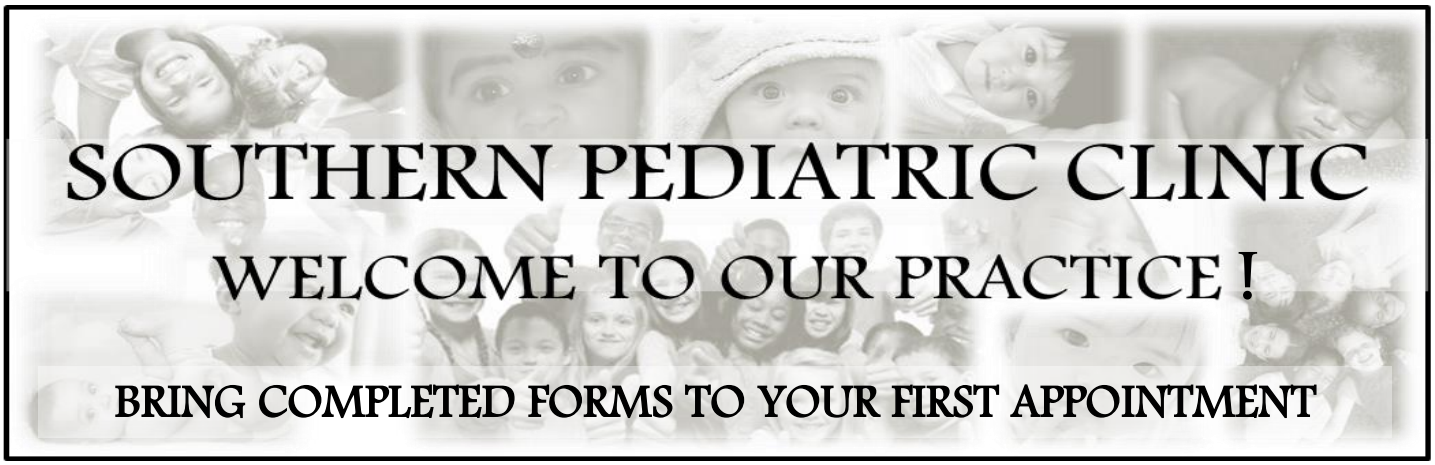

Please complete the following documents and bring them with you to your first appointment. Any documents NOT completed will need to be completed prior to being seen. Having these documents completed can significantly decrease your wait time at your first appointment. For your convenience, we have provided you a checklist of items that will need to be brought with you to your first appointment.

_____ Financial Consent

_____ Patient Update Form

_____ Patient Medical History

_____ Tuberculosis Risk Assessment Questionnaire

_____ Patient Eligibility Screening Record

_____ Statements of Persons Allowed to Accompany Patient to Office Visits

_____ Receipt of Notices/Policies for Southern Pediatric Clinic

_____ Social Security Card (if available for newborn)

_____ Insurance Card (if available for newborn)

Southern Pediatric Clinic, LLC
Charlene C. Blache, M.D.
Pediatrics and Adolescent Medicine

406-M Northside Drive
Valdosta, GA 31602
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Fax 229 • 241 • 2088

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Consent & Disclosure of PHI & Treatment of Patient

Patient Consent for Use and Disclosure of Protected Health Information (PHI) and for Treatment of

_____ (patient name).

Charlene Blache, M.D., may use and disclose PHI about the said patient above to carry out treatment, payment and healthcare operations (TPO). Please review the Notice of Privacy Practices for full information regarding this statement.

