PATIENT REGISTRATION FORM

☐ NEW PATIENT – NEW FAMILY ☐ NEW PATIENT – ESTABLISHED FAMILY ☐ FOSTER CHILD

☐ DR. JOHN CLARK ☐ DR. ZULMA LARACUENTE

PATIENT INFORMATION

PATIENT'S FULL LEGAL NAME (LAST, FIRST, MIDDLE)			PREFERRED NAME
SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER	PATIENT LIVES WITH ☐ MOTHER ☐ FATHER ☐ BOTH ☐ OTHER _____

PARENT/GUARDIAN INFORMATION

PRIMARY PARENT / GUARDIAN'S NAME (LAST, FIRST, MIDDLE)		RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER	
MAILING ADDRESS			CITY		STATE	ZIP
HOME PHONE	CELL PHONE	WORK PHONE	EMPLOYER			
SECONDARY PARENT / GUARDIAN'S NAME (LAST, FIRST, MIDDLE)		RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER	
MAILING ADDRESS			CITY		STATE	ZIP
HOME PHONE	CELL PHONE	WORK PHONE	EMPLOYER			

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME	POLICY EFFECTIVE DATE	POLICY NUMBER	GROUP NUMBER
SUBSCRIBER'S NAME (LAST, FIRST, MIDDLE)	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER
RELATIONSHIP TO PATIENT	EMPLOYER		
SECONDARY INSURANCE COMPANY NAME	POLICY EFFECTIVE DATE	POLICY NUMBER	GROUP NUMBER
SUBSCRIBER'S NAME (LAST, FIRST, MIDDLE)	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER
RELATIONSHIP TO PATIENT	EMPLOYER		

OTHER CHILDREN IN FAMILY

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	IS THIS CHILD A PATIENT OF PREMIER PEDIATRICS? ☐ YES, CURRENT PATIENT ☐ YES, FORMER PATIENT ☐ NO
NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	IS THIS CHILD A PATIENT OF PREMIER PEDIATRICS? ☐ YES, CURRENT PATIENT ☐ YES, FORMER PATIENT ☐ NO
NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	IS THIS CHILD A PATIENT OF PREMIER PEDIATRICS? ☐ YES, CURRENT PATIENT ☐ YES, FORMER PATIENT ☐ NO

ASSIGNMENT OF BENEFITS AND AUTHORIZATION FOR INFORMATION RELEASE

- I hereby assign and authorize payment of insurance benefits otherwise payable directly to Premier Pediatrics for my child's office and/or hospital services which are not paid by me at the time of service.
- I hereby authorize Premier Pediatrics to provide treatment for my child and to release any and all information pertaining to office and/or hospital services rendered to him/her by said practice, including any previous diagnosis and treatment rendered to him/her by physicians, hospitals, and/or other medical facilities/personnel.
- I understand that Premier Pediatrics will not file Medicaid as a secondary insurance for any office services rendered to my child; if my primary insurance does not pay in full for the charges incurred, it is my responsibility to pay the remaining balance.
- I understand that I am ultimately responsible for payment of any and all charges for treatment rendered to my child, and if this assigned claim is rejected, modified, or not paid within a reasonable amount of time after it has been filed, it will be my responsibility to pay any unpaid charges in full.

_____ Parent / Guardian Signature

_____ Date

INITIAL HISTORY QUESTIONNAIRE

PATIENT'S NAME	SEX	DATE OF BIRTH
FORM COMPLETED BY	**RELATIONSHIP TO PATIENT**	**DATE COMPLETED**

HOUSEHOLD

Please list all of those living in child's home

NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT	HEALTH PROBLEMS

Please list all siblings not living in child's home

NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT	HEALTH PROBLEMS

If child does not live with both biological parents, what is the living situation? ☐ Joint custody ☐ Single custody ☐ Lives with adoptive parents ☐ Lives with foster family

BIRTH HISTORY

Were there any prenatal or neonatal complications? ☐ Yes ☐ No
If yes, explain _____

