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PLEASE PRINT & Fill Out Completely

1 Patient Information

Full Name:____

Preferred Name:____

DOB:___________________ Age:________ Sex: M F

Street Address:____

City, State, Zip Code:_____________________________________

Primary Phone: (_______)__________________________________

EMAIL:____

Preferred Pharmacy:_______________________________________

2 Parent/Guardian/Guarantor Information

Full Name:____

Relationship to Child:________________________ Receive Texts: Y N

DOB:_______________ SSN#:________________________________

Cell: (____)__________________Work: (____)_________________

Street Address:____

City, State, Zip Code:_____________________________________

Employer & Occupation:____________________________________

3 Parent/Guardian Information

Full Name:____

Relationship to Child:________________________ Receive Texts: Y N

DOB:_______________ SSN#:________________________________

Cell: (____)__________________Work: (____)_________________

Street Address:____

City, State, Zip Code:_____________________________________

Employer & Occupation:____________________________________

Martial Status of Parents : Married_____Divorced____Separated_____
IF NOT MARRIED, Who has custodial rights:______________________

4 Insurance Information

Name of Insured:____

Insured DOB:____

Insurance Company:____

I.D. Number:____
I certify that I will be financially responsible for all medical expenses for the above patient in the event they should lose coverage of Medicaid or commercial insurance during the course of treatment.

Sign:____

5 Secondary Insurance Information

Name of Insured:____

Insured DOB:____

Insurance Company:____

I.D. Number:____
I certify that I will be financially responsible for all medical expenses for the above patient in the event they should lose coverage of Medicaid or commercial insurance during the course of treatment.
Sign:____

6 Emergency Contact (not living with you)

Name:____

Phone: (______)___________________Relation:_________________

7 Siblings (List other sibling(s) attending our clinic)

____

____

____

Previous Physician:______________________________

PLEASE READ: Payment is required ***in full*** at the time of each visit. The patient, their parent, or their guardian are responsible for all fees, regardless of Insurance coverage. We will file insurance only as a courtesy, but ultimately our patients are responsible for all outstanding balances regardless of coverage.
AUTHORIZATION: I understand that I will be charged (not my insurance) for canceled appointments unless I give 24 hours' notice. All of the office policies have been provided to me and I understand all policies. I agree to all policies that have been provided to me in writing.
RELEASE OF INFORMATION: I authorize the release of any medical information necessary to process insurance claims.
INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize and request payment of medical benefits directly to Premier Pediatrics of Bixby.
I CERTIFY THAT I AM THE RESPONSIBLE PARTY FOR THE PATIENT LISTED ABOVE AND THAT I HAVE THE AUTHORITY TO AGREE TO and SIGN ON BEHALF OF THE PATIENT FOR ALL SERVICES RENDERED. I, ALSO, CERTIFY THAT I AM THE FINACIALLY RESPONSIBLE PARTY FOR THE PATIENT LISTED ABOVE and THAT I HAVE THE AUTHORITY TO AGREE TO ALL PRACTICE POLICIES AND FINANCIAL POLICIES.

Printed Name:_____________________________________

Relationship:______________________________________

Signature:____

Date:____

Who can we thank for referring you?:__________________

INTIAL HISTORY QUESTIONNAIRE

Patient Name ______ DOB ______ Age ______ M/F ______

____
Form completed by

Relationship to patient ______ Date ______

HOUSEHOLD

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

Name	Relationship To Child	Birth Date	Health Problems

Are there siblings not listed? If so, please list their names, ages, and where they live.____

____

What is the child's living situation if not with both biological parents?

____ Joint Custody ____Single Custody If so, who has custody__________

____ Lives with adoptive family ____ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

____

____

BIRTH HISTORY

____ Don't know birth history

Birth Weight_________ Was baby born at term? Y N if not,

________weeks Name of hospital for

birth:____ Any prenatal or

neonatal complications? Y N Explain:_______________

____

_ Was a NICU stay required? Y N

Explain:___________________________

____

_ During pregnancy, did mother:

Use prenatal vitamins: Y N Use tobacco: Y N Use alcohol: Y N

Use drugs or medications: Y N

What_________________________ When___________________________

Was the delivery ____ Vaginal ____Cesarean

Initial feeding ____ Formula ____Breast Milk How long breastfed?

