theGROVE
Primary Care Clinic

Pediatric Patient Information (please print)

Last Name _____ **First Name**_____MI _____

Suffix •Jr. •Sr. •II •III •Other,_____Name child goes by:_____

Date of Birth _____ **Social Security Number** _____

Gender ☐ Male ☐ Female **Ethnicity** ☐ Not Hispanic ☐ Hispanic/Latino

Race ☐Black/African American ☐White/Caucasian ☐Hispanic/Latino Other _____

Language Preference☐ English ☐Spanish ☐Refused ☐Other _____

Student Status ☐Daycare ☐School Name _____ Phone_____

Parent or guardian email address:_____

Mailing Address _____

Apartment # _____ City_____St _____ Zip Code_____- _____

Physical Address (if different from mailing address):_____

City_____St _____ Zip Code_____- _____

Home Phone (___)____-_____ Work Phone (___)____-____ Cell Phone (___)____-_____

Primary Emergency Contact NAME_____Relationship_____

Home Phone (___)____-_____ Work Phone (_)____-___ Cell Phone (___)___-____

Other Emergency Contacts you wish us to have on file

NAME_____Relationship_____

Home Phone (___)____-_____ Work Phone (_)____-___ Cell Phone (___)___-____

**For insurance info, please note, even children with Tenncare, etc., must have a parent listed as guarantor. For commercial insurance, the information of the parent who is the insurance subscriber must be listed.

Patient's Primary Responsible Party Information

Guarantor's First Name_____MI__Last Name_____

Date of Birth_____SSN _____

Mailing Address _____

City_____State_____Zip _____

Home Phone (___)____-_____Work Phone (___)____-____Cell Phone (__)__-_____

Relationship to Patient: ☐Parent ☐Legal Guardian

Employer_____Job Title _____

Employer's Address (with city, ST, zip) _____

INSURANCE INFORMATION (please provide your card{s} or copies of the front and back)

Primary Insurance_____Telephone Number (____)_____-_____

Group or Policy Number_____Subscriber or ID Number _____

Subscriber Name_____Effective Date_____Co-Pay $_____Deductible $_____

Secondary Insurance_____Telephone Number (____)_____-_____

Group or Policy Number_____Subscriber or ID Number _____

Subscriber Name_____Effective Date•Co-Pay $_____•Deductible $____

By your signature below, you understand and acknowledge that you will be responsible for the charges of any services provided that are denied, non-covered, or not paid by your insurance.

Referred By:_____**Signature:** _____

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Release of Information TO another facility

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION FROM ANOTHER FACILITY

Patient Name: Date of Birth: SSN:
Other Names Known By:

Person/Organization Authorized to Disclose Protected Health Information:

Release Records to: Address: Fax: City & State:
The Grove Primary Care Clinic Telephone: Zip:
Attention:
CONFIDENTIAL

Purpose of Disclosure: ☐ Medical Care ☐ Insurance ☐ At the Request of the Patient
☐ Media, Public Relations, Marketing, Advertising, Posting, or Radio Broadcasting
☐ Other, Please Explain: _

Description of Information to be Used or Disclosed:

Dates of Treatment: Place of Treatment:

Choose From the Following:

☐ All Dictated Reports	☐ Lab (may include AIDS/HIV information)		☐ History & Physical
☐ Radiology Reports	☐ Pertinent Summary	☐ Discharge Summary	☐ Pathology Reports
☐ ER Record	☐ Consultation	☐ Anesthesia Record	☐ Billing Record
☐ Operative/Procedure Report	☐ Entire Chart	☐ Photographs/Images	☐ Other (specify):

I understand that:

1. I may revoke this authorization in writing at any time by notifying in writing the person/organization providing or disclosing the information. However, if I revoke this authorization, it will not have any effect on any actions taken by the person/organization providing, disclosing, or receiving the information prior to receiving the revocation, nor shall it be valid to the extent that the disclosing person/organization or receiving organization has taken action in reliance on this authorization.
2. This authorization allows **The Grove Primary Care Clinic** to obtain any and all documents in my medical record including those copies from other health care facilities and providers. I understand that the information that is released or provided may be re-disclosed and no longer protected by federal privacy regulations.
3. Any disclosure of records concerning diagnosis and/or treatment of alcohol and/or drug abuse is covered by Title 42 CFR, and if there is any such information; I hereby authorize the release of information. This authorization also includes any information related to diagnosis and/or treatment of any psychiatric or mental illness or any state of infection with the HIV (AIDS) virus.
4. The Office of **The Grove Primary Care Clinic** is hereby released from any liability and the undersigned will hold **The Grove Primary Care Clinic** harmless for requesting or seeking my protected health information.
5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal will affect my ability to obtain treatment, receive payment, or eligibility for benefits.
6. The authorization will expire in ninety (90) days unless I provide an alternate date or event. This authorization will not apply to any dates of service that occur after the date this authorization is signed.
7. A facsimile of this authorization or a copy of this authorization shall be valid and binding with the same force as an original signature, and the person/organization releasing the information shall be entitled to rely on the same.

I have read and understood this authorization. I hereby authorize the release of the above-requested medical information about me to **The Grove Primary Care Clinic** from the facility named above.

Signature of Patient

Signature of Patient's Authorized Representative

Telephone Number Date ,20___

Description of Representative's Authority to Act for Patient

General Consent for Treatment

1. _____ consents to examination, care and treatment from the physicians and other healthcare professionals of The Grove Primary Care Clinic, LLC, including but not limited to tests deemed necessary, medical treatment and surgical procedures.

