Carlile Pediatrics
78 Cambridge Court Wetumpka , AL 36093
334-567-6915 Accepting New Patients
www.carlilepediatrics.com

Patient Information

If you have any questions or need assistance filling out this form, please feel free to ask any of our staff.

Patient Name: _____
Other names used_____
Date of birth_____ Age_____ Gender ❒ M ❒ F
Race_____
Current Address _____
_____
Home phone # _____ Work # _____
Other phone # _____

Family information

Have we seen any other members of your immediate family? If yes, whom?
_____

If patient is a minor, who has custody of the patient? _____
Relationship of legal guardian to patient _____
Guardian's address_____
Guardian's phone # _____Guardian's social security # _____
Occupation _____ Employer _____
Work phone # _____

Mother's name_____ Social security # _____
Mother's address _____ Home phone # _____
Occupation _____ Work phone#_____
Employer _____

Father's name _____ Social security _____
Father's address _____ Home phone # _____
Occupation _____ Work phone #_____
Employer _____

Contact person in case of emergency
_____
Relationship to patient _____ Phone # _____
Insurance information

Primary insurance _____ Policy # _____
Group # _____
Person carrying insurance _____ Date of Birth_____

Secondary insurance _____Policy # _____
Group # _____

Person carrying insurance _____ Date of Birth_____
If patient is a minor, who is primarily responsible for paying? _____
Relationship to patient _____
Phone # _____

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As a new patient, may we request that you answer a few questions regarding your child's or your own health.

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

Person filling our form: _____ **Your Relationship to patient:** _____

Name of last physician seen: _____ **Name of pharmacy:** _____

Birth History

Where was patient born?_____
Was patient born _____**term or** _____**preterm**
If preterm how early?_____
Birth Weight?_____
Any problems at birth:_____

How did you hear about us?

------ **Physician Referral**
_____ **Yellow Pages**
_____ **Web Search**
_____ **Facebook**
_____ **Friend**

Past History

Has patient ever been hospitalized?____**Y**____**N**
If yes, for what and when?_____
_____
_____
_____
_____

Past History

Has patient ever had surgery? ___**Y** ____**N**
If yes what kind and where? _____
_____
_____
_____
_____

Does patient take any medication? ___**Y** ___**N**
If yes, what?
Medication Year started Dose/ Day
_____ _____ _____
_____ _____ _____
_____ _____ _____

Has patient ever had a major injury?__**Y** __**N**
If yes what kind and when? _____
_____
_____
_____
_____

Does patient have any allergies? ____**Y** ____**N**

If yes, to what?
_____
_____
_____

Are there any present concerns regarding patient's health?

_____
_____
_____

ADDITIONAL INFORMATION:_____
_____
_____
_____
_____
_____

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Past History

Has patient ever had any of the following? (Please circle ALL that apply)

Developmental/Speech/Motor Delay
Attention Deficit Hyperactivity Disorder
Seizures
Strep Throat
Pneumonia
Asthma
Allergies
Otitis Media (ear infection)
Diabetes
Urinary Tract Infection
High Blood Levels
Anemia
Sickle Cell Disease
Peptic Ulcer Disease
Inflammatory Bowel Disease
Cogenital Anomalies/Birth Defects
Heart Disease/Heart Murmur
Kidney Disease
Liver Disease
Joint Disease
Chickenpox (when_____)
Wears Glasses
OTHER: _____

Who Lives with patient at home

Name	Relationship	Age

What is the patient's fathers occupation?
_____
What is the patient's mothers occupation?
_____
How old is your current home? _____
Do you live next to a major highway? _____
Has your home recently been remodeled?____

Family History

Has parent, grandparents or siblings ever had any of the following? (Please mark ALL that apply)

	Parent	G/P	Sib
Diabetes	_____	_____	_____
Hypertension	_____	_____	_____
High Cholesterol	_____	_____	_____
Heart Disease	_____	_____	_____
Asthma	_____	_____	_____
Allergies	_____	_____	_____
Stroke	_____	_____	_____
Glaucoma	_____	_____	_____
Migraines	_____	_____	_____
Deafness	_____	_____	_____
Depression	_____	_____	_____
Psychiatric Illness	_____	_____	_____
Mental Retardation	_____	_____	_____
School Problems	_____	_____	_____
ADHD	_____	_____	_____
High Blood Level	_____	_____	_____
Cancer/Leukemia	_____	_____	_____
Sickle Cell	_____	_____	_____
Hepatitis	_____	_____	_____
HIV/AIDS	_____	_____	_____
Immune Disorder	_____	_____	_____
Chemotherapy	_____	_____	_____
TB/pos TB Test	_____	_____	_____

Other: _____

Does patient go to school? _____
Grade/Year _____
Name of School _____
Are there any concerns about patients school performance? _____
_____
_____
Are there other care giving arrangements?