1. I have reviewed the Notice of Privacy Practices for Southern Pediatric Clinic and I acknowledge that Southern Pediatric Clinic has the right to revise its Notice of Privacy Practices at any time and that I will have access to revisions.
2. I have read and understand the Notices of Privacy Practices that are in place and that I may contact the Privacy Officer listed for further questions.
3. Southern Pediatric Clinic, and all those associated, may call my home or other designated location and leave a message on voice mail or in person in reference that assist the practice in carrying out TPO, such as appointment reminders and patient statements.
4. Southern Pediatric Clinic may treat my child and order diagnostic tests and labs for diagnosis and treatment.
5. Southern Pediatric Clinic my disclose Individually Identifiable Health Information (IIHI) that will be used to carry out TPO as referred to above, to anyone specified below who brings my child(ren) to the office for treatment:

Name	**Relationship to Patient**

6. I have the right to request that Southern Pediatric Clinic restricts how it uses or discloses my PHI to carry out TPO. However, the practices is not required to agree to my requested restrictions, but if it doesn't, it is bound by this agreement. By signing this form, I am consenting to the practice's use and disclosure of my PHI to carry out TPO. I my revoke my consent in writing, except to the extent that which the practice has already made disclosures upon my prior consent. If I do not sign this consent, providers for Southern Pediatric Clinic may decline to provide treatment for my child(ren).

_____

Signature of Parent/Guardian Date

_____

Printed Name of Parent/Guardian

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Tuberculosis Risk Assessment Questionnaire

Date

Child's Name Date of Birth

Please answer the following questions regarding the child named above.

Questions	Yes	No
1. Is the child a close contact of a person with infectious tuberculosis?	◯	◯
2. Does the child have HIV infection or is he/she considered at risk for HIV infection?	◯	◯
3. Is the child or parent foreign born (especially Asian, African, Latin American), a refugee or a migrant?	◯	◯
4. Is the child in contact with an incarcerated person or a person who was incarcerated in the past five (5) years?	◯	◯
5. Is the child exposed to the following individuals: HIV infected, homeless individuals, residents of nursing homes, institutionalized adolescents or adults, users or illicit drugs, incarcerated adolescents or adults or migrant farm workers?	◯	◯
6. Does the child have a medical condition or treatment or a medical condition which suppresses the immune system?	◯	◯
7. Does the child live in a community in which it has been established that high risk exists for tuberculosis?	◯	◯
8. Other:	◯	◯

Doctor's Signature Date

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Patient Update Form

Today's Date _____

Child's Name _____ Birthdate _____ Sex M / F

Address _____ Zip Code _____ Social Security # _____

Name & birthdates of child's brothers and/or sisters (include last name if different)

Has your child ever been seen at our practice? ☐ YES ☐ NO

Have any of your child's brothers and/or sisters ever been seen at our practice? ☐ YES ☐ NO

If yes, which brothers or sisters? _____

If your child (or children) has not been seen before, who may we thank for referring you to our office? _____

Name of child's previous doctor _____

Name of parents' family doctor _____

Name of mother's obstetrician/gynecologist _____

MOTHER'S NAME WHO IS LEGAL GUARDIAN _____ Birthdate _____

Social Security # _____ Marital Status _____ Email _____

Address _____ Home Phone _____

Employer _____ Occupation _____ Work Phone _____

FATHER'S NAME WHO IS LEGAL GUARDIAN _____ Birthdate _____

Social Security # _____ Marital Status _____ Email _____

Address _____ Home Phone _____

Employer _____ Occupation _____ Work Phone _____

MEDICAL INSURANCE INFORMATION: PROVIDE A COPY OF EACH INSURANCE CARD

Primary Policy Holder Name	Primary Insurance	Secondary Ins./Medicaid

EMERGENCY CONTACT OTHER THAN PARENT Name _____

Relationship _____ Address _____ Home Phone _____

I authorize **Dr. Blache** to release any medical information necessary to process an insurance claim for my son/daughter _____ and request the insurance company to make payment to **Dr. Blache**. I also authorize **Southern Pediatric Clinic, LLC staff and/or Dr. Blache** to use the contact information listed above.

