ARK-LA-TEX CHILDREN'S CLINIC COVID-19 PREVISIT SCREEN:

DATE: _____ PHYSICIAN/NURSE PRACTITIONER SEEING PATIENT: _____

PATIENT NAME:_____ DOB:_____

ACCOMPANIED BY:_____

CELL PHONE #:_____ RELATIONSHIP TO PATIENT:_____

TODAY'S VISIT IS A: ☐ ***WELL*** ☐ ***SICK*** ☐ ***ADHD*** ☐ ***PROBLEM* VISIT** ☐ **SHOT ONLY** ☐ **Ear Piercing**

HAS YOUR INSURANCE CHANGED?..... ☐ YES ☐ NO ☐ NO INSURANCE
DO YOU HAVE A COPAY WITH YOUR INSURANCE?..... ☐ YES ☐ NO ☐ N/A
IF YOU HAVE A COPAY, HOW DO YOU PLAN TO PAY TODAY?... ☐ CASH ☐ CREDIT

DUE TO COVID-19 INFECTION CONCERNS, WE REQUIRE THE FOLLOWING QUESTIONS BE ASKED IN ORDER FOR US TO SEE YOUR CHILD TODAY:

1. PLEASE CHECK OFF ANY SYMPTOM THAT YOU, YOUR CHILD, OR ANY CLOSE CONTACTS HAVE HAD DURING THE LAST WEEK:

☐ FEVER &/OR CHILLS	☐ NAUSEA &/OR VOMITING	☐ DIARRHEA
☐ MUSCLE OR BODY ACHES	☐ HEADACHE	☐ SORE THROAT
☐ NEW LOSS OF TASTE	☐ NEW LOSS OF SMELL	☐ COUGH
☐ SHORTNESS OF BREATH	☐ DIFFICULTY BREATHING	☐ CONGESTION &/OR RUNNY NOSE

2. Have you, your child, any family members, or close contacts had any recent travel in the last 4 weeks?..... ☐ **YES** ☐ **NO**
3. Have you, your child, any family members, or close contacts tested POSITIVE for COVID-19?..... ☐ **YES** ☐ **NO**
4. Are you, your child, any family members, or close contacts waiting for results to determine if you or the person swabbed has COVID-19?..... ☐ **YES** ☐ **NO**
5. Have you, your child, any family members, or close contacts been told they may have COVID-19 and to self isolate, but were not swabbed for COVID-19?..... ☐ **YES** ☐ **NO**

PLEASE BE ADVISED THAT WE WILL CALL YOU TO LET YOU KNOW WHEN WE WILL BE MEETING YOU AT THE DOOR TO BRING YOU BACK FOR YOUR APPOINTMENT. WE MAY ALSO CALL TO ASK FURTHER QUESTIONS ABOUT THE ANSWERS ON YOUR SCREEN. PLEASE BE PATIENT WITH US AS WE DO OUR BEST TO KEEP YOU AND YOUR CHILDREN SAFE AS WELL AS TO PREVENT THE SPREAD OF COVID-19.

FOR OFFICE USE:

APPT TIME:_____ ARRIVAL TIME:_____

ARK-LA-TEX CHILDREN'S CLINIC 2400 HOSPITAL DRIVE, SUITE 120, BOSSIER CITY, LA 71111
PATIENT INFORMATION FOR PATIENTS >18YO

☐ DR. SANDERS ☐ DR. HUGHES ☐ DR. SINGH ☐ DR. GARDNER ☐ DR. MILNER

FULL NAME:_____ GOES BY:_____

DOB:_____ SEX: SELECT MALE/FE SSN:_____ RACE:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIPCODE:_____