Did mother have any illnesses during pregnancy? ☐ Yes ☐ No
If yes, explain _____

During pregnancy, did mother Use tobacco? ☐ Yes ☐ No Drink alcohol? ☐ Yes ☐ No Use medications or drugs? ☐ Yes ☐ No
If yes, list date and what was used _____

Baby was born ☐ Term ☐ Late ☐ Early _____weeks Birth Weight _____lbs _____oz Delivery was ☐ Vaginal ☐ Cesarean

Was a NICU stay required? ☐ Yes ☐ No If yes, why? _____ If cesarean, why? _____

Initial feeding ☐ Bottle ☐ Breast Did baby go home with mother from hospital? ☐ Yes ☐ No If no, why? _____

GENERAL

Do you consider your child to be in good health? ☐ Yes ☐ No If no, why? _____

Is your child currently taking any medications? ☐ Yes ☐ No Medication/dosage _____

Is your child allergic to any medications or foods? ☐ Yes ☐ No If yes, list all _____

HOSPITILIZATION	DATE	SURGERY	DATE	SERIOUS ILLNESS	DATE	SERIOUS INJURY	DATE

DEVELOPMENT AND BEHAVIOR

Are you concerned about your child's physical development? ☐ Yes ☐ No If yes, why? _____

Are you concerned about your child's mental/emotional development? ☐ Yes ☐ No If yes, why? _____

Are you concerned about your child's attention span? ☐ Yes ☐ No If yes, why? _____

IF YOUR CHILD IS IN SCHOOL

How is his/her behavior in school? _____

Has he/she failed or repeated a grade? _____

How is he/she doing in academic subjects? _____

Is he/she in special or resource classes? _____

INITIAL HISTORY QUESTIONNAIRE (continued)

FAMILY HISTORY

Do any family members have a history of

Anemia	☐ Yes ☐ No	Who _____	Explain _____
Asthma	☐ Yes ☐ No	Who _____	Explain _____
Bedwetting (after age 10)	☐ Yes ☐ No	Who _____	Explain _____
Bleeding disorder	☐ Yes ☐ No	Who _____	Explain _____
Cancer (before age 50)	☐ Yes ☐ No	Who _____	Explain _____
Deafness	☐ Yes ☐ No	Who _____	Explain _____
Developmental disability	☐ Yes ☐ No	Who _____	Explain _____
Diabetes (before age 50)	☐ Yes ☐ No	Who _____	Explain _____
Epilepsy or convulsions	☐ Yes ☐ No	Who _____	Explain _____
Heart disease (before age 50)	☐ Yes ☐ No	Who _____	Explain _____
High blood pressure (before age 50)	☐ Yes ☐ No	Who _____	Explain _____
High cholesterol	☐ Yes ☐ No	Who _____	Explain _____
Immune problems, HIV, or AIDS	☐ Yes ☐ No	Who _____	Explain _____
Kidney disease	☐ Yes ☐ No	Who _____	Explain _____
Liver disease	☐ Yes ☐ No	Who _____	Explain _____
Mental illness	☐ Yes ☐ No	Who _____	Explain _____
Nasal allergies	☐ Yes ☐ No	Who _____	Explain _____
Tuberculosis	☐ Yes ☐ No	Who _____	Explain _____
Alcohol abuse	☐ Yes ☐ No	Who _____	Explain _____
Drug abuse	☐ Yes ☐ No	Who _____	Explain _____

