Lifecare
Family Health & Dental Center

Patient Name: _____ **Date of Birth:** _____

PEDIATRIC HEALTH HISTORY 2021

Child's Legal Name: _____ **Date of Birth:** _____

Mother's Name: _____ **Father's Name:** _____

Parent's marital status: [ ] single [ ] married [ ] divorced [ ] separated [ ] widowed **Child's Sex:** Male Female

Legal guardian's name: _____ **Child adopted:** [ ] Yes [ ] No

Allergies (medication and foods): _____

List all surgeries/hospitalizations/Accidents/Serious illness the child has had. Please include the date.

Surgery/Hosp. Stay/Accident/Injury	Date	Treating physician/Surgeon

List any chronic medical conditions (diabetes, high blood pressure, etc) Please include the date.

Illness	Date or Year of Onset	Condition at Present

Does your child see another medical provider for treatment of a medical condition? [ ] Yes [ ] No
If yes, please list: _____

Medical Specialist: _____ Phone #: _____ Specialty: _____

Medical Specialist: _____ Phone #: _____ Specialty: _____

Are vaccines up to date? [ ] Yes [ ] No **Do you have their vaccine record?** [ ] Yes [ ] No

Child & Family History

Child's Birth Weight: _____ **Was birth premature?** [ ] Yes [ ] No **Was birth:** [ ] Vaginal [ ] C-Section

Last Dental Visit: _____ **Have they had sealants placed on their molars?** [ ] Yes [ ] No

Place an "X" in any box that applies to your child, their mother, or father (M=mother, F=father)

	Child	M	F		Child	M	F		Child	M	F
Diabetes				Rheumatic Fever				Bleeding /Hemophilia			
Glaucoma				Asthma				Leukemia			
Kidney Problems				Emphysema				HIV/AIDS			
High Blood Pressure				TB				Alcohol/Substance Abuse			
Heart Attack				Systemic Lupus				Liver Disease			
Coronary Artery Disease				Sickle Cell Trait				Hepatitis A/B/C			
Heart Murmur				Thyroid Disease				Eating Disorder			
Mitral Valve Prolapse				Arthritis				Mental Illness			
Prosthetic Heart Valve				Stroke				ADD/ADHD (circle one)			
Heart Stents				Neurological Disorder				RSV			
Pacemaker				Cancer Type: _____				☐ No family history			
Other: (Specify)											

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Patient Name:_____ **Date of Birth:**_____

Pharmacy Information

Local Pharmacy Name:_____Phone:_____

Mail Order Name:_____

List all prescription medications, over-the-counter medicines, or supplements your child is currently taking on a regular basis.

Name of Medication	Dosage	Frequency- (How many times a day)

☐ My child does not take any medications, over-the-counter medicine, or supplements on a regular basis.

Please complete this section for children OVER THE AGE OF 12

Tobacco: My Child

[ ] Has never used any tobacco

[ ] Smokes Cigarettes, Cigars, or Pipe

[ ] Chews tobacco

Tobacco indicated above:

- Amount per day_____
- Started at Age _____

[ ] Quit using tobacco

- Date: _____

Drug Use: My Child

[ ] Has never used any illicit drugs

[ ] Used illicit drugs in the past

[ ] Is currently using illicit drugs

- Drugs used: _____
- Date quit: _____

Alcohol: My Child

[ ] never consumes any alcohol

[ ] drinks alcohol 3 to 4 times yearly

[ ] drinks alcohol once a week

[ ] drinks alcohol 2 to 3 times per week

[ ] Drinks alcohol daily Amount_____

[ ] Beer [ ] Wine [ ] Liquor

[ ] Has quit drinking

- Date he/she quit drinking _____

Caffeine Use: My Child

[ ] Does not drink any caffeinated beverages

[ ] Drink caffeinated beverages

- Amount per day_____

Female children:

[ ] Is your child pregnant?

[ ] Does she think she may be pregnant?

[ ] Is she using contraceptives? (oral, implants, injections)

[ ] Is she nursing?

