PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR KNOWLEDGE:

PATIENT INFORMATION:

Last Name:____________________________ First Name:_____________________________

Date of Birth:_______________________________________ Gender: ( ) Male ( ) Female

Race:_____________________ Ethnicity: ( ) Hispanic/Latino ( ) Non Hispanic/Latino

Mailing Address:____

City:_____________________________ State:_____________ Zip Code:_________________

Cell Phone:( )______________________ Home Phone:( )__________________________

please put the cell number you would like appointment reminders to

Email Address:____@____________.com

this will be used for portal accounts (apt. reminders, copies of lab results, updating medical history, etc.)

Insurance Information: (please fill out policy information below)

__________Medicaid

__________ Self-Pay

__________ Private insurance

Policy Number:______________________ Group #_________________

Policy Holder Name:__________________________ Relationship:_________________________

Policy Holder's social sec #:__________________________Date of Birth:____________________

Parents Information:

_____Mother ______Father _____Legal Guardian

Last Name:________________________________ First Name:_________________________

Date of Birth:________________________ Social Security #(last four):___________________

Phone number:________________________ Cell phone:______________________________

Address (if different than patient's):____

City:_______________________________ State:_____________ Zip Code________________

Parents Information:

_____Mother ______Father _____Legal Guardian

Last Name:______________________________ First Name:________________________

Date of Birth:______________________ Social Security #(last four):__________________

Phone number:______________________ Cell phone:____________________________

Address (if different than patient's):____

City:_____________________________ State:_____________ Zip Code________________

Is this your child by: _____Birth, _____ Adoption, _____ Step-child, ______ Foster child

Release of Information/ Care Consents:

Please list any person or persons other than mom, dad, or legal guardian, that are authorized to bring your child to doctor visits or call inquiring about your child's care. Any person listed below will be able to stay with your child during the exam, sign for vaccinations, accompany him/her to the outpatient lab if necessary and get information about the child over the telephone. The information will also be used to verify authorization of a patient 17 year of age or older to see the doctor unaccompanied.

Name:________________________________Relationship:________________Phone#:______________

Name:________________________________Relationship:________________Phone#:______________

Name:________________________________Relationship:________________Phone#:______________

Name:________________________________Relationship:________________Phone#:______________

Billing Consent:

________(Initial)
I authorize the release of any medical or other information necessary to process a claim on my behalf. I agree to be fully responsible for all lawful debts incurred by myself or service received from Mansoor Pediatrics/Healthy Step Pediatrics/Pediatrics on the Red/Avoyelles Pediatrics whether it is covered by my insurance or not.

Consent to Treat:

_______(Initial)
Permission is granted to the physicians, nurse practitioners, and employees of any/al Mansoor Pediatrics clinics, to do such procedures as may be necessary to diagnose, treat, and care for the needs of my dependent minor child. Including but not limited to routine office examinations and laboratory procedures such as strep test, and throat cultures, urine studies, complete blood counts, hematocrit, bladder catheterizations, removal of cerumen (ear wax), removal of foreign bodies, draining abscess, medication injections, immunizations and treatment of skin lesions, warts, burns and lacerations

Email/ Text Patient Portal Authorization:

By providing my email address and or phone number to the office, I am authorizing Pediatrics on the Red/ Mansoor Pediatric, Healthy Step Pediatrics, Avoyelles Pediatrics to communicate with me by email/text and allowed to access to my child's medical health information through the patient portal.

______(Initial) I understand that the use of my email/phone number is for my convenience and that i am not obligate to communicate via email/text

______(Initial) I understand the inherent unsecure nature of email/text and therefore accept the risk of using email/text

______(Initial) I also understand that I am responsible for informing our office of any changes regarding my email/phone number.

