

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:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> 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:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> 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
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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 <input type="checkbox"/> M <input type="checkbox"/> F
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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: <input type="checkbox"/> vaginal <input type="checkbox"/> c-section <input type="checkbox"/> breech	Length	Weight
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ALLERGIES to any medications, X-Ray dyes or other substances? No Yes (if yes, please the list the type of reaction)

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MEDICATIONS-names, dosages

IMMUNIZATIONS

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

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

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

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 you 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: _____