Parent/Legal Guardian Signature: _____ Date: _____

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Patient Name: _____ **Date of Birth:** _____

AUTHORIZATION FOR TREATMENT OF MINOR

Patient Name: _____ Date of Birth: _____

I authorize the individuals listed below to bring my child to the office and sign for assessment and treatment of my child in the event I am unable to bring them myself.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____Phone: _____

Name: _____ Relationship: _____Phone: _____

Name: _____Relationship: _____ Phone: _____

Description of information to be disclosed – I authorize the practice to disclose the following protected health information about my child to the person(s) identified above:

[ ]Entire patient record: **or,** check **only** those items of the record to be disclosed:
[ ]office notes [ ]lab results [ ]x-rays
[ ]record of HIV and communicable disease record
[ ]hospital/nursing home/home health/hospice/and other physician records
[ ]records of mental health or substance abuse treatment
[ ]Other (please specify): _____

Limited Patient Authorization for Disclosure of Protected Health Information

Expirations or termination of authorization: This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue authorization. You have the right to terminate this authorization at any time. You must notify our privacy manager, in writing, if you decide to terminate the authorization prior to the normal expiration date.

Please list the date of expiration if earlier than the end of the calendar year:

_____

Right to revoke or terminate: as stated in our Notice of privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. You may revoke an authorization at any time, in writing, except to the extent that your health care provider or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Non-Conditioning Statement: The practice places no condition to sign this authorization on the delivery of health care or treatment.

Re-disclosure: We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

Patient Signature: _____ Date: _____

(Must be signed and dated each year. You have a right to receive a copy of signed authorization upon request

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Patient Name: _____ **Date of Birth:** _____

HIPAA

Limited Patient Authorization for Disclosure of Protected Health Information

(Allow the clinic to discuss your health information with the individuals listed below)

Purpose of Request (whom is authorized to receive health information) - I authorize the practice to disclose or provide health information, about me to the individual(s) listed below. (Please list each family member, friend, or other individual to receive Protect Health Information).

Name: _____ Phone Number: _____
Relationship: _____

Name: _____ Phone Number: _____
Relationship: _____

Name: _____ Phone Number: _____
Relationship: _____

Name: _____ Phone Number: _____
Relationship: _____

Description of Information to be disclosed – I authorize the practice to disclose the follow Protected Health Information about me to the person or persons identified above.

[ ] Entire patient record, **or** circle **only** those items of the record to be disclosed
[ ] Office notes [ ] lab results [ ] x-ray results

[ ] record of HIV and communicable disease record
[ ] hospital / nursing home / home health / hospice and other physician records
[ ] records of mental health or substance abuse treatment.
[ ] Other (please specify): _____

Purpose of disclosure (please record the purpose of the disclosure, or check patient request):

[ ] Patient request
[ ] Other (please specify):_____

Patient Name: _____ **Date of Birth:** _____

HIPAA

Limited Patient Authorization for Disclosure of Protected Health Information

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Please list the date of expiration if earlier than the end of the calendar year:

_____

Right to revoke or terminate: as stated in our Notice of privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. You may revoke an authorization at any time, in writing, except to the extent that your health care provider or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Non-Conditioning Statement: The practice places no condition to sign this authorization on the delivery of health care or treatment.

Re-disclosure: We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

Patient Signature: _____ Date: _____
(must be signed and dated each year)

You have a right to receive a copy of signed authorization upon request

Patient Name: _____ **Date of Birth:** _____

HOW SHOULD THE CLINIC CONTACT YOU?

I wish to be contacted in the following manner:

(PLEASE CHECK ALL THAT APPLY)

[ ]HOME: Telephone number: _____

[ ]OK to leave a message with detailed information.

[ ]OK to leave a message with call back number only.

[ ]Do not leave a message

[ ]**CELL PHONE:** Telephone number: _____

[ ]OK to leave a message with detailed information.

[ ]OK to leave a message with call back number only.

[ ]Do not leave a message

[ ] **WORK PHONE:** Telephone number: _____

[ ]OK to leave a message with detailed information.

[ ]OK to leave a message with call back number only.

[ ]Do not leave a message

[ ]**BY MAIL**: Address: _____

Patient Signature: _____ Date: _____

I have been offered a copy of Lifecare FHDC's Notice of Privacy Practice.

