Danielle Morgan, MD, FAAP
Ryan Mundy, MD, FAAP

7814 E 121st St Bixby, OK 74008
T: 918-943-5777
F:918-621-0505

PREMIER
PEDIATRIC AND ADOLESCENT CARE

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

Form completed by

Patient Name DOB Age M/F

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

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:_____

PREMIER PEDIATRIC & ADOLESCENT CARE

NOTICE OF PRIVACY PRACTICE

THIS NOTICE BRIEFLY DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION PLEASE REVIEW THIS NOTICE CAREFULLY.

The United States government has enacted a law known as HIPAA. This is an unfunded mandate that we must follow. This notice is to inform you of how we will handle your health information. Your information has always been kept sacred and safe in our office and we will continue to do so in the future.

Basically, we will use any information regarding your health condition to:

- Provide treatment
- For payment purposes with your carrier, and
- For the ongoing operation of our office

Treatment is, of course, based on the information you give us during your appointment, your office visit, and during the course of treatment. We may use this information to inform other health care providers of your situation when we request a consultation with them. The information may be used to inform the hospital of scheduled tests, x-rays, or procedures.

Payment is based upon those services provided and your carrier often demands copies of your health information to process claim.

The day-to-day operations of the office revolve around your health information. Internal audits to improve quality of care, training health care assistants, making decisions regarding business management planning and development all depend upon the information you provide to us.

Legally, we are a non-covered entity under the law. All of our transcription and billing is done in the office. Nothing is transmitted over the intranet.

There are several times when we have no control over your health information. This is, there are times as specified in state and federal statutes when we must surrender your information. Please see the complete policy manual for a complete discussion of these instances.

You also have several rights also under HIPAA regarding your medical information. You have a right to inspect and request copies. You have the right to request amendments be made to your records. You have the right to an accounting of disclosures. You have the right to request confidential communications with the office. You have the right to a paper copy of this notice. By law, we are required to have your signature in your medical record to attest to the fact that you have received and read this notice.

If you have further questions, please contact the office staff with your concerns. If you are concerned that your privacy rights are being violated, you may file a complaint directly with our office at the location and number above. You may also file directly with the Secretary of Department of Human Services. According to law, you must file your complaint within 180 days of when you knew or should have known of the circumstance that led to the complaint and must be submitted in writing. Our office staff can assist you with contact information. You will not be penalized for filing a complaint.

Thank you for taking the time to read this notice and to sign the required form for your chart. Please rest assured that your information will always be treated as a sacred trust, just as we always have, and always will treat our patient-doctor relationship

PREMIER
PEDIATRIC AND ADOLESCENT CARE

PREMIER PEDIATRIC & ADOLESCENT CARE

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGMENT AND CONSENT

The notice of Privacy Practices tells you how we may use and share your health records. Please read it. We will use and share your health records:

- **To treat you**
- **To bill for the services we provide**
- **To run our business**
- **As required by law**

All the ways we may use and share your health records are explained in More detain the Notice of Privacy practices. You have the right to:

- **Look at and receive a copy of your health records**
- **Receive a list of whom we have given your health records to**
- **Ask us to correct a mistake in your health records**
- **Ask that we not use or share your health records**
- **Ask us to change the way we contact you**

All of these rights are explained in more detail in the Notice of Privacy Practices.

I HAVE RECEIVED A COPY OF PREMIER PEDIATRIC'S NOTICE OF PRIVACY PRACTICES.

_____ ____/____/____

Signature of Patient or Legal Representative **Today's Date**

_____

Relationship of Legal Representative to Patient

PREMIER
PEDIATRIC AND ADOLESCENT CARE

Medical Information Release

Form (HIPAA Release Form)

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

Release of Information

☐ **I authorize the release of information including the diagnosis, records; examination rendered, and claims information. This information may be released to:**

Name:_____ **Relationship:**_____

Name:_____ **Relationship:**_____

Name:_____ **Relationship:**_____

Information should **NOT** be released to:

Name:_____ **Relationship:**_____

Name:_____ **Relationship:**_____

This **Release of information** will remain in effect until terminated by me in writing.

Messages

If unable to reach me:
☐ you may leave a detailed message
☐ please leave a message asking for me to return your call
☐ _____

Signature:_____ **Relationship:**_____ **Date:**_____

Witness:_____ **Date:**_____

7814 E 121st ST.
Bixby, OK 74008
Tel. 918-943-5777
Fax. 918-621-0505

PREMIER
PEDIATRIC AND ADOLESCENT CARE

2009 N Main
Muskogee, OK 74401
Tel. 918-816-4024
Fax. 918-816-4025

Date: _____

To: _____
Clinic/Physician/Medical Center

I, _____, authorize and request the disclosure of all protected
Parent/Legal Guardian's Name
information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

☐ All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers. All laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myelogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels and reports.

By State Law, you must be advised that:

The information authorized for release may include records which may vindicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus also known as Acquired Immune Deficiency Syndrome (AIDS).

RE: Patient(s) Listed Below

Name(s)	Date of Birth
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____
Parent, Legal Guardian, or Person Authorized To sign if other than Signature — Date

_____
Relationship to Patient

2009 N Main
Muskogee, OK 74001
P: (918) 816-4024
F: (918) 816-4025

PREMIER
PEDIATRIC AND ADOLESCENT CARE

7814 E 121st
Bixby, OK 74008
P: (918) 943-5777
F: (918) 621-0505

This Medical Home Agreement is an **AGREEMENT** between **YOU AND YOUR PROVIDER** to work together to meet ALL your Healthcare Needs.

As your Medical Home Primary Care Provider (PCP), we agree to:

1. Respect your rights as a patient. Treat you with dignity.
2. Focus on listening to your concerns. Educate you on your healthcare. Provide and track preventative services.
3. Focus on treating you as a whole person: physically, mentally, and emotionally.
4. Focus on providing you with quality and safe healthcare.
5. Work to schedule office appointments in a timely manner.
6. Be available to you 24 hours a day, by appointment, phone calls, and/or electronic communication.
7. Provide you with other healthcare resources when we are unavailable.
8. Provide you with referral to specialists as determined **medically** necessary.
9. Provide you with treatment, medications, equipment and any other resource as determined medically necessary.
10. Provide you with necessary immunizations that meet CDC requirements.

As your Medical Home Patient, YOUR RESPONSIBILTY is the following:

1. Work with us, as your *PCP*, to meet all your healthcare needs.
2. Communicate with us about all your healthcare concerns.
3. Report any changes related to your health, such as: treatments, all medications, medical equipment used, etc.
4. Call us ***before*** going to the Emergency Room unless it is life threatening.
5. Notify us ***after*** any Emergency Room, Urgent Care Clinic, or Hospital Visit.
6. Schedule all medical appointments in a timely manner.
7. Keep appointments as scheduled, with us ***AND*** any specialists.
8. If you cannot keep an appointment, call ***before*** your appointment time to cancel or reschedule.
9. You may be ***dismissed*** from your PCP panel if you repeatedly miss appointments without notice.
10. You may be ***dismissed*** from your PCP for ***NOT*** vaccinating your children according to CDC recommendations.

Your Healthcare is a TEAM approach involving BOTH YOU and YOUR PROVIDER.

_____ _____

Parent/Legal Guardian Signature Date

_____ _____

Provider Date

PREMIER
PEDIATRIC AND ADOLESCENT CARE

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.