PATIENT INFORMATION

(Please PRINT)

Daniel Clinic Emp: _____

PATIENT:

LAST NAME _____ **FIRST NAME** _____ **MI** _____ **SUFFIX** _____

GENDER ☐ M ☐ F SSN _____ MARITAL STATUS ☐ S ☐ M DOB _____

RACE ☐ WHITE ☐ BLACK/AFRICAN AMERICAN ☐ OTHER

MAILING ADDRESS: _____ APT/LOT NO _____

PHYSICAL ADDRESS: _____

CITY _____ ST _____ ZIP _____

HOME PH _____ CELL PH _____ WORK PH _____ EXT _____

E-MAIL ADDRESS: _____

PREFERRED CONTACT METHOD ☐ PHONE ☐ MAIL ☐ E-MAIL

PREFERRED REMINDER METHOD ☐ HOME PH ☐ CELL PH ☐ WORK PH

DRIVER'S LICENCE NO _____ **ST** _____ **EXP DATE** _____

Emergency Contact Name_____ **Phone#**_____

INSURANCE:

POLICY HOLDER _____ **RELATIONSHIP TO PATIENT** _____

GENDER ☐ M ☐ F SSN _____ DOB _____

MAILING ADDRESS _____ APT/LOT NO _____

CITY _____ ST _____ ZIP _____

DRIVER'S LICENCE NO _____ ST _____ EXP DATE _____

AUTHORIZATION & RELEASE

I AUTHORIZE RELEASE OF ANY INFORMATION CONCERMING MY (OR MY CHILD'S) HEALTH CARE, ADVICE AND TREATMENT PROVIDED FOR THE PURPOSE OF EVALUATING AND ADMINISTERING CLAIMS FOR INSURANCE BENEFITS. I ALSO HEREBY AUTHORIZE PAYMENT OF INSURANCE BENEFITS DIRECTLY TO DANIEL CLINIC FOR ANY FUNDS OTHERWISE PAYABLE TO ME.

X _____ ***DATE*** _____

SIGNATURE OF PATIENT (OR PARENT/GUARDIAN IF MINOR)

GUARANTOR: (Person Responsible For Payment)

NAME _____ **RELATIONSHIP TO PATIENT** _____

GENDER ☐ M ☐ F SSN _____ DOB _____

HOME PH _____ CELL PH _____ WORK PH _____ EXT _____

MAILING ADDRESS _____ APT/LOT NO _____

CITY _____ ST _____ ZIP _____

DRIVER'S LICENCE NO _____ ST _____ EXP DATE _____

X _____ ***DATE*** _____

SIGNATURE OF GUARANTOR

Pediatric Health History Form – Initial Visit

Child's Name _____ Date of Birth _____ Age _____
Your Name _____ Relationship to Child _____

Child's Past Medical History

Pregnancy/Neonatal Period

Where was your child born? _____
Is the child yours by ☐ birth ☐ adoption ☐ stepchild ☐ other
Pregnancy complications _____
Delivery by ☐ vaginal ☐ c-section
Reason for c-section _____
Complications _____
Was your child premature ☐ No ☐ Yes, born at _____ weeks
Complications _____
Apgar Scores 1 minute _____ 5 minutes _____
Birth weight _____ Length _____
Other problems in the newborn period _____
_____

Infancy/Childhood/Adolescence

Has your child ever been treated for or diagnosed with: (explain)
☐ Asthma or reactive airway disease _____
☐ Wheezing or bronchiolitis _____
☐ Seasonal allergies or eczema _____
☐ Food Allergy _____
☐ Recurrent ear infections _____
☐ Pneumonia _____
☐ Urinary tract infections _____
Genetic syndrome _____
Seizures _____
Anemia _____
Broken Bones _____
Mental retardation or learning disability _____
Depression/anxiety _____
Other chronic medical conditions _____
_____
Has your child ever been hospitalized ☐ No ☐ Yes (explain)
_____
Previous surgeries and dates _____
_____
Please list any specialist your child is currently seeing and reason:___
_____
_____

Medications

ALLERGIES to medicine/vaccines (list and describe reaction)
_____
_____
_____
Current medications and dose: _____
_____
_____
Vitamins_____
Herbal Supplements _____
Over-the-counter meds _____

Development/Nutrition

At what age did your child: 1st period (females)_____
Walk alone_____ Sit alone _____
Toilet train (day)_____ Say words _____
Was your child breastfed ☐ No ☐ Yes, How long? _____
Has your child had any unusual feeding/dietary problems? Explain.
_____
Current milk intake: Type:_____ Amount_____oz/d

Social History

Who lives in the household with the child? ☐ Mom ☐ Dad
☐ Siblings (#_____) ☐ Grandparents ☐ Other _____
Child's parents are ☐ married ☐ unmarried ☐ divorced ☐ other
Childcare ☐ parents ☐ relatives ☐ daycare ☐ babysitter/nanny
Days per week in childcare (not with parents) _____
Do any household members smoke ☐ Yes ☐ No
How many hours per day does your child spend:
Watching TV_____ Computer _____Video games_____
Child's school name _____Grade_____
Any concerns about school performance? ☐ No ☐ Yes, explain
_____
Any concerns about peer or teacher relationships? ☐ No ☐ Yes
_____
Sports/exercise: Type _____
How often? _____ How long? _____min

Family History

Do any family members have any of the following conditions:

Condition	Mother	Father	Sibling	Grandparents
Asthma	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Blood disorder	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Heart attack/disease	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Depression/anxiety	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐
_____	☐	☐	☐	☐

Please explain all positives: _____
_____
_____

Review of Systems (check all that apply)

Constitutional
☐ Fever/chills ☐ Fatigue
☐ Unexplained weight loss/gain
☐ Excessive thirst