Patient Signature: _____ Date: _____

Lifecare
Family Health & Dental Center

Patient Name: _____ **Date of Birth:** _____

PATIENT DEMOGRAPHIC FORM

First Name: _____ **Middle initial:** _____ **Last Name:** _____

Date of Birth: _____ **Email Address**_____

Marital Status: [ ]single [ ]married [ ]divorced [ ]widowed [ ]separated

Employment Status: [ ]full time [ ]part time [ ]unemployed [ ]self-employed [ ]retired

Occupation: _____**Education (highest grade/degree)**: _____

Race: [ ]White [ ]Black [ ]Asian [ ]Native Hawaiian [ ]Pacific Islander [ ]Native American/Alaska Native [ ]More than one race [ ]Choose not to disclose	**Sex at Birth:** [ ]Male [ ]Female **Preferred Pronouns:** [ ]he/him [ ]she/her [ ]they/them [ ]Other: _____	**Sexual Orientation:** [ ]Lesbian/Gay [ ]Straight [ ]Bisexual [ ]Something else:_____ [ ]Don't know [ ]Choose not to disclose
Ethnicity: [ ]Hispanic [ ]Non-Hispanic [ ]Choose not to disclose	**Veteran:** [ ]Yes [ ]No **Check if any of these apply to you:** [ ]Homeless [ ]Live in public housing **Preferred Language:** [ ]English [ ]Spanish [ ]Other: _____	**Gender Identity:** [ ]Male [ ]Female [ ]Non-Binary [ ]Transgender male to female [ ]Transgender female to male [ ]Other: _____ [ ]Choose not to dislose

Lifecare receives funding to offset the costs of treating uninsured or underinsured patients. We are required to report certain demographics on all of our patients including race, family size, and income. Reporting these items assists us to receive funding to continue providing care to all of our patients. Reported information **does not** contain your name, address, or social security information.

Please circle household size and check the correct income box in the same line:

Household members	Income less than:	Income between:	Income between:	Income more than:
1	[ ] $12,140	[ ] $12,141 - $18,210	[ ] $18,211 - $24,280	[ ] $24,281
2	[ ] $16,460	[ ] $16,461 - $24,690	[ ] $24,691 - $32,920	[ ] $32,921
3	[ ] $20,780	[ ] $20,781 - $31,170	[ ] $31,171 - $41,560	[ ] $41,561
4	[ ] $25,100	[ ] $25,101 - $37,650	[ ] $37,651 - $50,200	[ ] $50,201
5	[ ] $29,420	[ ] $29,421 - $44,130	[ ] $44,131 - $58,840	[ ] $58,841
6	[ ] $33,740	[ ] $33,741 - $50,610	[ ] $50,511 - $67,380	[ ] $67,481
7	[ ] $38,060	[ ] $38,061 - $57,090	[ ] $57,091 - $76,120	[ ] $76,121
8	[ ] $42,380	[ ] $42,381 - $63,570	[ ] $63,571 - $84,760	[ ] $84,761

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Patient Name: _____ **Date of Birth:** _____

PATIENT DEMOGRAPHIC FORM

First Name: _____ **Middle initial:** _____ **Last Name:** _____

Date of Birth: _____ **Social Security Number:** _____

Street Address: _____

City, State, Zip Code: _____ **County:** _____

Primary Phone Number: _____ **Additional Phone Number:** _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____ Relationship: _____
Phone Number(s): _____

INSURANCE INFORMATION

Primary Insurance: _____ ID#: _____ Group#: _____
Policyholder Name: _____ Policy Holder D.O.B.: _____
Relationship to Patient: _____

Secondary Insurance: _____ ID#: _____ Group#: _____
Policyholder Name: _____ Policy Holder D.O.B.: _____
Relationship to Patient: _____

REDUCED RATE PROGRAM

Lifecare offers a Reduced Rate Program as our way to offer services at a lower cost to families who meet certain requirements. The Reduced Rates are divided into different categories based on household size and gross income. Patients that qualify for the program would pay for services according to what finical category they fall into.

