐N	Who_____	Comment_____	
Mental Health History	☐Y ☐N	Who_____	Comment_____	
Other Medical History	☐Y ☐N	Who_____	Comment_____	
Other Medical History	☐Y ☐N	Who_____	Comment_____	

LaFollette Family Clinic & Pediatrics

2425 Jacksboro Pike LaFollette TN 37766
Phone: (423) 566-4748 Fax: (423) 566-4119

PATIENT CONSENT FORM

PATIENT/MINOR CONSENT FOR TREATMENT: I authorize my permission and consent for all physicians at LaFollette Family Clinic & Pediatrics to provide medical care for myself and my family members that I designate I also grant my permission to do photo ID, diagnostic tests and procedures necessary to provide quality care to my family members and myself. I release LaFollette Family Clinic & Pediatrics and their staff from any liability for the results of above diagnostic tests and procedures.

AUTHORIZATION FOR RELASE OF INFORMATION: The LaFollette Family Clinic & Pediatrics and attending physicians are authorized to furnish any medical information requested by insurance companies or companies with whom I have coverage or public agency which may be assisting in payment of my care. I also authorize and give permission for LaFollette Family Clinic & Pediatrics to release my medical records to appropriate specialists, outside lab companies, outside x-ray companies, etc., to diagnose patients.

STATEMENT OF FINANCIAL RESPONSIBILITY: I understand that I am directly responsible to LaFollette Family Clinic & Pediatrics for all private charges for medical, lab, and surgical services rendered to me or my family, regardless of insurance coverage. In the event of default, I agree to pay all cost of collection including reasonable attorney fees. **I have read and certify that this information is correct**. I will notify you of any changes in my above status.

_____ _____

Print Patient Name **Patient Signature**

_____ **Date:** _____/_____/_____

Parent / Guardian Signature

Do you have a living will? ☐ Yes ☐ No

If you would like to find out about a "Living Will" or "Durable Power of Attorney" go to www.livingwills.com to find out how you can obtain one.

LaFollette Family Clinic & Pediatrics

Patient Privacy Questionnaire

1) Please print the telephone number where you want to receive calls about your appointments, labs, and x-ray results, or other healthcare information. (_____)_____
2) Can we leave a message? ☐ YES ☐ NO
3) Please list the family members or significant others, if any, whom we may inform about your medical condition. (Only in an emergency)

NAME	RELATIONSHIP	PHONE NUMBER

4) Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis.

NAME	RELATIONSHIP	PHONE NUMBER

Patient Name _____ Patient Signature: _____
(Please Print)

Parent / Guardian Signature: _____ Date: _____/_____/_____

Acknowledgement of Receipt of Notice of Privacy Practices

("YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT")

I have received a copy of this office's notice of privacy practices.

Name: _____ Signature: _____
(Please Print)

Parent / Guardian Signature: _____ Date: _____/_____/_____

For Office Use Only

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

☐ Individual refused to sign
☐ Communication barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining acknowledgement
☐ Other(s) (please specify) _____

LaFollette Family Clinic & Pediatrics

2425 Jacksboro Pike, LaFollette TN 37766 **Phone:** (423) 566-4748 **Fax:** (423) 907-9882

Authorization to Release Medical Records/Information

Patient's Name: _____

Address: _____ **City:** _____ **ST** ____ **Zip** _____

Phone: _____ **D.O.B.:** _____ **SSN:** _____

Physician to Provide records: _____

Address: _____

Phone: _____ **Fax:** _____

Physician to Receive records: LaFollette Family Clinic & Pediatrics

Address: 2425 Jacksboro Pike LaFollette TN 37766

Phone: (423) 566-4748 **Fax:** (423) 907-9882

This request and authorization applies to:

☐ All healthcare information

☐ Healthcare information relating to the following treatment, condition, or dates of service and or treatment: _____

☐ Other

If you would like any of the following sensitive information disclosed, check the applicable boxes below:

☐ Alcohol/Drug Abuse Treatment ☐ HIV/AIDS

☐ Sexually Transmitted Diseases ☐ Mental Health

☐ Psychotherapy Notes Only (by checking this box, I am waiving any psychotherapist-patient privilege)

***Expiration or revocation of authorization** – I understand that I may revoke this authorization in writing at any time to the Medical Records Department, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature below.

Signature: _____ **Date:** _____

Relationship to patient (if signed by parent or guardian) _____

Witness: _____ **Date:** _____

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PARENT OR LEGAL GUARDIAN CONSENTING FOR TREATMENT OF MINORS

LaFollette Family Clinic & Pediatrics physicians and staff would not be able to treat patients under the age of eighteen without the consent of the parent or legal guardian except under certain circumstances provided by state law. We would really appreciate if the parent or legal guardian accompanies the child for their office visits so that we can make an informed decision about their medical care.

If you or the legal guardian is not able to accompany the child due to some valid reasons, you need to assign another adult to accompany them. We need you or the legal guardian another adult person and give permission for them to participate in the medical care of your child in your absence. We need your consent for us to do that and to provide the best possible medical care for you and your family members.

Please fill out the consent below:

I, _____ the parent/legal guardian of _____ (Date of birth) _____ give permission for _____ who is my child's _____to bring my child to Family Healthcare Clinic for medical treatment. My signature on this form indicates that I am authorizing this individual to make any necessary decisions regarding the treatment of my child in my absence.

_____ _____/_____/_____

(Print parent/legal guardian name) (Date)

_____

(Signature parent/legal guardian)

_____

(Witness)