NEW PEDIATRIC PATIENT HISTORY AND REVIEW

(To be filled out by the parent)

Mother's name:__________________ Age:______ Occupation:______________

Father's name:__________________ Age:______ Occupation:______________

Who referred you to our practice?____

PREGNANCY AND BIRTH HISTORY:

Mother's age at birth__________________

Any complications/infections during pregnancy? No Yes

If "yes," describe________________

Any medications during pregnancy? No Yes

If "yes," list____________________

Where was the baby delivered?__________________

Was the baby on time? No Yes

What was the birth weight? ____________________

What was the birth length? ____________________

Did the baby have difficulty starting to breathe? No Yes

Any problems in the first 3 months of life? No Yes

If "yes," list ____________________

Passed hearing screen? No Yes

Hepatitis B vaccination given at the hospital? No Yes

PAST MEDICAL/SURGICAL HISTORY:

Where has your child gone for health care?

____

Reason for change? __________________

Date of last checkup? ________________

Any hospitalizations or surgeries since birth? No Yes

If "yes," list ________________

Any serious injuries? No Yes

If "yes," list ________________

Any history of frequent infections? No Yes

If "yes," list ________________

Any medications taken regularly? No Yes

If "yes," list ________________

Has your child had any allergic reactions to any foods, medications, or insect bites? No Yes

If "yes," describe________________

List any other health problems________________

Does your child have a record of immunizations? No Yes

FAMILY HISTORY: Please list immediate family members with a history of any of the following:

Anemia__________	Hepatitis______________
Asthma__________	GI problems____________
Allergies_________	High cholesterol__________
Diabetes_________	Skin problems___________
Obesity__________	Alcoholism______________
Blood problems_______	Arthritis________________
Lung problems________	TB_____________________
High blood pressure______	Seizures________________
Heart disease__________	Migraines_______________
Mental retardation________	Stroke__________________
Kidney problems__________	Cancer__________________
Thyroid problems__________	Other___________________

SOCIAL HISTORY:

1. Parental marital status: please circle
   Married/Separated/Divorced/Widowed/Single parent
2. Sibling name(s) and age(s):________________
3. Who lives at home? ____________________
4. Does anyone at home smoke or is the child exposed to smoke? No Yes
5. Type of home: house/apt/mobile home/other
6. Water supply: city water/well water
7. Any pets?
   If "yes," indoor/outdoor? Type of pet(s)
   ____
8. Describe childcare outside of the home: ______________
9. Name of child's school and grade: __________________
10. Child's hobbies: ____________________________

FEEDING AND NUTRITION:

1. For the first six months, breast or bottle fed?
   If bottle, which formula? ______________
2. Any feeding problems? No Yes
3. Does child take vitamins? No Yes
   If "yes," list__________________
4. Is your child's appetite usually good? No Yes

DEVELOPMENT/BEHAVIOR:

1. At what age did your child sit alone? ____________
2. At what age did your child walk alone? ___________
3. Did he/she say any words at age 18 months? No Yes
4. How does your child compare to others of his/her own age? Below average/average/above average
5. Does he/she get along with other children? No Yes
6. Does he/she get in trouble at school? No Yes
7. Circle if your child has any of the following:

speech problems	nail biting
discipline problems	bad temper
thumb sucking > 4 yrs	bed wetting
toilet training problems	hyperactivity

SAFETY/ENVIRONMENT:

1. Is your hot water heater set at 120 degrees? No Yes
2. Are there home smoke alarms on each floor? No Yes
3. Is there a fire extinguisher in the house? No Yes
4. Are there any fire arms in the house? No Yes
   If "yes," are they unloaded/locked storage? No Yes
5. Does your child always wear a safety restraint in the car? No Yes
6. Does your child always wear a helmet when riding a bike or skating? No Yes

Patient Name:______________________

Date of Birth:______________________

Date of Exam:______________________

Pharmacy:__________________________

Pediatric Registration Form

Phillips Healthcare Group, PC - 6890 W. Andrew Johnson Hwy., Talbott, TN 37877 - Ph (423) 839-2120 Fax (423) 839-2125 Web: phillipshealthcaregroup.com

Name______________________ Preferred Name______________________ Birthdate__________

Address ____ Apt # __________

City ______________________ State __________ Zip ______________

Home Ph ______________________ Cell or Other Phone ______________________

E-Mail Address ______________________ Patient Social Security # ______________________

Sex: ____ Male ____ Female Mother's Social Security # (if patient is less than 1 year old ______________________

Patient's School: ______________________ School Ph#: ______________

Father's Name: ______________ Father's Employer: ______________ Employer's Ph # ______________

Mother's Name: ______________ Mother's Employer: ______________ Employer's Ph # ______________

How did you hear about us? ____

Emergency Contact: ______________________ Relationship __________ Phone # ______________

List anyone who may seek or discuss medical treatment for patient in parental absence: ______________________

For Minors Age 14 thru 18: Do you give permission for the patient to seek medical care alone? ____Yes ____ No

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Financial Responsibility: ** Please complete if different from patient or if patient is a minor.**

Responsible Party Name: ______________________________ Birthdate: ______________

Address (if different from above) ____

Telephone # ______________ Social Security # ______________ Relationship______________

Employer: ______________________________ Employer Ph # ______________________

Insurance Information: ** Please provide a copy of your insurance card(s) to our receptionist.**

Primary Insurance:	Secondary Insurance:
Insurance Co: ______________	Insurance Co: ______________
Name of Subscriber: ______________	Name of Subscriber: ______________
Birthdate of Subscriber: ______________	Birthdate of Subscriber: ______________
Social Security # of Subscriber: ______________	Social Security # of Subscriber: ______________
Patient Relationship to Insured: ______________	Patient Relationship to Insured: ______________

Advanced Directive for Healthcare:

I understand my right to execute a Living Will and/or Durable Power of Attorney for healthcare to assist in healthcare decisions if I become unable to make decisions.

