Patient Registration

Patient _____ Sex: ❑ M ❑ F DoB___/___/___ SS#_____

Language _____ Race _____ Ethnicity: ❑ Not Hispanic ❑ Hispanic ❑ Latin

Patient/Sibling _____ Sex: ❑ M ❑ F DoB___/___/___ SS#_____

Language _____ Race _____ Ethnicity: ❑ Not Hispanic ❑ Hispanic ❑ Latin

Patient/Sibling _____ Sex: ❑ M ❑ F DoB___/___/___ SS#_____

Language _____ Race _____ Ethnicity: ❑ Not Hispanic ❑ Hispanic ❑ Latin

Patient/Sibling _____ Sex: ❑ M ❑ F DoB___/___/___ SS#_____

Language _____ Race _____ Ethnicity: ❑ Not Hispanic ❑ Hispanic ❑ Latin

Mother/Guardian _____ DoB___/___/___ SS#_____

Address _____ Home Phone _____

Email _____

City/State/Zip _____ Work Phone _____

Employer _____ Occupation _____

Father/Guardian _____ DoB___/___/___ SS#_____

Address _____ Home Phone _____

Email _____

City/State/Zip _____ Work Phone _____

Employer _____ Occupation _____

Children live with: ❑ Mother ❑ Father ❑ Guardian _____

Emergency Contact:

Someone that does not live in home: _____ Relation _____ Phone _____

What Pharmacy do you use/Location: *(Kroger on Madison)* _____

INSURANCE INFORMATION

Primary_____ Policy #_____ Insured Name _____

Secondary_____ Policy #_____ Insured Name _____

AUTHORIZATION OF TREATMENT AND ASSIGNMENT OF BENEFIT

I authorize Rainbow Kids Clinic to treat my child. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to Rainbow Kids Clinic 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. Medical care of immunizations cannot be given unless my child is accompanied by one of the following:_____

I understand that if my child's physician, or any person employed by or under the direction and control of my child's physician(s), is directly exposed to my child's body fluids in any manner which may, according to the then current guidelines for the Center for Disease Control, transmit the the human immunodeficiency virus (HIV) or hepatitis B or C virus, that I am deemed by law to have consented to testing for infection with HIV or Hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to the release of these test results to the person who is exposed to my child's body fluids.

Parent/Guardian's signature _____ Relation _____ Date_____

OVER

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

Rainbow Kids Clinic
111 Otis Smith Drive
Clarksville, TN 37043
931-553-6666
Fax 931-553-4006

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do not agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date	Initials	Reason

RAINBOW KIDS CLINIC OFFICE POLICIES

APPOINTMENTS
Due to HIPPA requirements we are required to have each patient accompanied by a parent or legal guardian unless the parent has listed any other individual on initial paperwork. If your child is accompanied by a listed person from paperwork he or she must present picture ID.

- Scheduling: You can schedule appointments by calling our office or submitting a request on our website along with the date and time that works best for you. However, online scheduling is only for Well checks. Urgent appointments we ask that you please call our office directly.

- Rescheduling and Cancellations: In order to reschedule or cancel an appointment, please do so at least 24 hours before appointment time for well exams/physicals, ADHD and follow up appointments. We want to give all patients an opportunity to make an appointment if needed. If you are more that **10 minutes** late for an appointment it may have to be rescheduled (exceptions may be made for sick children on a case by case basis).

- No Shows: If you fail to show for an appointment that has been scheduled, it is considered a NO SHOW. Our office does not tolerate NO SHOW'S, we have the right to terminate you from our office.

- Well Checkups and Physical: All patients scheduled for a physical/well checkup should have a parent or legal guardian accompany the child so that the doctor or nurse practitioner can give your child the best possible care. We can only see **two siblings** at one given appointment time a day for well checkups/physicals.

