Lisa P. Allardice MD, F.A.A.P.
Mindy Scheible, NP-C
Diana Hess, CPNP
Carlie Frederick, APRN-BC

Pediatric Associates of LaGrange, P.C.

Today's Date: _____

P

Patient First Name: ☐ Middle Name: ☐ Last Name:

Mark the name patient goes by

Patient SSN: Patient DOB: Sex: M F

Bill Payer: Patient Lives With:

Address: Address:

City: State: Zip: City: State: Zip:

Mother's Cell Phone: - - Mother's Work Phone: - - Home Phone: - -

Father's Cell Phone: - - Father's Work Phone: - - Alt. Phone: - -

A

Mother's Name: Maiden Name: Mother's DOB:

Mother's Employer: Mother's SSN:

Father's Name: Father's SSN: Father's DOB:

Father's Employer:

Primary Insurance: Dad's Insurance Mom's Insurance Other:

Secondary Insurance: Dad's Insurance Mom's Insurance Other:

L

Number of people living in child's household Mother in Household: Y N Father in Household: Y N

Sibling: Age: Healthy: Y N

Sibling: Age: Healthy: Y N

Sibling: Age: Healthy: Y N

Sibling: Age: Healthy: Y N

S

Persons Allowed to bring child to office visits for treatment	Relationship to patient

PEDIATRIC ASSOCIATES OF LAGRANGE, P.C.

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Pediatric Associates of LaGrange, P.C. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Pediatric Associates of LaGrange's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Pediatric Associates of LaGrange reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Pediatric Associates of LaGrange's Privacy Officer at 205 Calumet Center Road, LaGrange, GA, 30241.

With my consent, Pediatric Associates of LaGrange may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Pediatric Associates of LaGrange may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, Pediatric Associates of LaGrange may e-mail and/or text to me appointment reminders and patient statements. I have the right to request that Pediatric Associates of LaGrange restrict how it 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.

By signing this form, I am consenting Pediatric Associates of LaGrange's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Pediatric Associates of LaGrange may decline to provide treatment to me.

I authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to Pediatric Associates of LaGrange, P.C., for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original.

_____ _____

Signature of Parent or Legal Guardian Date

_____

Print Name of Parent or Legal Guardian

_____

Print Patient's Name

PATIENT NAME:

Tuberculosis (TB) Risk Assesment

Check Yes or No

Y ☐ N ☐ 1. Is the child in close contact to a person with active TB disease?*

Y ☐ N ☐ 2. Does the child have or at risk to have HIV?

Y ☐ N ☐ 3. Was the child or the child's parent born outside the US?

Y ☐ N ☐ 4. Is the child exposed to a person in jail or a person who has been in jail in the past five years?

Y ☐ N ☐ 5. Is the child exposed to a person who has HIV, who is homeless or who lives in a nursing home or another group home?

Y ☐ N ☐ 6. Is the child exposed to drug users or migrant farm workers?

Y ☐ N ☐ 7. Does the child have a health problem that lowers their immune system?

Y ☐ N ☐ 8. Does the child live in a community that has a high risk for TB?

Y ☐ N ☐ 9. Has the child traveled to, or had any visitors from any foreign country since the last visit?

Y ☐ N ☐ IO. Does the child have any symptoms of TB (cough, fever, night sweats, loss of appetite, weight loss or fatigue) or an abmormal chest x-ray?*

*call the health department

Explain any yes answers:

_____

_____

_____

_____

Vision Risk Assesment

Check Yes or No

Y ☐ N ☐ 1. Has anyone in your child's family been diagnosed with congenital cateracts, retinoblastoma, metabolic disease, or ocular abnormalities?

Y ☐ N ☐ 2. Has anyone in your child's family been diagnosed with amblyopia {blurred vision) or strabismus (lazy eye)?

Y ☐ N ☐ 3. Has anyone in your child's family been diagnosed with epiphoria (excessive watery eyes), photophobia (light sensitivity), ptosis (drooping of the upper eyelid), or anisocoria (unequal pupil size)?

Y ☐ N ☐ 4. Has anyone in your child's family had glaucoma, eye surgery, or glasses

Y ☐ N ☐ 5. Do your child's eyes appear unusual?

Y ☐ N ☐ 6. Does your child seem not to see well?

Y ☐ N ☐ 7. Does your child exhibit difficulty with near or distance vision?

Y ☐ N ☐ 8. Do your child's eyes appear not to be straight?

Y ☐ N ☐ 9. Do your child's eyelids droop or does one eyelid tend to close?

Y ☐ N ☐ 10. Has your child ever had an eye injury?

Explain any yes answers:

_____

_____

_____

_____

Lead Risk Assesment

Check Yes or No

Y ☐ N ☐ 1. Does your child live in or often visit a house that may hav been built before 1978?

Y ☐ N ☐ 2. Does your child live in or often visit a house that is being remodeled or is having paint removed?