2. I am aware that the practice of medicine and surgery is not an exact science. I acknowledge that no guarantees have been made to me by the staff at The Grove Primary Care Clinic, LLC as to the results of diagnosis, examinations or treatments by the staff or facilities and healthcare providers they refer to me to.

3. I understand that medical information and records may be released to other institutions, agencies, healthcare organizations of healthcare providers, who accept me for medical or institutional care. I further understand that my medical information may be released to my insurer(s), managed care organization(s), governmental entities responsible for paying for my care, and/or pharmaceutical manufacturers, and their respective agents, for purposes including, but not limited to, payment, Utilization Review and Quality Assurance Review, and to support applications for patient assistance programs.

4. I hereby authorize The Grove Primary Care Clinic, LLC to contact me via phone, mail, and my given e-mail address with clinic results and with generalized clinic messages they deem reasonable to send me for management of my health and in answer to queries generated by me.

5. I hereby agree that a photocopied, digital or faxed copy or transmission of this authorization is as valid as the original.

6. I hereby assign all medical and/or surgical benefits, to which I am entitled, including Medicare, private insurance and any other health plans to The Grove Primary Care Clinic, LLC. This assignment is for services rendered to me by the medical providers and staff at The Grove Primary Care Clinic. This assignment will remain in effect until revoked by me in writing or revoked by a medical provider in writing. A photocopy/email of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize The Grove Primary Care Clinic, LLC to release all information necessary to secure this payment. I understand that failure to notify The Grove Primary Care Clinic, LLC of any changes or insurance coverage may result in the financial obligation to rest fully on me regardless of any contract between the insurance company and the medical providers and The Grove Primary Care Clinic, LLC.

_____

Signature of patient/Authorized Representative Date

_____

Signature of staff member Date

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Advance Directives

Advanced Directives:

Do you have a living will or durable power of attorney? _____ No _____ Yes

If you do have a durable power of attorney, please identify: _____

Would you like us to give you a packet of information regarding advance directives?

_____ No _____ Yes (Packet distributed)

_____ _____

Patient (or Guardian Signature) (Date)

_____ _____

Witness (Office staff is considered your witness) (Date)

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Release of Information

I,_____, give the office of The Grove Primary Care Clinic permission to release health information to (include the name and their relation to you):
Please list at least one other family member or friend

_____

_____

Other: _____

Employee Signature processing form: _____

Office of The Grove Primary Care Clinic use only:

(Employee note: explanation required here if other is marked above.)

_____

_____

Acknowledgment of Receipt of Notice of Privacy Practices

By signing this document, I acknowledge that a copy of the Medical Office of The Grove Primary Care Clinic Notice of Privacy Practices has been made available to me.

_____

Please print patient's name on above line

_____ _____/_____, 20__

Signature (if other than patient, your relation to the patient) Date

• Patient unable to sign/no family member available

• Patient refused to sign

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Pediatric Health History Form

Child's Name_____DOB_____Child's Previous Doctor_____

Allergies/Reactions to Medicine or Vaccines:_____

Current Medicines: _____

Has your child been seen by a Dentist? ☐No ☐Yes who? _____

Pregnancy & Birth:

Is the child yours by: ☐Birth ☐ Adoption ☐Stepchild ☐other:_____

Any problems with the pregnancy? ☐No ☐Yes (please specify) _____

Delivered by ☐vaginal birth ☐caesarian (please explain why):_____

Birth weight:_____Birth length: _____

Where was child born: (place,city,state) _____

Immunizations/exposures:

Are your child's immunizations up to date? No Yes *Please bring your child's shot record*.

Does your insurance cover immunizations? No Yes (if "no" your child may be eligible for free immunizations.)

Do any household members smoke? No Yes

Any concerns about lead exposure? (old home/plumbing) No Yes

Are there any concerns with Drug Exposure? No Yes (explain) _____

Past Medical History: Does your child have any of the following conditions? Please check all that apply:

- ☐ Asthma/hay fever/eczema
- ☐ Attention problems
- ☐ Anemia
- ☐ Broken bones
- ☐ Constipation
- ☐ Urinary Tract infections
- ☐ Frequent ear infections
- ☐ Pneumonia
- ☐ RSV
- ☐ Chicken Pox
- ☐ Obesity
- ☐ Croup

Past Surgical History: Has your child had any operations such as circumcision, hernia repair, or tonsillectomy? No Yes (please explain)

Family History: Please check any family history of the following and indicate who has/had the condition

(M = mother, F = father, B = bother, S = sister, G = grandparents, E = extend family)

	M	F	B	S	G	E
o Alcoholism/drug abuse						
o Heart disease or stroke						
o Cancer						
o Seizures						
o Inherited/genetic disease						
o Thyroid disease						
o Psychiatric disorders						
o Bleeding/clotting problems						
o Kidney disease						
o Asthma/hay fever/ eczema						
o Birth defects						
o Diabetes						

Social History: Please list the names of all people who live in the house with child

Name	Age	Relationship

The Child's Parents Are:
- ☐ Married
- ☐ Not Married, Living Together
- ☐ Separated
- ☐ Divorced

Father's Occupation: _____

Mother's Occupation: _____

Child care situation: ☐ lives with parents ☐ lives with others (please explain) _____

Is violence at home a concern? ☐No ☐Yes Are there guns at home? ☐No ☐Yes

Do you have any behavioral/developmental concerns? ☐No ☐Yes (explain) _____

Does your child attend preschool/school? ☐No ☐Yes Grade_____School _____

Any concerns about school performance? No ☐Yes (if yes, please explain) _____

_____