VACCINATIONS
The providers at Rainbow Kids Clinic believe in the safety and efficacy of all routine vaccinations. We require full participation in obtaining required vaccinations on schedule. By signing below you agree to discuss your questions or concerns with a provider today if you have any hesitations regarding vaccinations. Exceptions will be made on a case by case basis ONLY for existing families. **A parent or legal guardian must be present to sign for vaccinations before they can be given.**

PATIENTS IN WAITING ROOM AND EXAM ROOMS
Parents must watch their children in the waiting area. Please do not allow children to run or climb on the furniture. Children cannot be left alone in the waiting area or exam rooms. Children over the age of 13 can be seen in exam room without a parent **IF** they can answer history questions and relay information, but we ask that a parent be available in the lobby or by phone. Children must also be kept off the rolling stool in the exam rooms. Children are not to be left unattended on the exam tables. Due to HIPAA requirements, we cannot allow parent and patients to walk outside the exam rooms prior to the doctor or nurse practitioner entering the room. Please remain in the exam room with the door closed until the doctor or nurse practitioner has completed the examination of your child.

REQUESTS FOR PRESCTIPTION REFILLS OR FORMS
Requests for refills, forms for school, daycare or WIC can be submitted by telephone or on our website. **Please allow 24-48 hours to complete.**

MESSAGES FOR YOUR PCP
Messages can be submitted on our website of by calling our office directly. All telephone calls or messages of non-emergency will be answered by the end of the business day. If the matter is urgent PLEASE CALL OUR OFFICE IMMEDIATELY!

By signing these policy statements, I acknowledge that I have read all policies and practices of Rainbow Kids Clinic and agree to follow according to above policies.

Signature:_____ Date:_____

AUTHORIZATION TO OBTAIN OF RELEASE
PROTECTED HEALTH INFORMATION

Rainbow Kids Clinic
111 Otis Smith Drive
Clarksville, TN 37043
Phone 931-553-6666
Fax 931-553-4006

I, _____ hereby authorize **Rainbow Kids Clinic** to:

[] Release Copies [] All Records

[] Obtain Records [] Immunization Records

[] Other _____

of Protected Health Information of: _____
Patient

Patient's DOB _____

From _____

Address _____

City _____ State_____ Zip_____

or

Send Records to _____

Address _____

City _____ State _____ Zip _____

_____ _____
Patient/Parent/or Legal Guardian Signature Date of Authorization

NEWBORN QUESTIONNAIRE

NAME OF CHILD	DATE OF BIRTH

WHICH HOSPITAL WAS THE CHILD BORN?

PREGNANCY

DID YOU HAVE ANY OF THE FOLLOWING PROBLEMS DURING PREGNANCY?

❒ DIABETES ❒ HIGH BLOOD PRESSURE ❒ PRE-ECLAMPSIA ❒ PREMATURE ONSET OF LABOR

❒ OTHER MEDICAL PROBLEMS *(Specify)* _____

_____

DID YOU RECEIVE ANY MEDICATIONS DURING PREGNANCY OTHER THAN PRENATAL VITAMINS?

❒ NO ❒ YES *(Specify)* _____

_____

BIRTH

DELIVERY: ❒ VAGINAL ❒ C-SECTION

COMPLICATIONS? ❒ NO ❒ YES *(Explain)* _____

_____

WAS YOUR BABY JAUNDICED BEFORE LEAVING THE HOSPITAL?

❒ NO ❒ YES *(Explain)* _____

DID YOUR BABY HAVE ANY OTHER COMPLICATIONS?

❒ NO ❒ YES *(Explain)* _____

_____

_____

_____

BIRTH WEIGHT	DAYS BABY STAYED IN NURSERY

IF CHILD IS A BOY, WAS HE CIRCUMCISED? ❒ YES ❒ NO ❒ N/A

DO YOU KNOW HOW MUCH HE/SHE WEIGHED ON DAY OF DISCHARGE FROM HOSPITAL?

❒ NO ❒ YES _____ *(Weight)*

HOW IS YOUR BABY BEING FED? ❒ BREAST ❒ FORMULA

IF FORMULA, WHAT FORMULA?