____ Babysitter
____ Day care Center
____ Family Members
____ Others

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FAX# 334-514-7269

Patient Authorization for Requesting Medical Records/ Releasing Medical Information

Patient Name: _____DOB_____

Address:_____City:_____ State:_____Zip_____

Phone Number: _____ SS#_____

Name of Parent/Legal Guardian giving Authorization: _____

*If Legal Guardian is not Parent, please state your Relationship to patient: _____

Authorized Use & Disclosure of Information

The following information is requested:

__Medical Records for the past 18 months, immunization records, and growth charts

__ER Records from _____to_____

__Hospital Records from _____to_____

__This information is being requested from Dr. _____(**patient's prior physician**)

By Dr. Jim Carlile for the purpose of rendering treatment, obtaining payment or in the course of health care operation, unless as specified below:

_____

__This information is being released by Carlile MD to:_____

for the purpose of ❒transferring care ❒continuing care ❒an individual's request ❒other

_____

Revoking Authorization I understand that I may revoke this authorization by providing written notice to Carlile MD, except for any action taken before Carlile MD received such notice. This authorization may be revoked one year after it was signed or on the following date or event if stated here:_____ _____

I have read this authorization and agree with all statements made. I understand that Carlile MD is not responsible for the use and disclosure of this information by any other party to which I have authorized the disclosure of the above information. I understand that the medical records contain information which may include confidential remarks, information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug related conditions, alcoholism and/or disclosure of the protected health information described in this form with the people and/or organizations named

_____ _____

Signature of Patient, Parent, or Legal Guardian Date

YOU HAVE A RIGHT TO A COPY OF THIS FORM AFTER YOU SIGN IT.

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Non Parental Authorization for Consent to Medical Care and Treatment

I, _____, parent/legal guardian of the child(ren) listed below do hereby give authorization and consent for the below named authorized person(s) to consent to the medical care and treatment for my child(ren). I hereby authorize and grant that the below named person has/have permission from the natural parent to sign/give authorization for procedures and treatments deemed necessary for the wellbeing of my child(ren).

I am, by this document, representing that I have the authority to consent for all medical care and treatment of the said child(ren).

_____ _____ _____
Signature Relationship to child(ren) Date

Child(ren)

_____ _____
Name

_____ _____
Name

Person(s) other than parent/ legal guardian who are authorized to get medical care for the child(ren) listed above:

_____ _____
Name Relationship to Child (ren)

_____ _____
Name Relationship to Child (ren)

_____ _____
Name Relationship to Child (ren)

_____ _____
Name Relationship to Child (ren)

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU OR YOUR CHILD(CHILDREN) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Carlile Pediatrics, including staff, physicians and other health care providers on our staff, use and share health information about you or your child (children) for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. We are committed to protecting health information about you or your child (children). Your or your child's health information is contained in a medical record that is the physical property of Carlile Pediatrics.

HOW WE MAY USE YOUR HEALTH INFORMATION:

FOR TREATMENT. We may use your or your child's health information to provide, coordinate or manage medical treatment or related services. Information obtained by a nurse, physician, or other member of the healthcare team will be recorded in the medical record and used to determine the course of treatment that will work best for you or your child.
FOR PAYMENT. We may use and disclose health information to bill and collect payment for treatment and services that are received. For example, a bill may be sent to you or to your insurance company. The bill will contain information that identifies you or your child (children), as well as the diagnosis, procedures and supplies used in the course of treatment.
FOR HEALTH CARE OPERATIONS. We may use and disclose health information about you or your child (children) for office operations. For example, you or your child's health information may be disclosed to other staff members to:

- Evaluate the performance of our staff
- Assess the quality of care
- Learn how to improve our facilities and services; and
- Determine how we can make improvements in the care and services we provide

APPOINTMENTS/FOLLOW-UP CALLS. We may use your or your child's information to contact you as a reminder that you have an appointment for treatment or to follow-up regarding medical care.
INDIVIDUALS INVOLVED IN YOUR CARE. We may share information with a family member or other person identified by you or who is involved in your or your child's care or payment related to that care. We may tell a family member or friend about you or your child's) condition. If you do not want that information released to those involved in the care, see instructions for requesting a restriction under **YOUR HEALTH INFORMATION RIGHTS.**

HOW WE MAY DISCLOSE YOUR OR YOUR CHILD (CHILDREN'S) HEALTH INFORMATION OUTSIDE OF CARLILE PEDIATRICS:

REQUIRED BY LAW/PUBLIC HEALTH. We may disclose information about you or your child (children) when required to do so by federal, state or local laws.
For example, we may disclose information for the following purposes:

- To respond to a court order, subpoena or deposition.
- To assist law enforcement officials in their duties to locate a suspect, fugitive or missing person.
- To report information related to victims of child abuse or neglect.
- To report reactions to medication or recalls of products.
- To federal and state agencies for oversight activities authorized by law such as investigation, inspections, audits, surveys and licensing. (Examples may include organizations that ensure the quality/safety of the care we provide).