Y ☐ N ☐ 3. Does your child live with or often visit another child that has an elevated blood lead level?

Y ☐ N ☐ 4. Does your child live with anyone that works at a job where lead may be found or has a hobby that uses it?

Y ☐ N ☐ 5. Does your child chew on or eat any non-food items like paint chips or dirt?

Y ☐ N ☐ 6. Does your child live near an active lead smelter, battery recycling plant or other industry likely to release lead?

Y ☐ N ☐ 7. Does your child receive medicines such as greta, azarcon, kohl or pay-loo-ah?

Explain any yes answers:

_____

_____

_____

_____

Parent Signature: _____ Date: _____

PATIENT NAME:

Risk Factors for Hearing Loss

CHECK YES OR NO

Y ☐ N ☐ 1. Parent or caregiver concern regarding hearing, speech, language, or developmental delay

Y ☐ N ☐ 2. Family history of permanent childhood hearing loss

Y ☐ N ☐ 3. NICU stay greater than five days, ECMO, ototoxic medications, loop diuretics, exchange transfusion

Y ☐ N ☐ 4. In utero infections such as CMV, herpes, rubella, syphilis, Toxoplasmosis

Y ☐ N ☐ 5. Craniofacial anomalies, especially involving the ear and temporal bone

Y ☐ N ☐ 6. Stigmata of syndromes known to cause hearing loss, Eustachian tube dysfunction

Y ☐ N ☐ 7. Syndromes associated with hearing loss or progressive or late-onset hearing loss

Y ☐ N ☐ 8. Neurodegenerative disorders or sensory motor neuropathies

Y ☐ N ☐ 9. Postnatal infections associated with sensorineural hearin loss including bacterial meningitis

Y ☐ N ☐ 10. Head trauma

Y ☐ N ☐ 11. Chemotherapy

Y ☐ N ☐ 12. Recurrent or persistent ear infection for at least 3 months

Cholesterol Risk Assesment

CHECK YES OR NO

Y ☐ N ☐ 1. Have your child's parents or grandparents been diagnosed with high cholesterol at less than 55 years of age?

Y ☐ N ☐ 2. Have your child's parents or grandparents ever had a heart attack at less than 55 years of age?

Y ☐ N ☐ 3. Does your child smoke?

Y ☐ N ☐ 4. Have your child's parents or grandparents ever been diagnosed with heart disease, stroke or blood clot in the legs at less than 55 years of age?

Y ☐ N ☐ 5. Has your child ever had an elevated blood pressure?

Y ☐ N ☐ 6. Have your child's parents or grandparents ever had any heart surgery (angioplasty or bypass surgery) at less than 55 years of age?

EXPLAIN ANY YES ANSWERS:

_____

_____

_____

_____

PARENT SIGNATURE: _____ DATE: _____

Patient Medical History

PATIENT NAME: _____

Check if your child has had any of the following:

- ☐ Bronchiolitis
- ☐ Bronchitis
- ☐ Persistent Cough
- ☐ Wheezing
- ☐ Whooping Cough
- ☐ Allergies
- ☐ Sinusitus
- ☐ Scarlet Fever
- ☐ Strep Throat
- ☐ Tonsillitis
- ☐ Hay Fever
- ☐ Bed Wetting
- ☐ Kidney Disease
- ☐ Kidney Infections
- ☐ Problems Urinating
- ☐ Urinary Tract Infections
- ☐ Urologic Malformations
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excess Weight Gain
- ☐ Excess Weight Loss
- ☐ Frequent Vomiting
- ☐ Soiling Pants
- ☐ Stomach Ache
- ☐ Blackout Spells
- ☐ Brain Disease or Injury
- ☐ Cerebral Shunt
- ☐ Headaches
- ☐ Seizures
- ☐ Staring Spells
- ☐ Broken Bones
- ☐ Joint Problems
- ☐ Tuberous Sclerosis
- ☐ Chicken Pox
- ☐ Mumps
- ☐ Measles
- ☐ German Measles
- ☐ Poisoning
- ☐ High Blood Pressure
- ☐ Congenital Heart Disease
- ☐ Neurofibromatosis
- ☐ Solid Organ Transplant
- ☐ Malignancy or Bone marrow Transplant
- ☐ Treatment with medicine known to raise blood pressure
- ☐ Meningitis
- ☐ Behavior Problems
- ☐ Skin Problems
- ☐ Immune Problems
- ☐ Thyroid Problems
- ☐ Sleep Problems
- ☐ Bleeding Problems
- ☐ Eating Problems
- ☐ Prematurity

Please specify any allergies your child has had in the past: _____

Please list any medical problems, surgeries, specialists: _____

Please list all medications currently taken: _____

Hospitalizations: _____

Check if your child had any of the following symptons with baby shots (immunizations): ☐ High Fever ☐ Seizure ☐ Leg Sweeling ☐ Uncontrollable Screaming

