JMH Pediatrics

PLEASE PRINT

	Today's Date ______	Patient Registration	Please Complete All Areas
	Pharmacy (Please list the pharmacy you want to use for prescriptions.)	PHARMACY NAME	PHARMACY LOCATION

Mother's Information:				
MOTHER'S NAME: (FIRST, MIDDLE, LAST NAME)				
ADDRESS		CITY	STATE	ZIP
DOB		RACE	ETHNICITY	MARITAL STATUS
CELL PHONE	HOME PHONE		EMAIL	
EMPLOYER				
EMPLOYER ADDRESS			EMPLOYER PHONE	

Father's Information:				
FATHER'S NAME: (FIRST, MIDDLE, LAST NAME)				
ADDRESS		CITY	STATE	ZIP
DOB		RACE	ETHNICITY	MARITAL STATUS
CELL PHONE	HOME PHONE		EMAIL	
EMPLOYER				
EMPLOYER ADDRESS			EMPLOYER PHONE	

Message Authorization

PREFERRED METHOD OF CONTACT

I authorize JMH Pediatrics' staff to leave medical information pertaining to the care of my child(ren) by the following methods and will assume responsibility to notify JMH Pediatrics whenever this information changes. In addition to medical information concerning appointment confirmation, rescheduling of appointments and nurses follow-up may be left by the following methods.

MOTHER ☐ TEXT #__________ ☐ PHONE CALL #__________ ☐ EMAIL __________

FATHER ☐ TEXT #__________ ☐ PHONE CALL #__________ ☐ EMAIL __________

***** STOP *****

If you have more than one child please take this sheet back up to the receptionist before continuing. She will make a copy for each child's chart and return them to you to fill out the remaining information.

Patient Info	FIRST, MIDDLE, LAST NAME	DOB	SEX (M – F)	RACE	ETHNICITY	PREFERRED PROVIDER

As a service to you, our patients, we file insurance claims. Please be aware communication about copays and coinsurance with your insurance company is your responsibility.

I AGREE to pay my known portion and/or co-pay at the time services are provided. I also agree to pay any additional portion denied by my insurance company.

I understand that JMH will not forward bills to other parties regardless of court rulings or divorce decrees. The adult that regularly brings the child is responsible for co-pays and deductibles.

Guarantor Signature: ______________ Date: __________ Time: ________

JMH Pediatrics

Designation of Personal Representative

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA), you have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you or your child. By completing this form you are informing us that you wish to designate the named person(s) as your or your child's personal representative. You may revoke this designation at any time by signing and dating the revocation of your copy of this form and returning it to this office.

Designation:

I, ______________________ (print name), hereby nominate the following person(s) to act as my or my child's personal representative with respect to decisions involving the use and/or disclosure of health information that pertains to me or my child. **Our office requires a PARENT to accompany any child under the age of 18 for all New Patient, Well Child and/or Vaccination or Injection Visits.**

Please check the applicable box indicating if we may discuss your child's health status or financial (bill) matters with your selection(s) below.			Discuss Health Information	Financial (Bill)
Relationship:	Name:	Phone #:	☐ Yes ☐ No	☐ Yes ☐ No
Relationship:	Name:	Phone #:	☐ Yes ☐ No	☐ Yes ☐ No
Relationship:	Name:	Phone #:	☐ Yes ☐ No	☐ Yes ☐ No
Relationship:	Name:	Phone #:	☐ Yes ☐ No	☐ Yes ☐ No

The authority of this person when acting as my personal representative is restricted to the marked functions. **Representatives may accompany a child to "sick" visits only.** JMH Pediatrics reserves the right to collect copays that are due at the time of service from the designated representative.

Guarantor Signature: ______________________ Date: __________ Time: ________
(or patient, if 18 or older)

***** STOP *****

If you have more than one child please take this sheet back up to the receptionist before continuing. She will make a copy for each child's chart and return them to you to fill out the remaining information.

Patient Name: ______________________ Male / Female DOB: ____________
(Print Name)

Revocation:

I understand that by signing this Revocation Section of my copy of this form and returning it to JMH Pediatrics, I revoke this designation. I further understand that any such revocation does not apply to the extent that persons authorized to use and/or disclose my or my child's health information have already acted in reliance on this designation.

