Bloom and Grow Pediatrics

Susan Bruce, CPNP

1315 Burro Avenue Cloudcroft, NM 88317
Office: 575-682-2002 Fax: 575-682-2003

Child 1: Last Name: _____ First Name: _____ MI: _____

D.O.B.: _____/_____/_____ Sex: _____ Primary Language: _____

Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White /Unknown

Insurance Information

Primary Policy: Policy Holder's Name: _____

Policy Holder's Birth Date: _____ Insurance Carrier: _____

Policy ID#: _____ Group #:_____

Secondary Policy: Policy Holder's Name: _____

Policy Holder's Birth Date: _____ Insurance Carrier: _____

Policy ID#: _____ Group #:_____

Child 2: Last Name: _____ First Name: _____ MI: _____

D.O.B.: _____/_____/_____ Sex: _____ Primary Language: _____

Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White /Unknown

Insurance Information

Primary Policy: Policy Holder's Name: _____

Policy Holder's Birth Date: _____ Insurance Carrier: _____

Policy ID#: _____Group #:_____

Secondary Policy: Policy Holder's Name: _____

Policy Holder's Birth Date: _____ Insurance Carrier: _____

Policy ID#: _____ Group #:_____

Child 3: Last Name: _____ First Name: _____ MI: _____

D.O.B.: _____/_____/_____ Sex: _____ Primary Language: _____

Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White/ Unknown

Insurance Information

Primary Policy: Policy Holder's Name: _____

Policy Holder's Birth Date: _____ SSN: _____-_____-_____

Insurance Carrier: _____ Policy ID#: _____Group #:_____

Secondary Policy: Policy Holder's Name: _____

Policy Holder's Birth Date: _____ Insurance Carrier: _____

Policy ID#: _____ Group #:_____

Mailing Address: _____
(Street or PO Box) (City) (State & Zip)

Physical Address:_____

House Phone/Landline (if you have one): (_____) _____ - _____

Who lives at this household? _____
(Please note, this information is being requested to improve intake of your child's Social History.)

Contact Information

Contact 1: Name: _____ Date of Birth: ____ / ____ / ____

Lives with patient? Yes / No Relation to Patient: _____ Biological Relation to Patient: Yes / No

(Please note, this information is being requested to improve intake of your child's Family Medical History.)

Employer_____ Occupation_____

Work Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Preferred Email: _____ Home email / Work email (circle)

How would this contact ideally prefer to be contacted (**circle one**): Home Phone / Cell Phone / Email

Contact 2: Name: _____ Date of Birth: ____ / ____ / ____

Lives with patient? Yes / No Relation to Patient: _____ Biological Relation to Patient: Yes / No

(Please note, this information is being requested to improve intake of your child's Family Medical History.)

Employer_____ Occupation_____

Work Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Preferred Email: _____ Home email / Work email (circle)

How would this contact ideally prefer to be contacted (**circle one**): Home Phone / Cell Phone / Email

Emergency Contact, <u>other than parents</u>: Name & Relationship

1: _____ Relationship _____ Phone: (___) _____ - _____

Additional Contact Questions:

Who should receive billing statements? _____

May all contacts have access to the patient's records electronically? Yes / No

If no, list who may have access

_____

If parents are divorced or separated please fill out this section:
Who has custody? _____
Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

MEDICAL HISTORY *(please fill out additional history forms for each child)*

Allergy / Reaction Information

Medication Allergies: No: _____ Yes: ____ (explain below)

_____

(Medication) (Reaction)

Non-Medication Allergies: None: ___ Yes: (please describe)_____

Vaccine Reactions: None: ___ Yes: (please describe) _____

Current/Chronic Medications/Supplements/Vitamins

1. _____

(Medication) (Dose) (Date Started)

2. _____

(Medication) (Dose) (Date Started)

3. _____

(Medication) (Dose) (Date Started)

Problem List/Ongoing Medical Conditions

1. _____

(Diagnosis) (Date)

Details:

2. _____

(Diagnosis) (Date)

Details:

3. _____

(Diagnosis) (Date)

Details:

Pertinent Past Medical History

(check if Yes and provide details including date)

___ Birth Problems Please describe:_____

___Serious Injuries Please list: _____

___Surgeries Please list: _____

___Hospitalizations Please list: _____

Pertinent Family Medical History:

_____

Pertinent Social History:

_____

Does anyone in the household smoke ___yes ___no

Does anyone in the household own a gun ___yes ___no Are they locked up? ___yes ___no

Does your child have a dentist ___yes ___no Who_____

ASSIGNMENT OF INSURANCE AND PRIVACY POLICY

(please fill out one for each child)

- I understand that I am financially responsible for all the professional charges that my children may incur
- All copayments and non-covered charges are due at the time of service. All costs not paid by insurance are due upon receipt of statement.
- I hereby authorize payment of medical benefits direct to Bloom and Grow Pediatrics, LLC. I further authorize the release of any medical information necessary for processing the insurance claim. I understand that all costs not paid by insurance are my responsibility unless otherwise prohibited by state or federal regulations.
- Acknowledgement of receipt of HIPAA Notice of Privacy Practices: I have received or have been give the opportunity to receive a copy of HIPAA Notice of Privacy Practices.

Parent/Guardian Signature (Patient Signature if over 18)	**Printed Name**	**Date**

CONSENT FOR TREATMENT

I give my permission for Bloom and Grow Pediatrics, LLC to treat my child, _____ (Please Print), according to the standards of care defined by the American Association of Pediatrics (AAP) and the realm of medical necessity as deemed appropriate by the treating Provider.

Parent/Guardian Signature (Patient Signature if over 18)	**Printed Name**	**Date**

OPTIONAL: AUTHORIZATION FOR TREATMENT WHEN PARENT/GUARDIAN IS NOT PRESENT WITH CHILD

(ie. Nanny, Grandparent, Step-Parent, and/or teen by themselves)

I,_____ (Please Print), do hereby consent and authorize Bloom and Grow Pediatrics and its Providers and Staff to examine and/or treat my child in my absence. I affirm that I have the legal right to consent to this. I understand that this consent is legal and binding until specifically revoked by myself or another person who has the legal right to sign or revoke this authorization. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of examinations and/or treatments.

I give the Providers and Staff permission to treat my child in my absence with whatever treatment plan they deem necessary and appropriate. I understand that I will be contacted for a verbal consent if treatment plan includes vaccines.

Parent/Guardian Signature (Patient Signature if over 18)	**Printed Name**	**Date**

AUTHORIZATION TO RELEASE OR OBTAIN HEALTH INFORMATION

Bloom and Grow Pediatrics
Susan Bruce, CPNP

Name			
Mailing Address			Telephone Number
City	State	Zip Code	Medicaid or Social Security #

I AUTHORIZE:

Name: **Bloom and Grow Pediatrics**
Mailing Address: PO Box 1902 Cloudcroft, NM 88317
Phone: 575-682-2002 **Fax: 575-682-2003**

To: ___ RELEASE MY RECORDS TO _x_RELEASE MY RECORDS FROM

Name: _____
Mailing Address:_____
_____
Phone: _____
Fax: _____

The purpose of the authorization is:

___ Changing Medical Providers ___Legal Action ___Further Medical Care ___Personal

I authorize the release of the following information:

_x__Most recent well visit and sick visit _x__Immunizations _x__Growth Charts

___Hospital Discharge Summary ___Labs ___Imaging __ Entire record

Records from (date) _____to (date) _____
Records related to the following specific condition(s), test(s) or treatments(s):
_____

Other: _____

This authorization shall expire (date or event): .

I understand that if I do not specify an expiration date, this authorization will expire six months from the date on which it was signed. I understand that I may revoke this authorization at any time in writing.

_____ _____

Signature of Individual or Personal Representative Authorized by Law Date

If signed by Personal Representative, basis of authority: _____

Bloom and Grow Use only **Date(s) Requested: _____Date Received: _____**