HEALTH RISKS. You or your child's health information may be released for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability. We may disclose your or your child's health information to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease.
HEALTH AND SAFETY. We may disclose health information about you or your child (children) to avert a serious threat to the health or safety of you, any other person or the public. Any disclosure would only be to someone able to help prevent the threat.
DECEASED. Health information may be disclosed to funeral directors, medical examiners or coroners to enable them to carry out their lawful duties.
ORGAN/TISSUE DONATION. If you or your child (children) are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank.
RESEARCH. We may disclose information for research purposes when Carlile Pediatrics has reviewed and approved the research proposal. Medical record information that identities you or your child (children) will only be used when given permission for us to do so. Additionally, when given permission, CP may contact you regarding research purposes.
NATIONAL SECURITY. We may disclose your or your child's health information to federal officials for intelligence, counterintelligence, and national security activities authorized by law.

TREATMENT ALTERNATIVES. We may use and disclose health information to tell you about or recommend possible treatment options or other health-related benefits and services that may be of interest to you.

YOUR HEALTH INFORMATION RIGHTS

In accordance with federal regulations and Carlile Pediatrics policies and procedures, you have the right to:

· Request a restriction on certain uses and disclosures of your or your child's health information. We will make every effort to honor your request. However, in some situations, we may be required by law to share the health information. As an example, tuberculosis (TB) results are required by law to be reported to the Health Department. Carlile Pediatrics is not required to agree to all requested restrictions.

· Request to inspect and/or obtain a copy of your or your child's health record. You have the right to request to inspect and/or obtain a copy of the
health information and billing records. We may charge a fee for the costs associated with copying and/or mailing the information.

· Request to correct/amend information in your or your child's health record. If you feel that health information we have is incorrect or incomplete,
you may ask us to correct/amend the information. If the health information is determined to be incorrect or incomplete, we will revise the record.

· Request confidential communications. You have the right to request that we communicate with you about health information in a particular manner or at a location other than your permanent address. For example, you may ask that we contact you by mail rather than by telephone, or at work rather than at home. It is your responsibility to make sure that we have your correct address and contact information.

· Receive a listing of how your or your child's information has been shared. You have the right to receive a listing of disclosures of the health information for purposes outside of treatment, payment or office operations (not including disclosures made prior to April 14, 2003).

· Receive a paper copy of this notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of the notice at any time.

In order to request a restriction on how your or your child's health information is used or to request confidential communication, you must complete a "Restriction of Health Information Request Form".

In order to request a copy, an inspection, a correction/amendment, or a listing of disclosures you must submit a
request in writing to the Medical Records Department.

OBLIGATIONS OF CARLILE PEDIATRIC'S

We are committed to:

· Make sure that medical information that identifies you, your child (children) is kept private.
· Provide you with this notice of our legal duties and privacy practices with respect to you or your child's health information.
· Follow the terms of this notice.
· Notify you, after management's review, if we are unable to agree to a requested restriction on how health information is used or disclosed.
· Accommodate reasonable requests for communications of health information in a particular manner or to a location other than your permanent address.

• Obtain your written authorization to disclose health information for reasons other than those listed above and permitted.

Carlile Pediatrics reserves the right to change the terms of this notice and to make the new provisions effective for all protected health information it maintains. Revised notices will be made available to you by posting them in our office or posting them on our website at www.carlilepedatrics.com . Upon your request, we will provide you with a copy of the most recent copy of our Notice of Privacy Practices.

CONTACT INFORMATION

You may file a complaint to Carlile Pediatrics or to the United States Secretary of the Department of Health and Human Services if you believe your or your child's privacy rights have been violated. You will not be penalized for filing a complaint.

If you have any complaints or questions about information in this document, you may contact: Privacy Officer, at 78 Cambridge Court Wetumpka, Al 36092

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PATIENT'S HIPPA ACKNOWLEDGEMENT

Patient Name: _____
DOB:_____

I HAVE READ THE "NOTICE OF PRIVACY PRACTICES" FOR CARLILE PEDIATRICS.

_____ _____

Signature **Date**