Parent/Guardian Printed Name	Signature	Date

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Patient Eligibility Screening Record: Vaccines for Children Program

PATIENT

Last Name | First Name | MI | Date of Birth

PARENT/GUARDIAN

Last Name | First Name | MI

Provider: Southern Pediatric Clinic
A record must be kept in the healthcare provider's office that reflects the status of all children 18 years of age or younger, who receive immunizations with vaccines supplied by state programs. The record my be completed by the parent, guardian or individual of record, or by the healthcare provider. The same record may be used for all subsequent visits s long as the child's eligibility status has not changed. **While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine(s).**

NOTE: IF you do not have health insurance or if your insurance carrier does not cover vaccines, you can receive a vaccine provided by the Vaccines for Children Program. A fee of $21.93 per shot will be charged at the time of service. Only children 18 years and younger are eligible for this program.

Check only ONE (1) box. My child…		
(A) is enrolled in Medicaid	◯	OR
(B) is American Indian or Alaskan Native	◯	OR
(C) does not have health insurance	◯	OR
(D) has health insurance that does not pay for vaccines	◯	OR
(E) is enrolled in Peach State, WellCare or Medicaid	◯	OR
(F) has health insurance that pays for vaccines	◯	

.

Parent/Guardian Name (print) | Signature | Date

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Patient Medical History

PATIENT

Last Name | First Name | MI | Date of Birth

Name of Person Completing Form | Relationship to Child | Today's Date

1. Please list all medications that your child is currently taking. _____

_____

2. Does your child have any medicine or food allergies? _____

_____

3. Does your child have a history of any of the following? Please check all that apply.

___ Asthma	___ wheezing	___ chronic cough	___ pneumonia
___ bronchitis	___ RSV	___ allergies (nose)	___ eczema
___ chicken pox	___ frequent ear infections	___ urinary tract infections	___ kidney problems
___ heart condition	___ seizures	___ febrile seizures	___ develop delay
___ ADHD	___ psychiatric disorder	___ other: _____	

4. Please answer the following questions about your child's birth.

City and hospital where child was born. _____
Was baby born vaginally or by C- section? _____
Was baby premature? How many weeks? _____
Were there any complications at birth? _____
Did baby have any problems after birth? _____
What was baby's birth weight? _____

5. If your child has ever been hospitalized or had surgery, please list approximate dates and reasons.

_____

_____

6. If your child has ever been injured please list injuries, approximate dates and any treatment given.

_____

7. Is there a family history of any of the following? Please check all that apply and indicate WHICH family member had/has the medical condition.

PARENT, SIBLING, GRANDPARENT (maternal/paternal) or AUNT/UNCLE (maternal/paternal)

□ asthma	□ ADHD/ADD
□ allergies	□ seizures
□ eczema	□ developmental delay
□ diabetes	□ genetic disorder
□ obesity	□ mental disorder
□ high cholesterol	□ anemia/blood disorder
□ hypertension	□ cancer
□ heart disease	□ other

8. Please answer the following questions about your child's social history.

Who takes care of your child most of the time? _____
Who lives at home with the child? _____
Does child attend daycare/school? Where? _____
Does anyone smoke inside or outside the home? _____

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Receipt Of Notices/Policies For Southern Pediatric Clinic

CHILD

Last Name	First Name	MI	Date of Birth

PARENT/GUARDIAN

Last Name	First name	MI	Contact Number

I have received a copy of the following notices/policies from Southern Pediatric Clinic

Please check all that apply:

_____ Notice of Privacy Practices
_____ Insurance Information & Requirements
_____ No Show Policy
_____ Financial Policy

I have completed the following (if applicable):

_____ Financial Consent
_____ Patient Consent for Use & Disclosure of PHI
_____ Patient Update Form
_____ Patient Medical History
_____ Tuberculosis Risk Assessment Questionnaire
_____ Patient Eligibility Screening Record (Vaccines for Children Program)
_____ Statement of Persons Allowed to Accompany Patient to Office Visits
_____ Receipt of Notices/Policies for Southern Pediatric Clinic

Signature of Parent/Guardian or Patient Date