Guarantor Signature: ______________________ Date: __________ Time: ________
(or patient, if 18 or older)

CLEAR FORM

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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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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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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JOHNSON MEMORIAL HEALTH

Franklin, Indiana 46131

(To Be Completed by JMH Staff)
MRN#: ______________
FIN#: ______________

REQUEST AND AUTHORIZATION TO OBTAIN AND/OR RELEASE MEDICAL INFORMATION

I, the undersigned, hereby request and authorize disclosure of the indicated Medical Records from the following facility. (Please check box)

Johnson Memorial Health (hospital and/or hospital outpatient clinics):

□ Hospital □ Breast Center □ Immediate Care □ Pain Relief Specialists □ Occupational Health □ Oncology □ Wound Healing

Johnson Memorial Health Physician Network (JMH physician offices):

□Family Practice □Internal Medicine □Orthopedic Surgery/Sports Medicine □Pediatrics □Pulmonology □Surgical Specialists □Women's OB/GYN

□ **Obtain / Release Medical Records From - Facility Name:** ______________ PH#: ______________

Address: ______________ City/State/Zip: ______________ FAX#: ______________

SECTION 1 - PATIENT INFORMATION (Please Print)

First Name: ______________ Middle Initial: _____ Last Name: ______________ Date of Birth: ______________

Address: ______________ City: ______________ State: _______ Zip: _______

Primary Telephone Number: ______________ Alternate Telephone Number: ______________

SECTION 2 – INFORMATION TO BE RELEASED

Date(s) of service to be released from: _____/_____/_____ through _____/_____/_____

□ Pertinent Medical Records (dictations, labs, x-rays)
□ Physician Office Notes (Dr. ______________)
□ Rehabilitation / Therapy Records (PT, OT, Speech)
□ Pathology
□ Consultation
□ Return to School Note ( ) return date ( ) COVID status
□ Emergency (ER) Report
□ Discharge Summary / Instructions
□ Operative (Surgery) Report
□ Radiology Report
□ Radiology Images/Films (on a CD)
□ Other: ______________
□ Itemized Bill
□ Immunization Record
□ Paternity Affidavit
□ Lab Results
□ Cardiology

****Special Authorization*** State & Federal Laws protect the following health information.*
If your medical record may contain any of the protected health information below, please indicate if you would like to have this data released.

Alcohol, Drug or Substance Abuse Records □ *Yes* □ *No*
HIV Test and Results □ *Yes* □ *No*
Mental Health Records □ *Yes* □ *No*

SECTION 3 – RELEASE INFORMATION TO THE FOLLOWING FACILITY/PERSON

□ Me/Patient (or Legal Representative) □ Other (see below)

Company / Name: ______________ Attention: ______________

Address: ______________ City: ______________ State: _______ Zip: _______

Telephone Number: ______________ Ext: _______ Fax Number: ______________

SECTION 4 – PURPOSE OF RELEASE

□ Personal / Patient Use* □ Attorney / Legal Request* □ Insurance* □ Social Security / Disability*
□ Continuing Care / Physician □ Workman's Comp □ School / Daycare □ Other: ______________

*Fees may be applied in accordance with Indiana Statute 760IAC 1-71-3 and Federal Rule 45 C.F.R. §164.524

SECTION 5 – ACKNOWLEDGEMENT AND CONSENT TO RELEASE HEALTH INFORMATION

- This authorization will expire in 60 days from the date signed unless otherwise specified here: ______________
- I understand that I have the right to revoke this authorization at any time. In order to revoke this authorization, I must do so in writing and present my written revocation to the above named authorized entity. The revocation will not apply to information that has already been released in response to this authorization. Also, if applicable, I understand that JMH may charge for medical record copies.
- I understand that JMH cannot prevent re-disclosure of my information by the person/company who receives my data as directed by this authorization. By signing this authorization, I release JMH from any and all liability resulting from a re-disclosure by the recipient.
- I understand that my JMH record may contain data that was received from another facility & it may be released as part of this request.

Your signature indicates that you have read and understand this form and you authorize release of your JMH medical record as described above.

______________ ______________ ______________AM/PM
Patient Signature (or Legal Representative**) Date Time

**Relationship to Patient: ______________. Provide documentation of authority to act on behalf of Patient.

<u>To Be Completed By JMH Release of Information Staff:</u>
Signature Verified Via: Photo ID ____ Signature on File ____
Initials of Staff Releasing Records: _______ Date: _______