_____(Initial)***** I **DO NOT** wish to provide an email of phone number *****

Print Parents or Legal Guardians Name:____

Signature of Parent or Legal Guardian:____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT:

I understand that under the Health and Portability and Accountability Act of 1966 (HIPPA). I have certain rights of privacy regarding my protected health information, I understand 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 the treatment directly or indirectly
- Obtain payment from third parties
- Conduct normal healthcare operations such as quality assessments and physical certifications

I have received, read and understand your Notice of Privacy packets 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 addresses below to obtain a copy of the Notices 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 required to agree to my requested restrictions, but if you do not agree then you are bound to abide by my restrictions.

Parent Name:_______________________________ Date:____________________

Signature______________________________ Relationship__________________

Office use only: I attempted to obtain the necessary signature in acknowledgement on this notice of privacy practices acknowledgement but was unable to do as documented below.

Date_________________________ Initials_________________

Reason____

Patient Medical History:

BIRTH HISTORY: **(Under the age of 1 years old)**

Birth weight:_____lbs ______oz
Birth length: ________inches
Pregnancy length :________weeks
Any problems during pregnancy, labor or delivery? If so, please explain:
____
Any NICU stay? **Y / N**
If yes, Please explain:
____
Vaccines given in hospital? **Y / N** Passed hearing screening? **Y / N**
Breast or Formula? __________________formula name______________________________________
Mother's Last name at the time of baby's birth?____
Hospital born at?________________________________
Vaginal/ C-section?________________________________

MEDICAL HISTORY:

Has your child had any Serious Medical Illness? **Y / N**
If yes, explain:____
Has your child been hospitalized overnight (other than birth)? **Y / N**
If yes, please explain:
____
____

Does your child see a specialist for any reason? **Y / N**
If yes, who and for what____

ALLERGIES: Environmental:__________________________Food/s____________________________
Age at diagnosis?_______________ Daily Medications?:______________________________________

IMMUNIZATIONS:
Have you ever refused vaccines for your child? **Y / N**
If yes, why?____

SPEECH problems: ____
HEARING problems: ____
VISION problems: ____

INJURIES/ FRACTURES:____
which body part?:____

Parent/Legal Guardian Initial's:_______ Date:________

Patient Medical History cont.:

SURGERIES:
(Date and Age), on what?____
(Male only) Circumcised? If so, when?:____

DENTIST:____

ASTHMA:
Age of Diagnosis?:_____________
Medications?:____
Admission to Hospital:____
ER visit/s (with dates):____
Pulmonologist (Name & Hospital):____

ADD/ADHD:
Age at diagnosis?:__________Medication/s:____
Why meds stopped or changed:____

GROWTH AND DEVELOPMENT
Have you or your prior pediatrician ever had any concerns about your child's growth or development (speech/language, social skills, motor skills, etc.) (circle one) **Y / N**
If yes, explain:
____
____

MEDICATIONS:
Please list current medications, vitamins, and supplements, even those used intermittently:
____
____

MEDICATION ALLERGIES:
Please list any medications or vaccines your child is allergic to:

Allergy:	**Reaction:**

Parent/Legal Guardian Initial's:_______ Date:________

Family History: Please indicate with a check mark the family members who have had any of the following condition

Medical Condition	**Mom**	**Dad**	**Sibling**	**Mom's Mom**	**Mom's Dad**	**Mom's Sister**	**Mom's Brother**	**Dad's Mom**	**Dad's Dad**	**Dad's sister**	**Dad's brother**
Alcoholism											
Anemia											
Asthma											
Autism											
Autoimmune disorder											
Birth defect											
Bleeding problem **(S)**											
Cancer **(S)**											
Depression											
Diabetes											
Drug Use											
Eczema											
Genetic disorder **(S)**											
Hearing disorder											
Heart problems **(S)**											
High cholesterol											
High blood pressure											
Immune disorder **(S)**											
Crohn's disease/IBS											
Kidney disease **(S)**											
Learning disabilities											
Migraines											
Psychiatric Illness **(S)**											
Scoliosis											
Stroke											
Thyroid disorders											
Tobacco use											
Tuberculosis											