Additional family history _____

PAST HISTORY

Has your child ever had

Chickenpox	☐ Yes ☐ No	Explain _____
Frequent ear infections	☐ Yes ☐ No	Explain _____
Problems with ears or hearing	☐ Yes ☐ No	Explain _____
Nasal allergies	☐ Yes ☐ No	Explain _____
Problems with eyes or vision	☐ Yes ☐ No	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes ☐ No	Explain _____
Any heart problem or heart murmur	☐ Yes ☐ No	Explain _____
Anemia or bleeding problem	☐ Yes ☐ No	Explain _____
Blood transfusion	☐ Yes ☐ No	Explain _____
Frequent abdominal pain	☐ Yes ☐ No	Explain _____
Constipation requiring doctor visits	☐ Yes ☐ No	Explain _____
Bladder or kidney infections	☐ Yes ☐ No	Explain _____
Bedwetting (after age 5)	☐ Yes ☐ No	Explain _____
Chronic or recurrent skin problems (e.g. acne, eczema)	☐ Yes ☐ No	Explain _____
Frequent headaches	☐ Yes ☐ No	Explain _____
Convulsions or other neurologic problems	☐ Yes ☐ No	Explain _____
Thyroid or other endocrine problems	☐ Yes ☐ No	Explain _____
Diabetes	☐ Yes ☐ No	Explain _____
Developmental delay	☐ Yes ☐ No	Explain _____
ADD/ADHD, anxiety, mood problems, or depression	☐ Yes ☐ No	Explain _____
Use of alcohol or drugs	☐ Yes ☐ No	Explain _____
(For girls) Has had first menstrual period	☐ Yes ☐ No	Age at first menstrual period _____
(For girls) Problems with menstrual periods	☐ Yes ☐ No	Explain _____

Any other significant problems _____

VACCINATION POLICY & ACKNOWLEDGEMENT

Patient's Name _____ DOB _____

- Premier Pediatrics believes in the effectiveness of vaccines to prevent serious illness and to save lives.
- Premier Pediatrics firmly believes in the safety of our vaccines.
- Premier Pediatrics firmly believes that all children and young adults should receive all of the recommended vaccines according to the schedule published by the Centers for Disease Control and Prevention and the American Academy of Pediatrics.
- Premier Pediatrics firmly believes, based on all available literature, evidence, and current studies, that vaccines do not cause autism or other developmental disabilities. We firmly believe that thimerosal, a preservative that has been in vaccines for decades and remains in some vaccines, does not cause autism or other developmental disabilities.
- Premier Pediatrics firmly believes that vaccinating children and young adults may be the single most important health-promoting intervention we perform as health care providers, and that you can perform as parents/caregivers. The recommended vaccines and their schedule given are the results of years of scientific study and data gathering on millions of children by thousands of our brightest scientists and physicians.

These things being said, we recognize that there has always been and will likely always be controversy surrounding vaccination. Indeed, Benjamin Franklin, persuaded by his brother, was opposed to smallpox vaccine until scientific data convinced him otherwise. Tragically, he had delayed inoculating his favorite son Franky, who contracted smallpox and died at the age of four, leaving Ben with a lifetime of guilt and remorse. Quoting Mr. Franklin's autobiography:

"In 1736, I lost one of my sons, a fine boy of four years old, by the smallpox…I long regretted bitterly, and still regret that I had not given it to him by inoculation. This I mention for the sake of parents who omit that operation, on the supposition that they should never forgive themselves if a child died under it, my example showing that regret may be the same either way, and that, therefore, the safer should be chosen."

The vaccine campaign is truly a victim of its own success. It is precisely because vaccines are so effective at preventing illness that we are even discussing whether or not they should be given. Because of vaccines, many of you have never seen a child with polio, tetanus, whooping cough, bacterial meningitis, or even chickenpox, or known a friend or family member whose child died of one of these diseases. Such success can make us complacent or even lazy about vaccinating. But such an attitude, if it becomes widespread, can only lead to tragic results.

Over the past several years, many people in Europe have chosen not to vaccinate their children with MMR vaccine after publication of an unfounded suspicion (later retracted), that the vaccine caused autism. As a result of underimmunization, there have been small outbreaks of measles and several deaths from complications of measles in Europe over the past several years.

Furthermore, by not vaccinating your child you are taking selfish advantage of thousands of others who do vaccinate their children, which decreases the likelihood that your child will contract one of these diseases. We feel such an attitude to be self-centered and unacceptable.

We are making you aware of these facts not to scare you or coerce you, but to emphasize the importance of vaccinating your child. We recognize that the choice may be a very emotional one for some parents. We will do everything we can to convince you that vaccinating according to the schedule is the right thing to do. However, **should you have doubts, please discuss these with your health care provider in advance of your visit.** In some cases, we alter the schedule to accommodate parental concerns or reservations. **Please be advised, however, that delaying or "breaking up the vaccines" to give one or two at a time over two or more visits goes against expert recommendations, and can put your child at risk for serious illness (or even death) and goes against our medical advice as providers at Premier Pediatrics.** Such additional visits will require additional co pays on your part. Furthermore, please realize that you will be required to sign a "Refusal to Vaccinate" acknowledgement in the event of lengthy delays.