Pregnancy, labor, delivery and nursery: Was your pregnancy planned? ☐ Yes ☐ No

Check if you had any of the following during pregnancy:

- ☐ C-Section
- ☐ Reason for C-Section:
- ☐ _____
- ☐ Spinal/Anesthesia
- ☐ Infection or fever during labor
- ☐ Water leaking > 1 daylabor
- ☐ Labor longer than 1 day
- ☐ Early labor
- ☐ Vacuum
- ☐ Forceps
- ☐ Group B Strep
- ☐ HIV
- ☐ Hepatitis B or C
- ☐ Syphilis
- ☐ Gonorrhea
- ☐ High blood pressure
- ☐ Alcohol or drug abuse
- ☐ Cigarette use
- ☐ Other pain medicines
- ☐ Kidney infections
- ☐ Other infections
- ☐ Medicines other than prenatal vitamins
- ☐ Cigarette Exposure

What was the child's birth weight: _____ What was the child's Apgar scores: _____

Was the baby full term: ☐ Yes ☐ No | If not, how many weeks early? _____

If child stayed in the ICU, where and how long? _____ Problems while in ICU? _____

Any signs or symptoms of maternal/paternal depression since child's birth ☐ Yes ☐ No If yes Explain: _____

Family History:

Check if anyone in your family has any of the following:

- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Rheumatic Fever
- ☐ Kidney stones
- ☐ Congenital kidney disease
- ☐ Kidney disease
- ☐ Ulcers
- ☐ Bowel disease (Ileitis)
- ☐ Liver problems
- ☐ Alcohol problem
- ☐ Gallbladder disease
- ☐ Hepatitis B,C
- ☐ Thyroid disease
- ☐ Diabetes
- ☐ Overweight
- ☐ Excessive weight gain
- ☐ Height less than 5' 0"
- ☐ Height greater than 6'4"
- ☐ Immune problems
- ☐ Stroke
- ☐ Seizures
- ☐ Migraines
- ☐ Asthma
- ☐ Cystic Fibrosis
- ☐ TB (Tuberculosis)
- ☐ Abnormal fingers or toes
- ☐ Joint disease
- ☐ Crippling arthritis
- ☐ Sickle cell disease
- ☐ Blindness
- ☐ Eye problems
- ☐ Deafness
- ☐ Allergies
- ☐ Eczema
- ☐ Skin problems
- ☐ Cleft lip or palate
- ☐ Bleeding problems
- ☐ Leukemia
- ☐ Abnormal teeth
- ☐ Down's Syndrome
- ☐ Birth defects
- ☐ Cancer
- ☐ Early death
- ☐ Mental disease
- ☐ Mental retardation
- ☐ Behavior problems
- ☐ Learning problems
- ☐ Reading problems
- ☐ Hyperactivity/AOD/ADHD
- ☐ Other _____
- ☐ Heart Attack (man less than 40 years/ woman less than 50 years)

PERSON COMPLETEING FORM _____ DATE: _____

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AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

I, or the undersigned personal representative, hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or a health care provider, the released information may be re-disclosed and may no longer be protected by federal privacy regulations.

Patient Information:

Name: _____ Date of Birth: _____

The Information may be Disclosed by:

Doctor / Hospital Name _____

Address: _____

_____

Phone: _____ Fax: _____

The Information may be disclosed to:

Name: Pediatric Associates of LaGrange, P.C.

Address: 205 Calumet Center Rd.

LaGrange, GA 30241

Phone: 706.885.1961 Fax: 706.885.1963

Information to be Disclosed:

Check if your child has had any of the following:

☐ Complete Medical Record	☐ Consultation	☐ Ultrasound Report	☐ Drug/Alcohol Abuse Notes
☐ Emergency Department Record	☐ Progress Notes	☐ Immunization Records	☐ HIV-related Record/Notes
☐ History and Physical	☐ Laboratory Report	☐ Form 3231	☐ Paternity Test Results
☐ Discharge Summary	☐ Pathology Report	☐ Ear/Eye/Dental Form	☐ Other
☐ Operative Report	☐ Radiology Report	☐ Birth Record	☐ _____

Purpose for Disclosure: _____

I understand that this authorization will remain in effect for ninety (90) days after the authorization is signed and dated or whenever requested information is used/disclosed whichever first occurs. I also understand that I may revoke this authorization at any time by notifying in writing the Privacy Officer of Pediatric Associates of LaGrange, P.C. to whom this authorization was originally addressed, but if do, it will not have any effect on actions that Pediatric Associates of LaGrange took before it received the revocation. Aside from this, I understand that upon expiration of the authorization, no further use or disclosure of the information will be made.

Date: _____ **Signature:** _____

If signed by Personal Representative, indicate authority to act for individual:

☐ Parent ☐ Health Care Power of Attorney

☐ Guardian ☐ Other

Original-Medical Record Copy
Copy-Patient/Patient Representative