Are you interested in applying for our Reduced Rate Program? [ ]YES [ ]NO

LEGAL GUARDIAN – MUST BE COMPLETED IF PATIENT IS UNDER THE AGE OF 18

Patient Name/Legal Guardian: _____
Social Security Number: _____ Relationship to Patient: _____
Street Address if different from above: _____
City, State, Zip Code: _____ County: _____

Patient/Parent/Legal Guardian Signature: _____
Relationship if not the patient: _____ Date: _____

Lifecare
Family Health & Dental Center

Patient Name: _____ **Date of Birth:** _____

AGREEMENT OF TREATMENT EXPECTATIONS AND MEDICAL HOME RESPONSIBILITIES

This is an agreement between two parties: the Health Center and the Patient.

The purpose of this document is a positive one. It attempts to make the clear rights and responsibilities of both parties. Is says *who* is to do *what*.

A medical home is a care team working to provide you with the best care possible. We want to include you in making health care decisions. We will help you coordinate your care with providers outside of Lifecare when needed. We offer clinical advice during and after hours along with early morning appointments.

We promise to treat you to the best of our abilities, consistent with the standards of care in our community. You, in turn promise to be as understanding, cooperative, and responsible as possible.

This Health Center has a zero tolerance for violence or threat of violence of any kind. Therefore, there will not be any attempt or threat to kick, hit, or otherwise harm any staff member, patient, or visitors. Furthermore, neither party will yell or use profanity when addressing any staff member, patient, or visitors.

I have read (or have had read to me) the "Agreement of treatment Expectations" and fully understand its contents. I have been given an opportunity to ask questions. Any violation of this agreement may result in permanent dismissal from the office.

Patient Name: _____ Date: _____

If not the Patient, Relationship to Patient: _____

Health Care Witness: _____

Lifecare
Family Health & Dental Center

Patient Name: _____ **Date of Birth:** _____

FINANCIAL AGREEMENT

I hereby consent to all treatment deemed necessary by the staff of Lifecare Family Health & Dental Center, Inc. I authorize the Lifecare Family Health & Dental Center, Inc. (LIFECARE FHDC) to use, disclose, and/or receive any or all information relating to my treatment. My provider may contact any other covered entity that has provided services to me for the purpose of obtaining further diagnosis.

LIFECARE FHDC has made prior arrangements with many health plans to accept direct payments. LIFECARE FHDC will bill those plans for which it has made prior arrangement and will only require you to pay the authorized Co-pay at the time of service. I agree that I am responsible for any co-payments, deductibles and fees for non-covered services.

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits, otherwise payable to me, to the physician or group indicated on the claim. I am responsible for any referrals and/or authorizations required by my insurance company. I understand I am financially responsible for any balance not covered by my insurance. My insurance policy, if applicable, is a contract between me and my insurance company. LIFECARE FHDC is not responsible for collecting on an insurance claim or negotiating a settlement on a disputed claim.

As a courtesy to the patient, LIFECARE FHDC will submit claims to any insurance company. If the patient's coverage is with a plan that LIFECARE FHDC does not have prior arrangement, the charges for the patient's care and treatment are the patient's responsibility and due in full at the time of service.

I understand that unless other arrangements have been made in advance by either me or my health coverage provider, payment is due at the time of service. For all services rendered to minors, the custodial parent or legal guardian will be responsible for all charges.

For the patient's convenience LIFECARE FHDC will accept Visa, MasterCard, Cash, and Personal Check. There will be a $10.00 fee charged to patients for all non-sufficient funds checks and the patient will be required to pay cash for all future visits.

I further attest that, as of the date of my signature, the income sources listed constitute all of my household income, and that the number of family members listed are all solely dependent on that income. I verify my income level is truthful. I understand that LIFECARE FHDC is not in the business of extending credit and I agree to pay the above practice at the time its bill is presented. If prompt payment is not made, LIFECARE FHDC may take action to collect its charges.

I UNDERSTAND THAT THERE MAY BE CHARGES IN ADDITION TO MY COPAY BASED ON THE CLINIC'S SLIDING FEE SCALE. I AGREE TO PAY SAID CHARGES.

Patient Printed Name: _____

Patient Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____