√ PREFERRED CONTACT #: ☐ HOME: _____ ☐ WORK: _____ ☐ CELL: _____

RESPONSIBLE PARTY:_____ RELATIONSHIP TO PATIENT:_____

DOB:_____ SSN:_____ DRIVERS LICENSE #:_____ EMPLOYER:_____

RESPONSIBLE PARTY ADDRESS (☐ IF SAME AS ABOVE):_____

√ PREFERRED CONTACT #: ☐ HOME: _____ ☐ WORK: _____ ☐ CELL: _____

IS PATIENT COVERED BY MEDICAL INSURANCE: YES NO

INSURANCE COMPANY:_____ POLICY #:_____

INSURED NAME:_____ GROUP #:_____

EMERGENCY CONTACT (NOT LIVING IN SAME HOUSEHOLD):_____

PHONE#:_____ RELATIONSHIP TO PATIENT:_____

CONSENT FOR DISCUSSION WITH FAMILY MEMBER(S) AND/OR PERSONAL REPRESENTATIVE(S):

I have agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I hereby give my permission for Ark-La-Tex Children's Clinic to verbally discuss my personal medical information with the following individual(s) listed below. I also understand that when health information is discussed, the information could be shared with others by the recipient and may no longer be protected by federal or state privacy laws. I understand that by not listing anyone below, my health care will not be affected. I also understand that I can list specific topics to not be discussed such as alcohol and drug abuse, psychiatric conditions, sexually transmitted diseases and/or pregnancy.

Name:_____ Relationship to Patient:_____ Phone#: _____

Name:_____ Relationship to Patient:_____ Phone#: _____

Name:_____ Relationship to Patient:_____ Phone#: _____

Name:_____ Relationship to Patient:_____ Phone#: _____

I do NOT agree to any topics listed to be discussed with the above: [☐ Not applicable]_____

_____

I understand that the responsible party listed above must authorize the release of any medical or other information necessary to process this claim. They also authorize payment of medical benefits to the Ark-La-Tex Children's Clinic. I understand that my listed responsible party and myself are financially responsible for any remaining balance not paid by insurance. I also acknowledge that it is my responsibility to complete an updated form anytime the above information changes or whenever requested by Ark-La-Tex Children's Clinic.

_____ _____ _____

PATIENT SIGNATURE SIGNATURE OF RESPONSIBLE PARTY IF APPLICABLE DATE

ARK-LA-TEX CHILDREN'S CLINIC

2400 HOSPITAL DRIVE, SUITE 120, BOSSIER CITY, LA 71111
(318) 742-6710

PATIENT NAME:_____ **DOB:**_____

1. Please list the family members or other persons, if any, whom we may inform about the patient's general medical condition and diagnosis (including treatment, payment, and health care operations):
   - Father:_____ Last 4 digits of SSN:_____
   - Mother:_____ Last 4 digits of SSN:_____
   - Name:_____Relationship:_____ Phone#:_____
   - Name:_____Relationship:_____ Phone#:_____
   - Name:_____Relationship:_____ Phone#:_____

2. Please list the family members or significant others, if any, whom we may inform about the patient's condition ONLY IN AN EMERGENCY:
   - Name:_____Relationship:_____ Phone#:_____
   - Name:_____Relationship:_____ Phone#:_____
   - Name:_____Relationship:_____ Phone#:_____

3. Please print the address of where you would like your postcards and/or correspondence from our office to be sent if other than your home address:
   - Address:_____

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL"
   - YES:__☐__ NO:__☐__

5. Can confidential messages be left on your telephone answering machine?
   - YES:__☐__ NO:__☐__ If YES, preferred phone #:_____

6. Please list other children who attend this clinic:
   - Name:_____ DOB:_____
   - Name:_____ DOB:_____
   - Name:_____ DOB:_____
   - Name:_____ DOB:_____
   - Name:_____ DOB:_____

Patient/Guarantor Signature:_____ **Date:**_____

Relationship to Patient:_____

Ark-La-Tex Children's Clinic

2400 Hospital Drive, Suite 120, Bossier City, LA 71111
(318) 742-6710

PATIENT NAME:_____ **DOB:**_____

PLEASE READ AND SIGN STATING THAT YOU UNDERSTAND EACH POLICY:

- **ALL COPAYS ARE DUE AT TIME OF SERVICE.**
- **PRIMARY AND SECONDARY INSURANCES – ALL PRIMARY INSURANCE COPAYS ARE DUE AT TIME OF SERVICE.**
- **PLEASE COMPLETE THE ENTIRE SIGN-IN SHEET.**
- **PLEASE NOTIFY THE RECEPTIONIST IF THERE HAS BEEN A CHANGE IN YOUR PERSONAL INFORMATION.**
- **A NEW PATIENT INFORMATION SHEET IS TO BE COMPLETED EVERY 12 MONTHS OR WHENEVER THERE IS A CHANGE IN ANY PERSONAL INFORMATION.**
- **THERE WILL BE A $25.00 FEE ASSESSED FOR ALL RETURNED CHECKS.**
- **WE MUST OBTAIN THE SOCIAL SECURITY NUMBER ON EACH PATIENT. FOR NEWBORNS WE REALIZE THERE WILL BE A DELAY WHILE WAITING FOR THEIR SOCIAL SECURITY NUMBER TO BE RECEIVED.**
- **YOU ARE RESPONSIBLE FOR ANY BALANCE NOT COVERED BY YOUR INSURANCE COMPANY. MONTHLY PAYMENT ARRANGEMENTS ARE AVAILABLE.**
- **A COPAY WILL BE COLLECTED FOR A "SHOT ONLY" VISIT IF ANY OTHER ISSUES ARE ADDRESSED AT THAT VISIT.**
- **ALL PATIENTS 2 YEARS OLD AND OLDER SHOULD HAVE AN ANNUAL WELL VISIT. IF A PATIENT IS DUE AN ANNUAL WELL VISIT, A REQUEST FOR A SHOT VISIT WILL BE CONVERTED TO A WELL VISIT. ALL PATIENTS 0-24 MONTHS WILL BE SEEN FOR WELL VISITS AT MINIMUM WHEN THEY ARE 2-5 DAYS, 1 MONTH, 2 MONTHS, 4 MONTHS, 6 MONTHS, 9 MONTHS, 12 MONTHS, 15 MONTHS, 18 MONTHS AND 24 MONTHS.**
- **ALL PATIENTS ARE ENCOURAGED TO MAKE AN APPOINTMENT FIRST OR PLEASE CALL & NOTIFY US THAT YOU ARE IN ROUTE. PATIENTS WITH APPOINTMENTS WILL BE SEEN FIRST.**

_____ _____

GUARANTOR NAME **GUARANTOR SIGNATURE**

_____ _____

DATE **RELATIONSHIP TO PATIENT**

CLEAR FORM

Initial History Questionnaire

Form Completed By:	**Name:**		
Initial Date Completed:	ID Number:		
Date(s) Updated:	Birth Date:	Age:	Sex: M ○ F ○

GENERAL

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ Don't know Explain: _____

Does your child have any special health care needs? ☐ Yes ☐ No ☐ Don't know Explain: _____

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ Don't know Explain: _____

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ Don't know Explain: _____

SOCIAL HISTORY

Please list all those living in the child's home.

Name	Relationship to Child	Birth Date/Age

Please list other siblings not living in the home.

Name	Birth Date/Age	Where are they living?

Does the child live with both biological parents? ☐ Yes ☐ No

If no, what is the child's current living situation?

☐ Single-parent custody ☐ Joint custody ☐ Adoptive family

☐ Other family members: _____ ☐ Foster care

How often does the child have visitation with parent(s) not living in the home?

_____

BIRTH HISTORY

Birth weight: _____

☐ Full-term ☐ Preterm _____ weeks ☐ Post-term _____ weeks

Delivery: ☐ Vaginal ☐ Cesarean ☐ Reason: _____

Any complications during birth or after birth? ☐ No ☐ Yes

Explain: _____

Did the baby need to go to the NICU (neonatal intensive care unit)?