HOW MUCH?	HOW OFTEN?

APPROXIMATELY HOW MANY TIMES A DAY IS YOUR BABY HAVING BOWEL MOVEMENTS?

PATIENT'S NAME: _____ DATE: _____

SOCIAL HISTORY

HISTORY	*MOM*	*DAD*
Age:		
Health Problems:		
Employment:		
Smoking Cigarettes:		
Alcohol:		
Travel History:		
Children from previous relation(s):		

Are parents married? ❒ Yes ❒ No

OTHER HOUSEHOLD MEMBERS

Give names and ages of siblings and others who live in household with child:

Name	Age	Name	Age

HOUSEHOLD/PETS/ANIMALS

Type of house? ❒ Private ❒ Apartment ❒ Condo | Type of heating in house? ❒ Electric ❒ Gas ❒ Wood

Pets/Animals? ❒ Yes ❒ No Kind? _____ ❒ Inside house ❒ Outside house

SCHOOL/DAYCARE *(if applicable)*

Name of School/Daycare child attends:

Grade: | Teacher:

FAMILY HISTORY		INDICATE WHO
Asthma	❒ Yes ❒ No	
Allergies	❒ Yes ❒ No	
Heart Murmur	❒ Yes ❒ No	
Irregular Heartbeat	❒ Yes ❒ No	
Cystic Fibrosis	❒ Yes ❒ No	
Heart Attack *(age less than 50)*	❒ Yes ❒ No	
High Cholesterol	❒ Yes ❒ No	
Cancer	❒ Yes ❒ No	
Anyone in family being treated for cancer now	❒ Yes ❒ No	
Epilepsy	❒ Yes ❒ No	
Cerebral Palsy	❒ Yes ❒ No	
Mental Retardation	❒ Yes ❒ No	
Short Sightedness	❒ Yes ❒ No	
GU Reflux *(kidney reflux)*	❒ Yes ❒ No	
Diabetes in children	❒ Yes ❒ No	
Sickle Cell Disease	❒ Yes ❒ No	
Bleeding Disorders	❒ Yes ❒ No	
Migraines	❒ Yes ❒ No	
Crohns/IBD	❒ Yes ❒ No	
Lazy Eye	❒ Yes ❒ No	
Other:	❒ Yes ❒ No	

PATIENT'S NAME: _____ DATE: _____

SOCIAL HISTORY

1) Who lives in household with your child?

- □ Biological mom
- □ Biological dad
- □ Step mom
- □ Step dad
- □ Grandmother
- □ Grandfather
- □ Siblings, How many? _____
- □ Others: _____

2) Does anyone in the household smoke? □No □Yes; If yes, where? □Inside home □Outside home □Vehicle

3) Do you have any pets? □No □Yes, What type(s)? _____

Where do pets stay? □Inside home □Outside home

4) What type of home do you live in? □ Private □ Apartment □ Condo

5) What type of heating is used in your home? □ Electric □ Gas □ Wood

6) Does your child attend school/daycare? □ No □Yes, Name: _____

FAMILY HISTORY

	Biological Mother	Biological Father	Siblings	Grandparents	Other
ADHD					
Anemia					
Asthma					
Autism / Asperger's					
Bipolar Disorders					
Bleeding Disorders					
Cancer (if yes, what type?)					
Celiac Disease					
Crohn's / Ulcerative Colitis / IBS					
Cystic Fibrosis					
Diabetes					
Eczema					
Hearing Loss					
Heart Attack / Stroke before age 55					
Hepatitis					
High Cholesterol					
High Blood Pressure					
Irregular Heart Beats					
Kidney Reflux					
Kidney Stones					
Lupus					
Mental Retardation					
Migraine					
Neurofibromatosis					
Obesity					
PTSD					
Schizophrenia					
Seizure / Epilepsy					
Sickle Cell Anemia / Trait					
Sleep Apnea					
TB					
Thyroid Problem					
Other genetic disorders (If yes, what?)					