Ear, Nose, & Throat
☐ Loud voice, hearing problem
☐ Mouth-breathing, snoring
☐ Ear pain
☐ Frequent runny nose

Respiratory
☐ Cough, short of breath
☐ Chest tightness, wheeze

Musculoskeletal
☐ Muscle pain, weakness
☐ Joint pain, swelling
☐ Bone pain

Other (eye,skin,blood)
☐ Blurry vision ☐ Squinting
☐ "Crossed" eyes ☐ Itchy eyes
☐ Rashes ☐ Abnormal moles
☐ Abnormal bruising, bleeding

Gastrointestinal
☐ Nausea, vomiting, diarrhea
☐ Constipation, blood in stool
☐ Abdominal pain

Cardiovascular
☐ Chest pain, palpitations
☐ Tires easily with exertion
☐ Fainting

Genitourinary
☐ Frequent or painful urination
☐ Bedwetting/frequent accident
☐ Vaginal or penile discharge

Neurologic
☐ Headaches ☐ Milestone delay
☐ Clumsiness ☐ Seizures

Psychiatric/Emotional
☐ Anxiety/stress ☐ Depression
☐ Sleep problem
☐ Concerns with attention
☐ Anger concern

DANIEL CLINIC/WFPH PHYSICIAN CLINIC
5326 Oak Street / P.O. Box 487
Saint Francisville, LA 70775
Ph (225) 635-5848 Fax (225) 635-5847

Patient Name: _____ Date: _____

CONSENT FOR MEDICAL TREATMENT

I consent to and authorize Daniel Clinic personnel to perform care and treatment including but not limited to medical treatment, laboratory, and/or diagnostic testing that may be ordered by said personnel.

I certify that I have read and understand the above authorization for medical treatment.

X_____
Signature of Patient (or Guardian)

ADVANCE DIRECTIVES

I have a Living Will ☐ Yes ☐ No
I have a Medical Power of Attorney ☐ Yes ☐ No

If Yes, I understand it is my responsibility to provide a copy for my medical records.

X_____
Signature of Patient (or Guardian)

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received a copy of Daniel Clinic's Privacy Notice.

I understand that a privacy officer has been appointed and that any questions regarding that Privacy Act may be directed to the HIPAA Privacy Officer.

I have read and understand the facility's Privacy Notice. I understand that I have the right to restrict how my protected health information may be used. I also understand that the facility may refuse admission should the restrictions I place on my protected health information interfere 1) with the clinic's ability to treat and/or bill me for services rendered or 2) with the operations of the facility.

X_____
Signature of Patient (or Guardian)

Daniel Clinic
5326 Oak St / PO Box 487
St. Francisville, LA 70775
Ph #: 635-5848 Fax #: 635-5847

AUTHORIZATION FOR INDIVIDUALS INVOLVED IN THE CARE OF THE PATIENT

Patient's Name: _____ DOB: _____

From time to time it may be necessary for individuals other than the parent(s) or legal guardian(s) of a patient to accompany the patient to our office. In such cases, the patient's parent(s) or legal guardian(s) must formally designate the individual(s) who have been asked to serve on behalf of the parent(s) or legal guardian(s). If you wish to designate such an individual, please complete the following:

In my absence, I authorize the following individual(s) to act on my behalf in allowing the patient to receive medical treatment, including lab work, injections, treatments or procedures, etc., deemed necessary for the patient. At the time of service, medical and/or billing information may be released to the individual present with the patient.

It is the responsibility of the patient's parent(s) or legal guardian(s) to keep this form updated with any additions and/or deletions. I understand that this consent will remain in effect until I request otherwise in writing.

Authorized Person(s)' Names (Please Print)	Relationship To The Patient (Please Print)
_____	_____
_____	_____
_____	_____

_____
Parent's/Legal Guardian's Name (Print)

_____ _____
Parent's/Legal Guardian's Signature Date

Effective Date: _____ Discontinue Date: _____

DANIEL CLINIC
5326 Oak Street / P. O. Box 487
Saint Francisville, LA 70775
Phone (225) 635-5848 Fax (225) 635-5847

RECORDS OVER 25 PAGES SHOULD BE MAILED

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name	DOB	SSN
Guardian's Name (if patient is a minor)	DOB	SSN

This authorization shall expire on: _____ If I fail to specify an expiration date, this authorization will expire six (6) months from the date on which it was signed.

Purpose of disclosure:

☐ Medical Care ☐ Legal ☐ Insurance ☐ Personal ☐ Other _____

Description of Information to be used or disclosed:

☐ Complete Medical Information ☐ Clinic Visit Information ☐Lab work/Radiology

☐ Verbal Information ☐ Other _____

Information may be released **from**:

Name of Dr.(*First & Last Name*)**/Clinic**

_____

Address

_____

_____

Phone Number(*Please Provide*)

_____

Fax Number

_____

Information may be released **to**:

DANIEL CLINIC

☐ Dr. Chaillie Daniel ☐ Dr. Timothy Lindsey

☐DewanaBobo ☐ Patty Hayden

☐ Rachel Simmons ☐ Dawn Hanna

☐KamerynFevella

I acknowledge, and hereby consent to such, that the released information may contain genetic test results, alcohol/drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ **(initial)**

I understand that:

1) I may refuse to sign this authorization and that it is strictly voluntary.
2) If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3) I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4) If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
5) I understand that I may see and obtain a copy of the information described on this form if I ask for it.
6) I may get a copy of this form after I sign it.

I have read the above and authorize the disclosure of the protected health information as stated.

***Printed* Name of Patient**_____

Printed Name of Guardian(if minor) _____

Relationship to Patient _____

***Signature* of Patient/Guardian** _____

Witness Signature _____ Date _____