ARK-LA-TEX CHILDREN'S CLINIC, 2400 HOSPITAL DRIVE, SUITE 120, BOSSIER CITY, LA 71111
PATIENT INFORMATION FOR PATIENTS <18YO

DR. SANDERS DR. HUGHES DR. SINGH DR. GARDNER DR. MILNER

FULL NAME:____GOES BY:____________________

DOB:______________ GENDER:______________ SSN:_________________ RACE:____________________

ADDRESS:______________________________________ CITY:___________________STATE:_______ZIPCODE:_______

RESPONSIBLE PARTY:______________________________________RELATIONSHIP TO PATIENT:_______________

RESPONSIBLE PARTY ADDRESS (IF SAME AS ABOVE):____

FATHER'S FULL NAME:____GOES BY:______________________

DOB:_____________ SSN:________________ DRIVERS LICENSE #:_________________ EMPLOYER:__________________

√ If address same as above:____

EMAIL: _________________________ WORK #: ______________________ DAD CELL #:________________________

√ ALL THAT APPLY: MARRIED DIVORCED/SEPARATED WIDOWED SINGLE ADOPTIVE PARENT/LEGAL GUARDIAN DECEASED

MOTHER'S FULL NAME:____GOES BY:______________________

DOB:_____________ SSN:________________ DRIVERS LICENSE #:_________________ EMPLOYER:__________________

√ if address same as above:____

EMAIL: _________________________ WORK #: ______________________ MOM CELL#:________________________

√ ALL THAT APPLY: MARRIED DIVORCED/SEPARATED WIDOWED SINGLE ADOPTIVE PARENT/LEGAL GUARDIAN DECEASED

EMERGENCY CONTACT (NOT LIVING IN SAME HOUSEHOLD):____

PHONE#:_______________________________________ RELATIONSHIP TO PATIENT:__________________________

IS PATIENT COVERED BY MEDICAL INSURANCE: YES NO

INSURANCE COMPANY:____________________________________ POLICY #:__________________________________

INSURED NAME:____ GROUP #:__________________________________

IF YOU ARE A NEW PATIENT, WHO CAN WE THANK FOR YOUR REFERRAL?______________________________________

SIBLINGS:____

As the parents or guardians of the patient listed above, we authorize the release of any medical or other information necessary to process this claim. Also, we authorize payment of medical benefits to the Ark-La-Tex Children's Clinic. We understand that we are financially responsible for any remaining balance not paid by insurance. We also acknowledge that it is our responsibility to complete an updated form anytime the above information changes or whenever requested by Ark-La-Tex Children's Clinic.

_____________________________________ ______________________________ __________________

SIGNATURE OF PARENT/GUARDIAN RELATIONSHIP TO PATIENT DATE

ARK-LA-TEX CHILDREN'S CLINIC

2400 HOSPITAL DRIVE, SUITE 120, BOSSIER CITY, LA 71111
(318) 742-6710

PATIENT NAME:____DOB:_______________

1. Please list the family members or other persons, if any, whom we may inform about the patient's general medical condition and diagnosis (including treatment, payment, and health care operations):
    - Father:__________________________________ Last 4 digits of SSN:_______
    - Mother:_________________________________ Last 4 digits of SSN:_______
    - Name:_____________________Relationship:___________ Phone#:______________
    - Name:_____________________Relationship:___________ Phone#:______________
    - Name:_____________________Relationship:___________ Phone#:______________

2. Please list the family members or significant others, if any, whom we may inform about the patient's condition ONLY IN AN EMERGENCY:
    - Name:_____________________Relationship:___________ Phone#:______________
    - Name:_____________________Relationship:___________ Phone#:______________
    - Name:_____________________Relationship:___________ Phone#:______________

3. Please print the address of where you would like your postcards and/or correspondence from our office to be sent if other than your home address:
    - Address:____

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL"
    - YES:_________ NO:_________

5. Can confidential messages be left on your telephone answering machine?
    - YES:_________ NO:_________ If YES, preferred phone #:___________________

6. Please list other children who attend this clinic:
    - Name:____________________________________ DOB:________________
    - Name:____________________________________ DOB:________________
    - Name:____________________________________ DOB:________________
    - Name:____________________________________ DOB:________________
    - Name:____________________________________ DOB:________________

Patient/Guarantor Signature:_______________________________ Date:______________

Relationship to Patient:__________________________________

Ark-La-Tex Children's Clinic

2400 Hospital Drive, Suite 120, Bossier City, LA 71111
(318) 742-6710

PATIENT NAME:____ DOB:_____________________

PLEASE READ AND SIGN STATING THAT YOU UNDERSTAND EACH POLICY:

- **ALL COPAYS ARE DUE AT TIME OF SERVICE.**
- **PRIMARY AND SECONDARY INSURANCES – ALL PRIMARY INSURANCE COPAYS ARE DUE AT TIME OF SERVICE.**
- **PLEASE COMPLETE THE ENTIRE SIGN-IN SHEET.**
- **PLEASE NOTIFY THE RECEPTIONIST IF THERE HAS BEEN A CHANGE IN YOUR PERSONAL INFORMATION.**
- **A NEW PATIENT INFORMATION SHEET IS TO BE COMPLETED EVERY 12 MONTHS OR WHENEVER THERE IS A CHANGE IN ANY PERSONAL INFORMATION.**
- **THERE WILL BE A $25.00 FEE ASSESSED FOR ALL RETURNED CHECKS.**
- **WE MUST OBTAIN THE SOCIAL SECURITY NUMBER ON EACH PATIENT. FOR NEWBORNS WE REALIZE THERE WILL BE A DELAY WHILE WAITING FOR THEIR SOCIAL SECURITY NUMBER TO BE RECEIVED.**
- **YOU ARE RESPONSIBLE FOR ANY BALANCE NOT COVERED BY YOUR INSURANCE COMPANY. MONTHLY PAYMENT ARRANGEMENTS ARE AVAILABLE.**
- **A COPAY WILL BE COLLECTED FOR A "SHOT ONLY" VISIT IF ANY OTHER ISSUES ARE ADDRESSED AT THAT VISIT.**
- **ALL PATIENTS 2 YEARS OLD AND OLDER SHOULD HAVE AN ANNUAL WELL VISIT. IF A PATIENT IS DUE AN ANNUAL WELL VISIT, A REQUEST FOR A SHOT VISIT WILL BE CONVERTED TO A WELL VISIT. ALL PATIENTS 0-24 MONTHS WILL BE SEEN FOR WELL VISITS AT MINIMUM WHEN THEY ARE 2-5 DAYS, 1 MONTH, 2 MONTHS, 4 MONTHS, 6 MONTHS, 9 MONTHS, 12 MONTHS, 15 MONTHS, 18 MONTHS AND 24 MONTHS.**
- **ALL PATIENTS ARE ENCOURAGED TO MAKE AN APPOINTMENT FIRST OR PLEASE CALL & NOTIFY US THAT YOU ARE IN ROUTE. PATIENTS WITH APPOINTMENTS WILL BE SEEN FIRST.**

______________________________ ______________________________
GUARANTOR NAME **GUARANTOR SIGNATURE**

______________________________ ______________________________
DATE **RELATIONSHIP TO PATIENT**

ArkLaTex Children's Clinic

2400 Hospital Drive, Suite 120
Bossier City, Louisiana 71111
(318) 742-6710
(318) 747-5393 (Fax)

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

______________________________ ______________________________
PATIENT NAME **PREVIOUS NAMES, IF APPLICABLE**

______________________________ ______________________________
DATE OF BIRTH **DAYTIME TELEPHONE NUMBER**

SEND INFORMATION TO: ______________________________

ARK-LA-TEX CHILDREN'S CLINIC
2400 HOSPITAL DRIVE, SUITE 120
BOSSIER CITY, LA 71111
(318) 742-6710
(318) 747-5393 (FAX FOR GARDNER, SANDERS, & SINGH)
(318) 747-6240 (FAX FOR HUGHES & MILNER)

PURPOSE OF DISCLOSURE: Transfer of Care Self Specialist Other_______________
(MUST COMPLETE)

INFORMATION TO BE DISCLOSED:

☐ Medical Records from last 2 years
☐ Summary Health Information Date(s) of Service:_________________
☐ Complete Designated Record Set
☐ Other_______________________________ Expiration Date (or event:____________

RELEASE OF INFORMATION FROM:

NAME: ____
ADDRESS: ____
____
PHONE #: ____________________ **FAX #:**____________________

If the patient is unable to sign, please indicate such and the authority to act of the person who is signing for the patient. This form must be dated within 90 days of receipt, and may be revoked at any time, providing the information has not already been disclosed. Please see our Notice of Privacy Practice for instructions as to how to revoke this authorization. We will not condition treatment on the completion of the authorization. Also, please be aware that once we disclose this information per your instructions the information is subject to re-disclosure and may no longer be protected by the HIPAA of 1996.

______________ ______________________________ ______________________
DATE **SIGNATURE OF PATIENT OR LEGAL GUARDIAN** **RELATIONSHIP TO PATIENT**

FOR FACILITY USE:

DATE RECEIVED:_______________ **DATE INFORMATION RELEASED:** _______________ **PERSON SENDING RECORDS:**_____________________

Initial History Questionnaire

Form Completed By:	Name:		
Initial Date Completed:	ID Number:		
Date(s) Updated:	Birth Date:	Age:	Sex: M F

GENERAL

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ Don't know Explain: ______

Does your child have any special health care needs? ☐ Yes ☐ No ☐ Don't know Explain: ______

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ Don't know Explain: ______

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ Don't know Explain: ______

SOCIAL HISTORY

Please list all those living in the child's home.