I have a Living Will. ____Yes ____ No If yes, copy provided for chart. ____ Yes ____ No

I have granted Durable Power of Attorney. ____ Yes ____ No If yes, copy provided for chart. ____ Yes ____ No

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I hereby authorize Phillips Healthcare Group, PC to disclose any information necessary for the processing of my claims related to my treatment at Phillips Healthcare Group, PC. I understand that this authorization extends to the treatment and furnishing a copy of all reports related to my treatment. The question of privacy between Phillips Healthcare Group, PC my treating physician and myself are waived with regards to the information contained in the records and reports furnished to my insurance carrier. I understand my insurance carrier may not cover and/or pay for services rendered, and I agree to be financially responsible for any services that are not covered by my insurance carrier.

Patient/Responsible Party Signature: ______________ Relationship to Patient______________ Date: __________

Phillips Healthcare Group, PC

6890 W. Andrew Johnson Hwy., Talbott, TN 37877

Ph: 423-839-2120 Fax: 423-839-2125

F. Edward Phillips, Jr., MD - Lucinda Hicks, NP - Amber Moore, FNP-BC - L. Peyton Satterfield, PA-C

PATIENT AUTHORIZATION FOR DISCLOSURE

Patient Name: ______________________________ Date of Birth: ______________

*** I authorize Phillips Healthcare Group, PC to obtain information from (Ex: former physician):

____

Name of Provider or Facility

____

City, State, and Zip Code

____

Phone Number and Fax Number

Description of Information for disclosure/use:

___ Entire Medical Record ___ Lab Work ___ Financial Information

___ Immunization Record ___ Radiology Results ___ Other ______________

Purpose of the use or disclosure:

___ Personal Use ___ Moving ___ Specialty consult (i.e. Allergist/ENT)

___ Insurance ___ Changing Doctor ___ Other ______________

I understand the information disclosed pursuant to this authorization may be subject to disclosure by the recipient and no longer protected by federal privacy regulations. I understand that I may revoke this authorization at any time by sending a written request to the Practice Administrator. However, the revocation will not have any effect on any uses or disclosures the practice may have made before the revocation was received. I understand that unless I revoke the authorization earlier, this authorization will automatically expire one year after the date this authorization is signed. I understand that I may refuse to sign this authorization and that the practice will not condition treatment on whether or not I sign this authorization. I understand that a copy of this authorization will be provided upon patient request.

I certify that I am: ___ the patient ___ authorized representative

Signature: ______________________________ Date: ______________

If signature is not that of patient: Name: ______________________ Relationship to the Patient ______________

Witness Signature: ______________________________ Date: ______________

Important Notice

This facsimile may contain Privileged and Confidential Information intended only for the use of the specified individual or entity noted above. If you are not the intended recipient, or agent responsible for delivering this transmission to the intended individual or entity, you are hereby notified that any consideration, copying, or dissemination of this communication is strictly prohibited. If you have received this facsimile in error, please notify this office as soon as possible by telephone at (423) 839-2120 to arrange for the return of the original document.

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Patient Name: ____________________ Patient Date of Birth: ____________

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Phillips Healthcare Group, PC *Notice of Privacy Policy* and have been provided an opportunity to review it.

Initial ____________

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I understand that Phillips Healthcare Group, PC will take all reasonable steps to ensuring my medical records are kept confidential. I give Phillips Healthcare Group, PC permission to contact me at the address(es) and phone number(s) provided to them.

Initial ____________

INFECTION CONTROL

If any employee of Phillips Healthcare Group, PC or other healthcare worker is exposed to my blood or other body fluids, I hereby authorize Phillips Healthcare Group, PC to test my blood for Hepatitis B, Hepatitis C and HIV (the virus that cause AIDS). I understand the tests will be done at the expense of Phillips Healthcare Group, PC.

Initial ____________

RELEASE OF CONFIDENTIAL INFORMATION FOR BILLING PURPOSES

Disclosure of substance abuse, psychiatric treatment, and HIV information is protected by federal and state law. Federal and State Law prohibit making any disclosure of confidential information without the consent of the person to whom it pertains, or as otherwise permitted or required by federal or state law. The undersigned hereby authorizes Phillips Healthcare Group, PC and affiliates and any involved physician(s) and/or employees to release to the patient's insurance company or third party payer, for the purpose of securing payment of insurance benefits, information contained in the patient's medical record regarding the patient's treatment for alcohol or drug abuse, the patient's treatment for mental illness, and the fact that an HIV test was performed on the patient and the patient's HIV test results.

____________________	____________________	____________
Signature of Patient or Authorized Representative	Print Name	Date

____________________	____________________
Witness	Date