Did your baby go home with mother from hospital? Y N

If no, explain____

GENERAL

Answer Yes No or Don't Know

Do you consider child to be in good health? Y N DK

Explain:____

Has your child had any surgery? Y N DK

Explain:____

Has your child ever been hospitalized? Y N DK

Explain:____

Do you feel your family has enough to eat? Y N DK

Explain:____

Is your child allergic to any mediciations? Y N DK

Explain:____

MEDICATION LIST

Please list any medications your child currently takes.

Medication	Dose/How often

PREMIER
PEDIATRIC AND ADOLESCENT CARE

12/20

Condition	Patient	Explain	Family History	Family Member
Pregnancy	Y N DK			
Chicken Pox	Y N DK			
Frequent ear infections	Y N DK		Y N DK	
Problems with ear or hearing loss	Y N DK		Y N DK	
Nasal allergies	Y N DK		Y N DK	
Problems with eyes or vision	Y N DK		Y N DK	
Asthma, bronchitis, or pneumonia	Y N DK		Y N DK	
Heart problems or heart murmur	Y N DK		Y N DK	
Anemia or bleeding disorder	Y N DK		Y N DK	
Blood transfusion	Y N DK		Y N DK	
Immune problems, HIV or AIDS	Y N DK		Y N DK	
Organ transplant	Y N DK		Y N DK	
Malignancy/bone marrow transplant	Y N DK		Y N DK	
Chemotherapy	Y N DK		Y N DK	
Frequent abdominal pain	Y N DK		Y N DK	
Constipation requiring dr visits	Y N DK		Y N DK	
Frequent UTIs/kidney disease	Y N DK		Y N DK	
Congenital cataracts/retinoblastoma	Y N DK		Y N DK	
Metabolic/Genetic disorders	Y N DK		Y N DK	
Urologic malformations	Y N DK		Y N DK	
Bed-wetting (after 5 years old)	Y N DK		Y N DK	
Sleep problems; snoring	Y N DK		Y N DK	
Skin problems (ex: acne, eczema)	Y N DK		Y N DK	
Frequent headaches	Y N DK		Y N DK	
Convulsions,epilepsy,seizure,neurological issue	Y N DK		Y N DK	
Obesity	Y N DK		Y N DK	
Thyroid or other endocrine problems	Y N DK		Y N DK	
High blood pressure	Y N DK		Y N DK	
Diabetes	Y N DK		Y N DK	
History of serious injuries/fractures/concussion	Y N DK		Y N DK	
Use of alcohol or drugs	Y N DK		Y N DK	
Tobacco use	Y N DK		Y N DK	
ADHD/anxiety/depression/mental illness/mood	Y N DK		Y N DK	
Developmental delay	Y N DK		Y N DK	
Dental decay	Y N DK		Y N DK	
Tuberculosis	Y N DK		Y N DK	
High cholesterol/takes medication	Y N DK		Y N DK	
Liver disease	Y N DK		Y N DK	
History of family violence	Y N DK		Y N DK	
Sexually transmitted infections	Y N DK		Y N DK	
For Girls Problems with periods	Y N DK		Y N DK	
Has had first period	Y N DK		Start Date:	
Cancer	Y N DK		Y N DK	Age:
Other chronic conditions	Y N DK		Y N DK	

Patient Name:____

VACCINE FOR CHILDREN PROGRAM

PATIENT ELEGIBILITY SCREENING RECORD

1. Date Screened (Today's Date): ___________/___________________/_______________

   Month Day Year

2. Child's Name: ____

   LAST FIRST MIDDLE INITIAL

3. Child's Date of Birth: ___________/___________________/_______________

   Month Day Year

4. Parent/Guardian/Individual Record: ____

   LAST FIRST MIDDLE INITIAL

5. This child qualifies for Immunization through the VFC Program because he/she (check only one):
   a. Is enrolled in Medicaid
   b. Does not have health insurance
   c. Is an American Indian of Alaskan Native
   d. Is underinsured (has health insurance that does not pay for vaccinations)

6. Provider Record: ____

   LAST FIRST MIDDLE INITIAL

Parent/Legal Guardian Signature: ____

A record of VFC eligibility for all children18 years of age or younger who receive VFC program vaccines, must be kept in the health care provider's office. The record may be completed by the parent, guardian, individual or record, or by the health care provider. This same record will satisfy the requirements for all subsequent vaccinations, as 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 VFC eligible child receiving vaccine for three years.