

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**, other than parents: 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)***

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| **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)  |
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| **Problem List/Ongoing Medical Conditions**1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Diagnosis) (Date)Details:2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Diagnosis) (Date) Details: 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (Diagnosis) (Date) Details:  |
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| **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 \_\_\_noDoes anyone in the household own a gun \_\_\_yes \_\_\_no Are they locked up? \_\_\_yes \_\_\_noDoes your child have a dentist \_\_\_yes \_\_\_no Who\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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**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**

|  |  |
| --- | --- |
| Name  | Request Date  |
| 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 88317Phone: 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 \_\_\_PersonalI 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**