Name	Relationship to Child	Birth Date/Age

Please list other siblings not living in the home.

Name	Birth Date/Age	Where are they living?

Does the child live with both biological parents? ☐ Yes ☐ No

If no, what is the child's current living situation?

☐ Single-parent custody ☐ Joint custody ☐ Adoptive family

☐ Other family members: ______ ☐ Foster care

How often does the child have visitation with parent(s) not living in the home?

______

BIRTH HISTORY

Birth weight: ______

☐ Full-term ☐ Preterm _____ weeks ☐ Post-term _____ weeks

Delivery: ☐ Vaginal ☐ Cesarean ☐ Reason: ______

Any complications during birth or after birth? ☐ No ☐ Yes

Explain: ______

Did the baby need to go to the NICU (neonatal intensive care unit)?

☐ No ☐ Yes Explain: ______

During pregnancy, did the mother:

- Take prenatal vitamins? ☐ Yes ☐ No ☐ Unknown
- Smoke or use e-cigarettes? ☐ Yes ☐ No ☐ Unknown
- Drink alcohol? ☐ Yes ☐ No ☐ Unknown
- Use marijuana? ☐ Yes ☐ No ☐ Unknown
- Use illicit drugs? ☐ Yes ☐ No ☐ Unknown
- Take other medications? ☐ Yes ☐ No ☐ Unknown

If yes, please list:

Blood type:

Mother: ______ ☐ Unknown

Baby: ______ ☐ Unknown

Mother's lab results:

- Hepatitis B ☐ Pos ☐ Neg ☐ Unknown
- HIV ☐ Pos ☐ Neg ☐ Unknown
- Group B streptococcus (GBS) ☐ Pos ☐ Neg ☐ Unknown

After birth, did the baby get:

- Vitamin K shot? ☐ Yes ☐ No ☐ Unknown
- Erythromycin eye ointment? ☐ Yes ☐ No ☐ Unknown
- Hepatitis B shot? ☐ Yes ☐ No ☐ Unknown

How was the baby fed? ☐ Bottle formula ☐ Bottle breast milk

☐ Breastfed How long was baby breastfed? ______

Did baby go home with biological mother from hospital after birth? ☐ Yes

☐ No Explain: ______

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®

The recommendations in this questionnaire do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. Original questionnaire included as part of the *Bright Futures Tool and Resource Kit,* 2nd Edition. The American Academy of Pediatrics (AAP) does not review or endorse any modifications made to this questionnaire and in no event shall the AAP be liable for any such changes.

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Name: ______________________________

PAST MEDICAL HISTORY

Has your child ever had any of the following problems? DK = Don't know

Condition	DK	No	Yes	Details
Eye problems, cataracts, or retinoblastoma				
Vision impairment or concerns				
Nasal allergies (dust, pets, or environmental)				
Frequent ear infections				
Hearing loss or concerns				
Multiple cavities or problems with teeth				
Frequent colds or sore throats				
Asthma, wheezing, or breathing problems				
Bronchitis, bronchiolitis, or pneumonia				
Heart murmur or other heart problems				
High blood pressure				
Frequent stomach pain				
Constipation needing medical treatment				
Food allergies or intolerance (eg, milk, gluten)				
Feeding issues or underweight				
Overweight or obesity				
Urinary tract infections				
Bed-wetting (after 5 years old)				
Kidney, ureter, or bladder problems				
Serious injuries or fractures				
Bone, joint, or muscle problems				
Frequent headaches or dizziness				
Concussion or head injury				
Convulsions, seizures, or neurological issues				
Sleep problems or snoring				
Skin rashes, eczema, or hives				
Acne				
Thyroid or other endocrine problems				
Diabetes				
Metabolic/genetic disorders				
Anemia or bleeding problems				
Cancer or chemotherapy				
Bone marrow or organ transplant				

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Name: ______________________________

PAST MEDICAL HISTORY *(continued)*

Has your child ever had any of the following problems? DK = Don't know

Condition	DK	No	Yes	Details
Blood transfusion				
HIV or AIDS				
Chickenpox or zoster (shingles)				
Developmental delays (speech or motor)				
School problems or learning difficulties				
ADHD or behavioral concerns				
Anxiety, depression, or mood problems				
Tobacco, alcohol, or drug use				
Exposure to family violence				
Pregnancy or miscarriage				
Sexually transmitted infections				
Females: issues with periods				
Age of first period:				

Other medical problems (Please list.)

SURGICAL HISTORY

Has your child ever had surgery? ☐ No ☐ Yes If yes, please provide details below.

