Clinico Rural Health Clinic, LLC

Subramaniam Krishnamurthi, MD
Kerri Ellis, APRN
Misty Anderson, APRN

103 E Main st, P.O. Box 478, Beggs OK 74421
PH:918-267-7000 Fax:918-267-7077

PEDIATRIC REGISTRATION FORM

(Please Print)

Today's Date:			
PATIENT INFORMATION			
Patient's full name:	Birth date:	Age:	Sex: ☐ M ☐ F
Street address/ PO Box:			Social Security no.
Home Phone: ( )	City:	State:	ZIP Code
Father's Name	Social Security no.	Date of Birth	Business Phone ( )
Mother's Name	Social Security no.	Date of Birth	Business Phone ( )
Name of person not living with patient to contact for emergency			Phone:
Chose clinic because/referred to clinic by (Please check one box):	Dr.	☐ Insurance plan	☐ Hospital
☐ Family	☐ Friend	☐ Close to home/work	☐ Phonebook	Other
Other Family Members Seen here:			

INSURANCE INFORMATION				
Primary Insurance Carrier Name	Policy ID			Group#
Insured's Name:		Soc. Sec. No (if not listed above):		Date of Birth (if not listed above)
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	Other
Secondary Insurance Carrier Name	Policy ID			Group#
Insured's Name:		Soc. Sec. No (if not listed above):		Date of Birth (if not listed above)
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	Other

PARENTAL PRE-AUTHORIZATION FOR MEDICAL CARE TO CHILDREN

I give my permission for the physicians at Clinico LLC to provide any necessary medical care to my minor child whose name is:

Printed name of legal guardian/parent	Parent/Guardian Signature
_____	_____

REQUIRED SIGNATURE

I have been provided with the following documents from Clinico LLC: Your Rights and Responsibilities as a Patient, Notice of Privacy Practices.

I authorize the release of information concerning my child's healthcare, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits, otherwise payable to me, directly to Clinico, LLC (For Medicare beneficiaries, this serves as a lifetime authorization assigning payment of Medicare benefits to Clinico, LLC). I understand that I am personally responsible for all charges not covered by my insurance.

Parent/Guardian Signature

_____

Date

_____

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Pediatric History form

Name	DOB	Age	Sex ☐ M ☐ F

BIRTH HISTORY			
Were there any complications during the pregnancy or at birth ☐ No Yes-please explain: ☐ jaundice ☐ respiratory distress ☐ feeding problems			
If premature, born at how many weeks?	Delivery: ☐ vaginal ☐ c-section ☐ breech	Length	Weight

ALLERGIES to any medications, X-Ray dyes or other substances? ☐ No ☐ Yes (if yes, please the list the type of reaction)

MEDICATIONS-names, dosages			

IMMUNIZATIONS
Are your child's immunizations up to date? ☐ Yes ☐ No ☐ Unsure

PAST MEDICAL HISTORY				
Any delays in development? ☐ No ☐ Yes-explain: ☐ motor ☐ speech ☐ hearing				
☐ ADD/ADHD	☐ Anemia	☐ Acid Reflux	☐ Appendix removal	☐ Asthma
☐ Blood Transfusion	☐ Cancer	☐ Chicken pox	☐ Chronic ear infections	☐ Diabetes
☐ Eczema	☐ Epilepsy	☐ Eye or vision problems	☐ Heart Murmur	☐ Hernia/Hernia repair
☐ Kidney/bladder problems	☐ Liver disease/jaundice	☐ Mono	☐ Rheumatic fever	☐ Tuberculosis
Other:				

FAMILY HISTORY Adopted? ☐ Yes- you may skip this section			
Illness	Father	Mother	Sibling (s)
Bleeding/Clotting Disorder	☐	☐	☐
Cancer (list the type)			
Depression/Anxiety	☐	☐	☐
Diabetes	☐	☐	☐
Heart Attack	☐	☐	☐
High Blood Pressure	☐	☐	☐
High Cholesterol	☐	☐	☐

SOCIAL AND ENVIRONMENTAL HISTORY	
Who does the child live with?	Is the home tobacco free?

I attest that the above information is accurate to the best of my knowledge.

Parent/Guardian Name _____ Parent/Guardian Signature

_____ Date _____

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Please note if your wish for anyone other than yourself to communicate with the doctor or our staff in regard to your care, appointments or account status. I understand that sensitive information, like STDs (including HIV/AIDS) results, pregnancy test results, mental health or substance abuse will not be shared unless specifically stated by me at the time.

Patient Name _____ Date of Birth _____

Does the Patient have an Advanced Directive (Living Will)? ☐ Yes ☐ No

Do not release information about _____

Authorized contact name:_____

Relationship to patient: _____

Contact phone number: _____

Authorized contact name:_____

Relationship to patient: _____

Contact phone number: _____

Authorized contact name:_____

Relationship to patient: _____

Contact phone number: _____

Patient Signature: _____ Date Signed: _____

Phone Release

I authorize Clinico LLC staff to leave messages with anyone that answers my phone or on my answering machine in regards to appointments, test results, or issues in regard to my care.

Patient Signature: _____ Date Signed: _____