the GROVE Primary Care Clinic, LLC.

PEDIATRIC NEW PATIENT FORMS

PATIENT INFORMATION

LAST NAME:	FIRST NAME: MI:	PREVIOUS NAME (IF APPLICABLE):

MAILING ADDRESS:

CITY / STATE / ZIP:

HOME PH:	CELL PH:	WORK PH:

DATE OF BIRTH:	SEX: ⌋ MALE FEMALE	SOCIAL SECURITY #:	MARITAL STATUS:

EMERGENCY CONTACT NAME:	EMERGENCY CONTACT #:	RELATIONSHIP TO PATIENT:

PHYSICAL ADDRESS (IF DIFFERENT FROM MAILING):

EMAIL ADDRESS:

CAN WE LEAVE MESSAGES REGARDING YOUR MEDICAL CARE/RESULTS? YES NO

RACE (PLEASE FILL OUT ALL SECTIONS BELOW)

⌋ WHITE AMERICAN INDIAN OR ALASKA NATIVE ASIAN
⌋ HISPANIC BLACK OR AFRICAN AMERICAN OTHER
⌋ NATIVE HAWAIIAN OR PACIFIC ISLANDER DECLINE

ETHNICITY (PLEASE SELECT ONE):

⌋ HISPANIC
⌋ NOT HISPANIC OR LATINO
⌋ DECLINE

PREFERRED LANGUAGE (PLEASE SELECT ONE):

⌋ ENGLISH SPANISH OTHER ____________________________

PREFERRED PHARMACY NAME AND LOCATION:

INSURANCE INFORMATION- please provide a copy of your card

PRIMARY MEDICAL INSURANCE	SECONDARY MEDICAL INSURANCE
INSURANCE COMPANY NAME:	INSURANCE COMPANY NAME:
POLICY HOLDER NAME:	POLICY HOLDER NAME:
POLICY HOLDER DOB:	POLICY HOLDER DOB:
GROUP/POLICY NUMBER AND SUBSCRIBER ID:	GROUP/POLICY NUMBER AND SUBSCRIBER ID:
RELATIONSHIP TO POLICY HOLDER:	RELATIONSHIP TO POLICY HOLDER:

RESPONSIBLE PARTY- if the patient is a minor (under the age of 18), the parent or guardian will be listed as the guarantor

LAST NAME:	FIRST NAME

DATE OF BIRTH:	SOCIAL SECURITY #:	PHONE:

ADDRESS OF PERSON RESPONSIBLE:

CITY / STATE / ZIP:	RELATIONSHIP TO PATIENT:

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

Signature of Responsible Party:_________________________ _____________Date: ______________________________________

the GROVE Primary Care Clinic, LLC.

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 programs.

4. I hereby authorize, the GROVE Primary Care Clinic, LLC. to contact me via phone, mail, and my given email address with clinic results and with generalized clinic messages they deem reasonable to send me for management of my health and in answer to questions 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 the staff at the GROVE Primary Care Clinic, LLC. 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 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

the GROVE Primary Care Clinic, LLC.

RELEASE OF INFORMATION

Please list a family member or friend; someone that is okay to release medical information to in case of an emergency.

I,___________________________________, give the office of the GROVE Primary Care Clinic, LLC. permission to release health information to (include the name and their relation to you):

Name:_______________________________ Relationship: _______________________________

Name: ______________________________ Relationship: ________________________________

☐ Do not release my information

ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that a copy of the medical office the GROVE Primary Care Clinic Notice of Privacy Practices has been made available to me.

PLEASE PRINT PATIENT'S NAME ____

____ ________________________

PATIENT SIGNATURE (if other than the patient, please state your relation to patient) DATE

ADVANCED DIRECTIVES

Do you have a living will or durable power of attorney? YES______ NO ______

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

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

YES______ NO ______

PATIENT (OR GUARDIAN) SIGNATURE ____________________ DATE ____________________

WITNESS (office staff can witness) ____________________ DATE ____________________

the GROVE Primary Care Clinic, LLC.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

AGENCY REQUESTING PROTECTED HEALTH INFORMATION

the GROVE Primary Care Clinic, LLC.