Surgery/Procedure	Date of Surgery/Child's Age	Where Completed	Details

Other surgical/procedural problems (Please list.)

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Initial History Questionnaire

Name: ______________________________

FAMILY HISTORY

Have any of your child's parents, grandparents, aunts, uncles, brothers, or sisters ever had any of the following conditions? DK = Don't know

Condition	DK	No	Yes	Who?	Details
Anemia or bleeding problems					
Asthma					
Allergies					
Alcohol use problems					
Bed-wetting (after age 10 years)					
Cancer (before age 55 years)					
Childhood hearing loss					
Dental decay or multiple cavities					
Depression or anxiety					
Developmental disability					
Diabetes					
Heart attack (myocardial infarction)					
Heart disease (before age 55 years)					
High blood pressure					
High cholesterol					
HIV or AIDS					
Kidney disease					
Liver disease					
Mental health conditions					
Obesity					
Seizures or epilepsy					
Stroke					
Substance use problems					
Sudden death (before age 50 years)					
Thyroid or other endocrine disease					
Tobacco use problems					
Tuberculosis					
Vision or eye problems					

Other medical problems (Please list.)

PRINT NAME.	SIGNATURE
Provider 1	
Provider 2	

Consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 4th Edition

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ARK-LA-TEX CHILDREN'S CLINIC

2400 HOSPITAL DR, STE 120; BOSSIER CITY, LA 71111; (318) 742-6710 (318)747-5393(fax)

COMPLETE FORM ONLY IF APPLICABLE:

Authorization for Evaluation And/Or Treatment of A Minor Child Unaccompanied By Parent Or Legal Guardian

A parent or legal guardian must accompany a child younger than 18 years of age to consent for all medical and/or surgical treatment provided by Ark-La-Tex Children's Clinic. Please complete this form if your child will be coming for a visit, treatment, or procedure, without a parent or legal guardian. This consent is valid until an updated copy has been signed and received by our office. ***(Examples of when this may be needed are when a grandparent, relative, or babysitter bring your child to our office. You do not need to list parents or legal guardians in the authorization list.)***

Patient Full Name:________________________________ **Date of Birth:**____________________

I authorize ________________________________ ____________________

(Name of person(s) being authorized) (Relationship to Patient)

I authorize ________________________________ ____________________

(Name of person(s) being authorized) (Relationship to Patient)

I authorize ________________________________ ____________________

(Name of person(s) being authorized) (Relationship to Patient)

I authorize ________________________________ ____________________

(Name of person(s) being authorized) (Relationship to Patient)

I authorize ________________________________ ____________________

(Name of person(s) being authorized) (Relationship to Patient)

To give consent to medical treatment by Ark-La-Tex Children's Clinic on behalf of my child listed above. The above-named individual(s) may also receive test results and additional information pertinent to the care and treatment of this minor child. I also authorize them to participate in medical decision making which includes but is not limited to consent for vaccinations, consent for injections, etc. I agree that a parent or legal guardian should be available via phone at all times while my child is being seen. I understand that I am still financially responsible for all medical expenses incurred by my child during these appointments. I acknowledge that I may void this agreement at any time and that this agreement will also be voided by any agreements signed on future dates.

________________________________ ____________________

Parent/Legal Guardian Signature Date Signed

____

Parent/Legal Guardian Name

ARK-LA-TEX CHILDREN'S CLINIC

2400 HOSPITAL DR, STE 120; BOSSIER CITY, LA 71111; (318) 742-6710 (318)747-5393(fax)

COMPLETE FORM ONLY IF APPLICABLE:

Authorization for Evaluation And/Or Treatment of a Child Unaccompanied by an Adult:

Patient Full Name:____ **Date of Birth:**____________________

I authorize and give consent for my child, listed above, to go independently to appointments and consent to all medical and/or surgical treatment without the presence of a parent or legal guardian. I understand that I am still financially responsible for all medical expenses incurred by my child during these appointments. I understand that a parent or legal guardian should be available via phone at all times during my child's appointment. I understand that my child's treatment and management maybe affected by no parent or guardian being present and that the physicians and staff at Ark-La-Tex Children's Clinic are not responsible since I'm allowing my child to come unaccompanied. I also understand that I am responsible for contact Ark-La-Tex Children's Clinic with any questions or concerns in regards to my child's unaccompanied visit. If at any time I choose to void the consent for my child to be seen unaccompanied, I know that I can do so and that also this agreement will be voided by any agreements signed on future dates. ***(Examples: Patient is <18yo but is able to legally drive and comes to an appointment alone and/or a patient is brought to an appointment by someone <18yo that is able to legally drive them to their appointment).***

____ ______________________

Parent/Legal Guardian Signature Date Signed

____

Parent/Legal Guardian Name