☐ No ☐ Yes Explain: _____

During pregnancy, did the mother:

Take prenatal vitamins?	☐ Yes	☐ No	☐ Unknown
Smoke or use e-cigarettes?	☐ Yes	☐ No	☐ Unknown
Drink alcohol?	☐ Yes	☐ No	☐ Unknown
Use marijuana?	☐ Yes	☐ No	☐ Unknown
Use illicit drugs?	☐ Yes	☐ No	☐ Unknown
Take other medications?	☐ Yes	☐ No	☐ Unknown

If yes, please list:

Blood type:

Mother: _____ ☐ Unknown

Baby: _____ ☐ Unknown

Mother's lab results:

Hepatitis B	☐ Pos	☐ Neg	☐ Unknown
HIV	☐ Pos	☐ Neg	☐ Unknown
Group B streptococcus (GBS)	☐ Pos	☐ Neg	☐ Unknown

After birth, did the baby get:

Vitamin K shot?	☐ Yes	☐ No	☐ Unknown
Erythromycin eye ointment?	☐ Yes	☐ No	☐ Unknown
Hepatitis B shot?	☐ Yes	☐ No	☐ Unknown

How was the baby fed? ☐ Bottle formula ☐ Bottle breast milk

☐ Breastfed How long was baby breastfed? _____

Did baby go home with biological mother from hospital after birth? ☐ Yes

☐ No Explain: _____

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®

HE0564

Initial History Questionnaire

Name: _____

PAST MEDICAL HISTORY

Has your child ever had any of the following problems? DK = Don't know

Condition	DK	No	Yes	Details
Eye problems, cataracts, or retinoblastoma				
Vision impairment or concerns				
Nasal allergies (dust, pets, or environmental)				
Frequent ear infections				
Hearing loss or concerns				
Multiple cavities or problems with teeth				
Frequent colds or sore throats				
Asthma, wheezing, or breathing problems				
Bronchitis, bronchiolitis, or pneumonia				
Heart murmur or other heart problems				
High blood pressure				
Frequent stomach pain				
Constipation needing medical treatment				
Food allergies or intolerance (eg, milk, gluten)				
Feeding issues or underweight				
Overweight or obesity				
Urinary tract infections				
Bed-wetting (after 5 years old)				
Kidney, ureter, or bladder problems				
Serious injuries or fractures				
Bone, joint, or muscle problems				
Frequent headaches or dizziness				
Concussion or head injury				
Convulsions, seizures, or neurological issues				
Sleep problems or snoring				
Skin rashes, eczema, or hives				
Acne				
Thyroid or other endocrine problems				
Diabetes				
Metabolic/genetic disorders				
Anemia or bleeding problems				
Cancer or chemotherapy				
Bone marrow or organ transplant				

Name: _____

PAST MEDICAL HISTORY (*continued*)

Has your child ever had any of the following problems? DK = Don't know

Condition	DK	No	Yes	Details
Blood transfusion				
HIV or AIDS				
Chickenpox or zoster (shingles)				
Developmental delays (speech or motor)				
School problems or learning difficulties				
ADHD or behavioral concerns				
Anxiety, depression, or mood problems				
Tobacco, alcohol, or drug use				
Exposure to family violence				
Pregnancy or miscarriage				
Sexually transmitted infections				
Females: issues with periods				
Age of first period:				

Other medical problems (Please list.)

SURGICAL HISTORY

Has your child ever had surgery? ☐ No ☐ Yes If yes, please provide details below.

Surgery/Procedure	Date of Surgery/Child's Age	Where Completed	Details

Other surgical/procedural problems (Please list.)

Initial History Questionnaire

Name: _____

FAMILY HISTORY

Have any of your child's parents, grandparents, aunts, uncles, brothers, or sisters ever had any of the following conditions? DK = Don't know

Condition	DK	No	Yes	Who?	Details
Anemia or bleeding problems					
Asthma					
Allergies					
Alcohol use problems					
Bed-wetting (after age 10 years)					
Cancer (before age 55 years)					
Childhood hearing loss					
Dental decay or multiple cavities					
Depression or anxiety					
Developmental disability					
Diabetes					
Heart attack (myocardial infarction)					
Heart disease (before age 55 years)					
High blood pressure					
High cholesterol					
HIV or AIDS					
Kidney disease					
Liver disease					
Mental health conditions					
Obesity					
Seizures or epilepsy					
Stroke					
Substance use problems					
Sudden death (before age 50 years)					
Thyroid or other endocrine disease					
Tobacco use problems					
Tuberculosis					
Vision or eye problems					

Other medical problems (Please list.)

PRINT NAME.	SIGNATURE
Provider 1	
Provider 2	

Consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 4th Edition