⌡ 541 West Park Place Henderson, TN 38340 P: 731.983.0499 F: 731.983.0573	⌡ 702 S. Main Street Middleton, TN 38052 P: 731.376.1311 F: 731.376.1314	⌡ 9458 Highway 100 Scotts Hill, TN 38374 P: 731.549.3010 F: 731.549.3013

PATIENT INFORMATION

PATIENT NAME ______________________ DATE OF BIRTH ______________________ SOCIAL SECURITY NUMBER ______________________

PURPOSE OF DISCLOSURE

☐ Medical Care ☐ Insurance ☐ At the Request of the Patient
☐ 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)	☐ Discharge Summary	☐ Pathology Reports
☐ Radiology Report	☐ Consultation	☐ Anesthesia Record	☐ Billing Record
☐ ER Records	☐ 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 one (1) year from this date 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 ______________________

Date ______________________ Description of Representative's Authority to Act for Patient ______________________

the GROVE Primary Care Clinic, LLC.

CONSENT FOR TREATMENT
AUTHORIZATION FOR MEDICAL TREAMTENT

I the undersigned, a patient of the GROVE Primary Care Clinic, LLC., hereby request and authorize the office and its personnel to administer such medical treatments as necessary.

Patient Name ______________ (PLEASE PRINT) Date of Birth ______________

Signature of Patient or Legal Guardian ______________ Date ______________

Witness ______________ Date ______________

Complete the following **ONLY** if the patient is a minor or has a legal guardian

The above patient will be accompanied by a parent or legal guardian for all Well Child Check/ Physicals and any visits where immunizations will be given.

In the event that the above patient is sick, he/she:

( ) **DOES NOT** have my permission
( ) **DOES** have my permission

to be seen and treated without being accompanied by his/her legal guardian or parent for the visit and any and all future visits for the current year. I give permission to the following **adults** to bring my child:

____
____
____

I understand that I will be responsible for the bill, should insurance not pay, even if I am not present at the time of the patient's visit.

Signature of Parent or Legal Guardian ______________ Date ______________

Relationship to Patient ______________

If there are any special parental or custodial relationships (such as custody with one parent only, legal custody/guardians with no parents, etc.) please explain in the space below with your signature, printed name and phone number at which you can be contacted.

____
____
____

Signature/ Phone Number ______________ Printed Name ______________

PEDIATRIC HEALTH HISTORY FORM

the GROVE Primary Care Clinic, LLC.

Child's Name:__________________________DOB:________________Previous Provider: ____________________

Allergies/Reactions to Medicine or Vaccine: ____

Current Medicines: ____

Has your child been seen by a dentist? • YES • NO who? _________________________

PREGNANCY AND 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/EXPOSURE

Are your child's immunizations up to date? • NO YES (Please bring your child's shot record)

Does your insurance cover immunizations? • NO • YES (your child may be el igible for free immunizations)

Do any household members smoke? • NO • YES

Any concerns about lead exposure? • 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
- Broken bones
- Attention problems
- Constipation
- Frequent ear infections
- Pneumonia
- Obesity
- Anemia
- Urinary Tract Infection
- RSV
- Croup
- Chicken Pox

PAST SURGICAL HISTORY Has your child had any operations such as circumcision, hernia repair, tonsillectomy? YES NO

Specify:

____
____
____
____
____
____
____

the GROVE Primary Care Clinic, LLC.

FAMILY HISTORY Please check any family history of the following and indicate who has/had the following conditions

(M= mother, F= father, B=brother, S=sister, G=grandparents, E= extended family)

Alcoholism/drug abuse	M	F	B	S	G	E
Heart disease or stroke	•	•	•	•	•	•
Cancer	•	•	•	•	•	•
Seizures	•	•	•	•	•	•
Inherited/genetic disease	•	•	•	•	•	•
Thyroid disease	•	•	•	•	•	•
Psychiatric disorders	•	•	•	•	•	•
Bleeding/clotting problems	•	•	•	•	•	•
Kidney disease	•	•	•	•	•	•
Asthma/hay fever/eczema	•	•	•	•	•	•
Birth defects	•	•	•	•	•	•
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 • Unmarried (but living together) • Separated • Divorced

Mother's occupation:______________________________ Father's occupation: ____________________________

Child's living situation: • Lives with parents • Lives with others (please explain): ______________________

Is violence at home a concern? • NO • YES (explain): ____

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 (explain): __________________________