JACKSON HOSPITAL & CLINIC

Professional Pediatrics at The Jackson Clinic
Patient Registration Form

PLEASE PRINT

Name of Patient (First)_____ (Middle)_____ (Last)_____ Preferred Name_____

Date of Birth_____ Sex_____ Race_____ Child's Home Phone_____

Child's Home Address_____ City_____ State_____ Zip_____

Person Responsible for Paying & Address_____

Father's Name_____ SS#_____ Date of Birth_____

Home Phone_____ Cell Phone_____Email_____

Employer_____Work Phone_____

Mother's Name_____ SS#_____ Date of Birth_____

Home Phone_____ Cell Phone_____Email_____

Employer_____Work Phone_____

Parent's Marital Status (Circle One) Single Married Divorced Separated Widow Other_____

Do we see any other siblings? Yes No If yes, give full name_____

In case of emergency or unable to locate parents, please notify_____ Relationship to Child_____

Home Phone_____ Cell Phone_____ Work Phone_____

Who referred you to our office?_____

Does insurance apply to all siblings? Yes No If no, please explain_____

Primary Insuarance Company_____ Primary Insurance Holder_____

Contract/Member ID #_____ Group #_____ Date of Birth_____

Secondary Insuarance Company_____ Primary Insurance Holder_____

Contract/Member ID #_____ Group #_____ Date of Birth_____

In signing below you are authorizing us to file claims and assign benefits to our physicians from Aetna, Allkids, BlueCross-PMD-PPO-Sefect, Bluecard PPO, CIGNA, Multiplan/PHCS (Private Healthcare Systems), Tricare-Standard, Tricare-Reserve Select, United Healthcare, Viva Health, and CHAMP/ VA. I understand I am responsible for all co-pays, deductibles and non-covered charges by my insurance carriers. If your child does not have this type coverage you are expected to pay for your child's visit at the time of service in order to help keep the cost of health care down. Your insurance company will reimburse you directly. You will receive two copies of our itemized statement: one for insurance purposes and the other for your tax records. In the event of hospitalization, if we have record of your insurance carrier, we will automatically file the hospital charges incurred for our doctor treating your child. In case of default of payment and if this account is placed in the hands of a collector or any attorney for collection, all collection fees, attorney's fees, costs and all other expenses will be paid by the undersigned.

In signing below, you have read and understand our office policies and procedures and our NOTICE OF PRIVACY PRACTICES which tiave been provided for you. You also declare that THIS CHILD AND ANY OF YOUR OTHER CHILDREN are not covered by Medicaid and that you do not plan to apply for Medicaid for this child or any of your other children while patients of our practice.

I understand that the physicians of Professional Pediatrics, P.C. use blood and/or blood products when, in their judgement, is a medical necessity. I do hereby consent to the administration of blood and/or blood products when my attending physician deems they are necessary for the proper treatment of the patient. I realize I am responsible for accompanying my child or children while on the premises.

_____ _____

Patient/Guardian Signature Date

CLEAR FORM

Initial History Questionnaire

Form Completed By:	**Name:**		
Initial Date Completed:	ID Number:		
Date(s) Updated:	Birth Date:	Age:	Sex: M ○ F ○

GENERAL

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ Don't know Explain: _____

Does your child have any special health care needs? ☐ Yes ☐ No ☐ Don't know Explain: _____

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ Don't know Explain: _____

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ Don't know Explain: _____

SOCIAL HISTORY

Please list all those living in the child's home.

Name	Relationship to Child	Birth Date/Age

Please list other siblings not living in the home.

Name	Birth Date/Age	Where are they living?

Does the child live with both biological parents? ☐ Yes ☐ No

If no, what is the child's current living situation?

☐ Single-parent custody ☐ Joint custody ☐ Adoptive family

☐ Other family members: _____ ☐ Foster care

How often does the child have visitation with parent(s) not living in the home?

_____

BIRTH HISTORY

Birth weight: _____

☐ Full-term ☐ Preterm _____ weeks ☐ Post-term _____ weeks

Delivery: ☐ Vaginal ☐ Cesarean ☐ Reason: _____

Any complications during birth or after birth? ☐ No ☐ Yes

Explain: _____

Did the baby need to go to the NICU (neonatal intensive care unit)?