Finally, if you should absolutely refuse to vaccinate your child despite all of our efforts, we will ask you to find another health care provider who shares your views. We do not keep a list of such providers, nor would we recommend any such physician. Please recognize that by not vaccinating you are putting your child at unnecessary risk for life-threatening illness and disability, and even death.

As medical professionals, we feel very strongly that vaccinating children on schedule with currently available vaccines is absolutely the right thing to do for all children and young adults. Thank you for your time in reading this policy, and please feel free to discuss any questions or concerns you may have about vaccines with any one of us.

I have been informed of Premier Pediatrics vaccination policy and understand that if I do not comply to the above policy, my child will be discharged from Premier Pediatrics and will no longer receive medical care from any of the providers.

Parent/Guardian Signature	Printed Name	Date

VACCINATION SCHEDULE POLICY & ACKNOWLEDGEMENT

Patient's Name _____ DOB _____

Premier Pediatrics maintains the highest standards regarding vaccinations in children in accordance with the AAP, CDC, and ACIP. In order to continue with providing the highest standards to children of all ages, Premier Pediatrics requires that each child complete the required primary series by his/her first birthday. These vaccines include:

- **Hep. B—3 Doses**
- **Dtap—3 Doses**
- **Hib—3 Doses**
- **Prevnar (pcv7)—3 Doses**
- **IPV—3 Doses**

In addition, I further agree to have my child receive the MMR and Varicella vaccine by age 2.

I have been informed of the immunization schedules published by the CDC and understand that if the above recommendations are not met, my child will be discharged from Premier Pediatrics and will no longer receive medical care from any of the providers.

Parent/Guardian Signature	Printed Name	Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Patient's Name _____ DOB _____

I, _____, being the parent/guardian of the above named patient acknowledge that I was provided with a copy of Premier Pediatrics' Notice of Privacy Practices.

_____ _____ _____

Signature of Parent/Guardian | Printed Name | Date

I, _____, being the parent/guardian of the above name patient hereby authorize the following people are allowed to accompany my child to his/her healthcare visits and authorize them to be his/her healthcare management.

_____ _____

Authorized Chaperone's Name | Relationship to Patient

_____ _____

Authorized Chaperone's Name | Relationship to Patient

_____ _____

Authorized Chaperone's Name | Relationship to Patient

_____ _____

Authorized Chaperone's Name | Relationship to Patient

_____ _____ _____

Signature of Parent/Guardian | Printed Name | Date

JOHN L. CLARK, MD
ZULMA LARACUENTE, MD

Jane Ann Bush, APRN, CPNP
Amanda Cole, APRN, CPNP
Rachel Milligan, APRN, CPNP

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patient's Name _____ Date of Birth _____

MEDICAL INFORMATION TO BE RELEASED BY

_____
Practice/Provider Name

_____ _____
Office Number Fax Number

I authorize the release of the following medical information

☐ Complete Medical Record ☐ Diagnostic Imagining ☐ Laboratory/Pathology Reports ☐ Hospital Records
☐ Immunizations ☐ Medical History, Consultation/Evaluation Records ☐ Other _____

Reason for request

☐ Changing Physicians ☐ Personal ☐ Continuing Medical Care ☐ Other (Specify) _____

MEDICAL INFORMATION TO BE RELEASED TO

Premier Pediatrics
Attention: Medical Records
P.O. Box 12610
Alexandria, Louisiana 71315

I hereby consent to the release of the specified information relating to diagnosis, testing, or treatment to the person or entity named above. I understand that such information cannot be released without my informed consent. I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree to and authorize the release of patient health information to the above named organization. I understand that I have the right to revoke or cancel this authorization, in writing, at any time. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits).

_____ _____
Patient or Representative's Signature Printed Name

_____ _____
Relationship to Patient Date