Specify any other conditions not listed, ANY CONDITION MARKED WITH (S) and deaths if before age 56 that are not listed:

____

____

Are Child's Parents: _____**Married** _____**Unmarried** _____**Separated** _____**Divorced**

What is child's home situation: _____**Both Parents** _____**Mother** _____**Father** _____**Relatives**

_____**Foster Parents** _____**Adoptive parents**

Child-Care: _____**None** _____**Daycare center/Head start** _____**Private Sitter**

Are there any smokers in the home? **Y / N** Are there pets in the home? **Y / N**

Does your child use a seatbelt/car seat? **Y / N** Is child able to walk without restrictions? **Y / N**

Has your child expressed any issues with bullying? **Y / N** Is your child in School? **Y / N** **What Grade?** _______

What is your child's exercise level? **Occasional** **Moderate** **Heavy**

What type of diet is your child on? **Regular** **Vegetarian** **Gluten-Free** **Diabetic**

Any concerns about your child: _____ **Alcohol use** _____ **Tobacco use** _____**Sexually active** _____**Aggressive Behavior**

Parent/Legal Guardian Initial's:_______ **Date:________**

Medical Records Release (to be used to request medical records from other providers, must complete for all patients. Only do highlighted areas.)

Avoyelles Pediatrics **Healthy Steps Pediatrics** **Mansoor Pediatrics** **Pediatrics on the Red**

REQUEST FOR MEDICAL RECORDS RELEASE

HIPAA Compliant Medical Authorization [Pursuant to 45 C.F.R. sec. 164.508 (6)]

Patient Name: ____ ***Date of Birth:*** ______________________________

Parent/Guardian Name: ______________________________ ***Relationship to patient:*** _______________________

Hereby Authorizes: ____

*Address*___________________________________*City*____________________________ *State*________________

Phone: ___________________________________ *Fax:* ____

to disclose my child's healthcare information as follows:

I . You may use or disclose the following healthcare information:

_______ ***Labs***

_______ ***X-Rays***

_______ ***Shot Record***

_______ ***Entire Chart***

_______ ***Date of Visit*** ___________________

II. You may disclose this health information to: (name of person the information is to be released to:

_____***Mansoor Pediatrics*** *2226 Worley Dr. Alexandria, LA 71301* ***PH: 318.561.0003 Fx: 833.975.0960***

_____***Pedi. On The Red*** *501 Medical Center Dr. St 3B2 Alex., LA 71301* ***PH: 318.484.3899 FX: 833.992.2203***

_____***Healthy Steps Pediatrics*** *192 Stilly Rd. Pineville, LA 71360* ***PH: 318.484.3401 FX: 833.989.2159***

_____***Avoyelles Pediatrics*** *338 Moreau St St E. Marksville, LA 71351* ***PH: 318.253.7022 FX: 833.989.2469***

III. **Purpose of this authorization: *( ) At my request. ( ) Other:* ____

IV. This authorization ends: *( ) On (date):* ______________________________ *( ) When the following event occurs:*

____

V. My Rights:

- *I understand that I do not have to sign this authorization in order to get healthcare benefits (treatment, payment, enrollment, or eligibility). However, I do have to sign an additional authorization form to take part in a research study or to receive health care when the purpose is to create health information for a third party.*
- *I may revoke this authorization in writing by sending a letter to the healthcare provider to whom the authorization is directed. If I did, it would not affect any actions already taken by the healthcare provider based upon this authorization.*
- *I may not be able to revoke this authorization if its purpose was to obtain insurance.*
- *I understand that once the healthcare provider discloses my health information, the person or entity that receives it, may re-disclose it. The HIPAA Privacy laws may no longer protect it.*

By signing below, I authorize the healthcare providers and/or facilities listed *above to release the medical records and health information, as **described above to Mansoor Pediatrics.

Patient/Parent/Guardian ____***Date*** ______________________

Staff Initials: _______________ ***Date:*** _______________________ ***Faxed***____________ ***Mailed***______________