☐ No ☐ Yes Explain: _____

During pregnancy, did the mother:

Take prenatal vitamins?	☐ Yes	☐ No	☐ Unknown
Smoke or use e-cigarettes?	☐ Yes	☐ No	☐ Unknown
Drink alcohol?	☐ Yes	☐ No	☐ Unknown
Use marijuana?	☐ Yes	☐ No	☐ Unknown
Use illicit drugs?	☐ Yes	☐ No	☐ Unknown
Take other medications?	☐ Yes	☐ No	☐ Unknown

If yes, please list:

Blood type:

Mother: _____ ☐ Unknown

Baby: _____ ☐ Unknown

Mother's lab results:

Hepatitis B	☐ Pos	☐ Neg	☐ Unknown
HIV	☐ Pos	☐ Neg	☐ Unknown
Group B streptococcus (GBS)	☐ Pos	☐ Neg	☐ Unknown

After birth, did the baby get:

Vitamin K shot?	☐ Yes	☐ No	☐ Unknown
Erythromycin eye ointment?	☐ Yes	☐ No	☐ Unknown
Hepatitis B shot?	☐ Yes	☐ No	☐ Unknown

How was the baby fed? ☐ Bottle formula ☐ Bottle breast milk

☐ Breastfed How long was baby breastfed? _____

Did baby go home with biological mother from hospital after birth? ☐ Yes

☐ No Explain: _____

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®

HE0564

Name: _____

PAST MEDICAL HISTORY

Has your child ever had any of the following problems? DK = Don't know

Condition	DK	No	Yes	Details
Eye problems, cataracts, or retinoblastoma				
Vision impairment or concerns				
Nasal allergies (dust, pets, or environmental)				
Frequent ear infections				
Hearing loss or concerns				
Multiple cavities or problems with teeth				
Frequent colds or sore throats				
Asthma, wheezing, or breathing problems				
Bronchitis, bronchiolitis, or pneumonia				
Heart murmur or other heart problems				
High blood pressure				
Frequent stomach pain				
Constipation needing medical treatment				
Food allergies or intolerance (eg, milk, gluten)				
Feeding issues or underweight				
Overweight or obesity				
Urinary tract infections				
Bed-wetting (after 5 years old)				
Kidney, ureter, or bladder problems				
Serious injuries or fractures				
Bone, joint, or muscle problems				
Frequent headaches or dizziness				
Concussion or head injury				
Convulsions, seizures, or neurological issues				
Sleep problems or snoring				
Skin rashes, eczema, or hives				
Acne				
Thyroid or other endocrine problems				
Diabetes				
Metabolic/genetic disorders				
Anemia or bleeding problems				
Cancer or chemotherapy				
Bone marrow or organ transplant				

Name: _____

PAST MEDICAL HISTORY (*continued*)

Has your child ever had any of the following problems? DK = Don't know

Condition	DK	No	Yes	Details
Blood transfusion				
HIV or AIDS				
Chickenpox or zoster (shingles)				
Developmental delays (speech or motor)				
School problems or learning difficulties				
ADHD or behavioral concerns				
Anxiety, depression, or mood problems				
Tobacco, alcohol, or drug use				
Exposure to family violence				
Pregnancy or miscarriage				
Sexually transmitted infections				
Females: issues with periods				
Age of first period:				

Other medical problems (Please list.)

SURGICAL HISTORY

Has your child ever had surgery? ☐ No ☐ Yes If yes, please provide details below.

Surgery/Procedure	Date of Surgery/Child's Age	Where Completed	Details

Other surgical/procedural problems (Please list.)

Initial History Questionnaire

Name: _____

FAMILY HISTORY

Have any of your child's parents, grandparents, aunts, uncles, brothers, or sisters ever had any of the following conditions? DK = Don't know

Condition	DK	No	Yes	Who?	Details
Anemia or bleeding problems					
Asthma					
Allergies					
Alcohol use problems					
Bed-wetting (after age 10 years)					
Cancer (before age 55 years)					
Childhood hearing loss					
Dental decay or multiple cavities					
Depression or anxiety					
Developmental disability					
Diabetes					
Heart attack (myocardial infarction)					
Heart disease (before age 55 years)					
High blood pressure					
High cholesterol					
HIV or AIDS					
Kidney disease					
Liver disease					
Mental health conditions					
Obesity					
Seizures or epilepsy					
Stroke					
Substance use problems					
Sudden death (before age 50 years)					
Thyroid or other endocrine disease					
Tobacco use problems					
Tuberculosis					
Vision or eye problems					

Other medical problems (Please list.)

PRINT NAME.	SIGNATURE
Provider 1	
Provider 2	

Consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 4th Edition

THE JACKSON CLINIC

JACKSON HOSPITAL & CLINIC

RELEASE OF INFORMATION, BENEFIT ASSIGNMENT, PAYMENT AUTHORIZATION, FULL DISCLOSURE AND AGREEMENT TO PAY FOR PROFESSIONAL SERVICES.

