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 (PLEASE CIRCLE ONE) *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: MALE / FEMALE SSN:_____-_____-_____ RACE:_____

ADDRESS:_____ CITY:_____STATE:_____ZIPCODE:_____

RESPONSIBLE PARTY:_____RELATIONSHIP TO PATIENT:_____

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

FATHER'S FULL NAME:_____GOES BY:_____

DOB:____/____/____ SSN:_____-_____-_____ DRIVERS LICENSE #:_____ EMPLOYER:_____

☐ √ IF ADDRESS SAME AS ABOVE; OR ADDRESS:_____

√ PREFERRED CONTACT #: ☐ HOME: (_____)_____-_____ ☐ WORK: (_____)_____-_____ ☐ CELL: (_____)_____-_____

√ ALL THAT APPLY: ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ SINGLE ☐ ADOPTIVE PARENT/LEGAL GUARDIAN ☐ DECEASED

MOTHER'S FULL NAME:_____GOES BY:_____

DOB:____/____/____ SSN:_____-_____-_____ DRIVERS LICENSE #:_____ EMPLOYER:_____

☐ √ IF ADDRESS SAME AS ABOVE; OR ADDRESS:_____

√ PREFERRED CONTACT #: ☐ HOME: (_____)_____-_____ ☐ WORK: (_____)_____-_____ ☐ CELL: (_____)_____-_____

√ ALL THAT APPLY: ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ SINGLE ☐ ADOPTIVE PARENT/LEGAL GUARDIAN ☐ DECEASED

EMERGENCY CONTACT (NOT LIVING IN SAME HOUSEHOLD):_____

PHONE#:_____ RELATIONSHIP TO PATIENT:_____

IS PATIENT COVERED BY MEDICAL INSURANCE: ☐ YES ☐ NO

INSURANCE COMPANY:_____ POLICY #:_____

INSURED NAME:_____ GROUP #:_____

IF YOU ARE A NEW PATIENT, WHO CAN WE THANK FOR YOUR REFERRAL?_____

SIBLINGS:_____

As the parents or guardians of the patient listed above, we authorize the release of any medical or other information necessary to process this claim. Also, we authorize payment of medical benefits to the Ark-La-Tex Children's Clinic. We understand that we are financially responsible for any remaining balance not paid by insurance. We also acknowledge that it is our responsibility to complete an updated form anytime the above information changes or whenever requested by Ark-La-Tex Children's Clinic.

_____ _____ _____

SIGNATURE OF PARENT/GUARDIAN RELATIONSHIP TO PATIENT 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

ARK-LA-TEX CHILDREN'S CLINIC

2400 HOSPITAL DR, STE 120; BOSSIER CITY, LA 71111; (318) 742-6710 (318)747-5393(fax)

Authorization for Evaluation And/Or Treatment of A Minor Child Unaccompanied By Parent Or Legal Guardian

A parent or legal guardian must accompany a child younger than 18 years of age to consent for all medical and/or surgical treatment provided by Ark-La-Tex Children's Clinic. Please complete this form if your child will be coming for a visit, treatment, or procedure, without a parent or legal guardian. This consent is valid until an updated copy has been signed and received by our office.

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

I authorize _____ _____
(Name of person(s) being authorized) (Relationship to Patient)

I authorize _____ _____
(Name of person(s) being authorized) (Relationship to Patient)

I authorize _____ _____
(Name of person(s) being authorized) (Relationship to Patient)

To give consent to medical treatment by Ark-La-Tex Children's Clinic on behalf of my child listed above. The above-named individual(s) may also receive test results and additional information pertinent to the care and treatment of this minor child. I also authorize them to participate in medical decision making which includes but is not limited to consent for vaccinations, consent for injections, etc. I agree that a parent or legal guardian should be available via phone at all times while my child is being seen. I understand that I am still financially responsible for all medical expenses incurred by my child during these appointments. I acknowledge that I may void this agreement at any time and that this agreement will also be voided by any agreements signed on future dates.

_____ _____
Parent/Legal Guardian Signature Date Signed

_____
Parent/Legal Guardian Name

I do NOT give consent for my child to be seen by anyone other than a parent or legal guardian. I understand that if my child presents to the clinic with anyone besides a parent or legal guardian, that they will not be seen and the physicians at Ark-La-Tex Children's Clinic are not liable for your child's condition. I understand that I may void this agreement at any time and this agreement will also be voided by any agreements signed on future dates.

_____ _____
Parent/Legal Guardian Signature Date Signed

_____
Parent/Legal Guardian Name

ARK-LA-TEX CHILDREN'S CLINIC

2400 HOSPITAL DR, STE 120; BOSSIER CITY, LA 71111; (318) 742-6710 (318)747-5393(fax)

Authorization for Evaluation And/Or Treatment of a Child Unaccompanied by an Adult:

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

I authorize and give consent for my child, listed above, to go independently to appointments and consent to all medical and/or surgical treatment without the presence of a parent or legal guardian. I understand that I am still financially responsible for all medical expenses incurred by my child during these appointments. I understand that a parent or legal guardian should be available via phone at all times during my child's appointment. I understand that my child's treatment and management maybe affected by no parent or guardian being present and that the physicians and staff at Ark-La-Tex Children's Clinic are not responsible since I'm allowing my child to come unaccompanied. I also understand that I am responsible for contact Ark-La-Tex Children's Clinic with any questions or concerns in regards to my child's unaccompanied visit. If at any time I choose to void the consent for my child to be seen unaccompanied, I know that I can do so and that also this agreement will be voided by any agreements signed on future dates.

_____ _____

Parent/Legal Guardian Signature Date Signed

_____

Parent/Legal Guardian Name

PLEASE READ AND SIGN BELOW IF YOU DO NOT GIVE CONSENT FOR YOUR CHILD TO BE SEEN UNACCOMPANIED BY AN ADULT:

I do NOT give consent for my child to be seen by anyone other than a parent or legal guardian. I understand that if my child presents to the clinic with anyone besides a parent or legal guardian, that they will not be seen and the physicians at Ark-La-Tex Children's Clinic are not liable for your child's condition. I understand that I may void this agreement at any time and this agreement will also be voided by any agreements signed on future dates.

_____ _____

Parent/Legal Guardian Signature Date Signed

_____

Parent/Legal Guardian Name