I hereby authorize Jackson Clinic to release any information necessary to process any insurance claim acquired in the course of my examination or treatment, to allow a photocopy of my signature to be used to process my insurance claim. I claim, direct, and authorize my carrier to issue payment check(s) directly to Jackson Clinic for any insurance benefits to which I am entitled. I understand that failure to disclose pre-certification/second opinion requirements for any and all plans to which I subscribe may cause me to incur full liability for professional charges as a result of non-payment by my carrier. I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary. I waive, now and forever, my right of exemption under the laws of the constitution of the State of Alabama and any other state. I understand that my insurance is filed as a courtesy, and I am responsible for the bill. I understand that I am responsible for paying any deductible, co-insurance, co-payment, or service deemed non-covered/patient responsibility, by my insurance carrier.

Date:_____ **Signature of Patient or Guarantor:**_____

EXPRESS PRIOR CONSENT TO CONTACT CONSUMER BY CELL PHONE

You agree, in order for us to service your account or to collect monies you may owe, Jackson Clinic, and/or our agents may contact you by telephone, at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages, and/or use of automatic dialing devices, as applicable.

I/we have read this disclosure and agree that Jackson Clinic, it's employees and/or agents may contact me as described above.

Responsible Party:_____ **Date:**_____

ACKNOWLEDGEMENT OF NOTICE OF HIPAA

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are described in the Notice of Privacy Practices. The Notice of Privacy Practices may be revised at any time. WE WILL PROVIDE YOU WITH A CURRENT COPY UPON YOUR REQUEST.

By signing below, you are acknowledging that you have read or received a copy of the HIPAA policy. **Patient**

Name: _____ **Date:** _____

Signature: _____ **Date:** _____

If state authorized to act on behalf of patient please sign below:

Name:_____ Signature:_____

Practice Use Only:

I, _____ attempted to obtain the acknowledgement of receipt of the HIPAA policy, but was unable to do so for the following reason: _____

Signature:_____ Date:_____

JACKSON HOSPITAL & CLINIC

Professional Pediatrics at The Jackson Clinic
Authorization for Release of Medical Record Information

PLEASE PRINT

Name of Patient (First)_____ (Middle)_____ (Last)_____

Date of Birth_____ Social Security Number_____

Home Address_____ City_____ State_____ Zip_____

I hereby authorize_____to release information from the medical record of

_____ to Professional Pediatrics at The Jackson Clinic, 4154 Carmichael Road, Montgomery, AL 36106

(Phone: 334-271-5959/Fax: 334-272-8775) for the purpose of _____.

(See below if patient is requesting his/her own information)

The authorization is subject to the limitations checked below:

1. Confined to records concerning treatment for the following medical condition or injury:

(Describe injury/illness)_____

2. Covering records for the period from: (Date) _____/_____/_____ to (Date)_____/_____/_____

3. Confined to the following specific information (check all those that apply):

☐ Face Sheet	☐ Discharge Summary	☐ X-Ray Reports
☐ Consultation	☐ Lab Reports	☐ EKG
☐ Operative Reports	☐ Pathology Reports	☐ Progress Notes
☐ Nurse Notes	☐ Medications	☐ Other_____
☐ EEG	☐ History & Physical	_____

Disclosure Requiring Special Consent: My signature below specifically authorizes the release of healthcare information relating to the testing, diagnosis, or treatment for:

- ☐ HIV/AIDS Virus
- ☐ Sexually Transmitted Disease
- ☐ Mental Health/Psychiatric Disorders
- ☐ Drug/Alcohol Abuse

Patient Signature_____ Date_____

If patient is unable to sign, please indicate such and the authority to act of the person who is signing for the patient.

Signature_____ Date_____ Witness_____

This authorization shall expire on_____or 90 days from the date of the signature . It is subject to revocation by the patient on any time by writing to Professional Pediatrics, 4154 Carmichael Road, Montgomery.,AL 36106, except to the extent that action has been taken in reliance thereon. If treatment is rendered for HIV, AIDS, Hepatitis, Psychiatric and/or alcohol/drug abuse this release will be restricted to a one (1) time release of information only. An updated Release of Information will be required for any subsequent release of information . Please be aware that once we disclose this information per your instructions , the information is subject to re-disclosure an may no longer be protected by HIPAA.

Facility Use Only

Date Received _____/_____/_____ Date Information Released _____/_____/_____

Person Sending Information_____ Dept_____