HINTON HEALTHCARE GROUP

NEW PEDIATRIC PATIENT INFORMATION FORM

(The information provided is strictly confidential)

PATIENT INFORMATION

Childs First Name: _____ Childs Last Name: _____

Date of Birth: _____ Gender: _____ Ethnicity: _____

Address: _____ APT #: _____ City: _____

State: _____ Zip: _____ Social Security #: _____

Is child in foster care N / Y **If yes, is it temporary or permanent** _____ (paperwork is needed)

With whom does this child live with primarily: ☐Both parents ☐ Mother ☐ Father ☐ Other Relatives ☐Foster Home ☐Guardian(s)

PARENT/GUARDIAN INFORMATION

Name: _____

Relationship: _____

DOB: _____ SSN: _____

Address: _____

APT #: _____City: _____

State: _____ Zip: _____

Phone: _____

Voicemail

☐ May leave Detailed Voice Message

☐ Call Back Number Only

Email: _____

Name: _____

Relationship: _____

DOB:_____ SSN:_____

Address: _____

APT #: _____ City: _____

State: _____ Zip: _____

Phone: _____

Voicemail

☐ May Leave Detailed Voice Message

☐ Call Back Number Only

Email: _____

INSURANCE INFORMATION

Primary Insurance: _____ Policy Holder: _____

Relationship to Patient: _____ D.O.B: _____ S.S: _____

Secondary Insurance: _____ Policy Holder: _____

Relationship to patient: _____ D.O.B: _____ S.S: _____

I authorize my family insurance benefits to be paid directly to Hinton Healthcare Group. I understand that I am financially responsible for any services not covered by my insurance, as verified by the information above.

_____ _____

Signature of Patient/Guardian **Date**

Child's Past Medical History

Has your child ever been treated for or diagnosed with: (explain)

Allergies: _____ ADHD: _____ Anemia: _____

Asthma: _____ Autism: _____ Cancer: _____

Constipation: _____ Diabetes: _____ Depression: _____

Ear Infections: _____ Eczema: _____ Fractures: _____

Food Allergies: _____ Heart Problems: _____ Hearing Issues: _____

Mental Illness: _____ Migraine Headaches: _____ Obesity: _____

Orthopedic Issues: _____ RSV: _____ Seizures: _____

Strep Throat: _____ Sinus Infections: _____ Speech Delay: _____

Urinary Tract Infections: _____ Vision Issue: _____ Wheezing: _____

Other chronic medical conditions: _____

Has your child had any surgeries or procedures: No / Yes (explain) _____

_____

Is your child in counseling currently or previously: No / Yes (explain) _____

_____

Does your child receive therapies of any kind? _____

Current Medications: _____

Social History/Preventative Care

Do any household members use tobacco products: (cigarettes, vape, chewing tobacco, etc) N / Y

Any recent family changes or stress: _____

Do you have any concerns about your child? _____

Has your child seen a dentist in the past year? N / Y Has your child had a vision screen in the past year? N / Y

Has your child had a hearing screen in the past year? N / Y Is your child up to date on immunizations? N / Y

Family History

If any blood relative has had any of the following, please list who

ADHD: _____ Allergies: _____ Anemia: _____

Asthma: _____ Anxiety: _____ Bleeding Tendency: _____

Cancer: _____ Chronic Lung Disease: _____ Depression: _____

Diabetes: _____ Drug/Alcohol Problem: _____ Epilepsy: _____

Glaucoma: _____ Hearing Issues: _____ Heart Disease: _____

High Blood Pressure: _____ High Cholesterol: _____ Kidney Disease: _____

Mental Illness: _____ Migraine Headaches: _____ Obesity: _____

Pneumonia: _____ Stroke: _____ Thyroid Disease: _____

Tuberculosis: _____ Ulcers: _____ Vision Issues: _____

Please list other family history if not listed above: _____

Siblings

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

EMERGENCY CONTACT (OTHER THAN PARENT/GUARDIAN)

Name: _____Number: _____Relationship:_____

Name: _____ Number: _____ Relationship: _____

HIPPA rule gives individuals the right to request a restriction on uses and disclosures of their protected health information. Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Person(s) who we may discuss your health information with

(Please be aware that you are authorizing Hinton Healthcare Group to discuss any of your child (s) health information with the person(s) listed below, and that if at any time those person(s) listed should change it is your responsibility to inform Hinton Healthcare Group.)

Name: _____ Number: _____ Relationship: _____

Name: _____ Number: _____ Relationship: _____

Assignment of Medical Benefits, Consent to Treat and Authorization to Release Information

*I authorize Hinton Healthcare Group to release any medical information necessary to process insurance claims relating to the medical care provided

*I authorize payment of medical benefits to Hinton Healthcare Group for any medical care provided to me and/or my dependent(s),

*I understand that I will be responsible for any charges not covered by my insurance

*I understand that it is my responsibility to contact Hinton Healthcare Group with any changes to my insurance, address or phone number

By my signature, I verify that the information I provided is correct and I acknowledge that I understand my rights as a patient concerning my protective health information. I authorize Hinton Healthcare Group to perform the necessary health care services I/My child may need.

_____ _____

Signature of Patient/Guardian **Date**

HINTON HEALTHCARE GROUP

Provider Policies and Expectations

Regular Office Hours: Hinton Healthcare Group hours vary from each location. All locations are closed from 12:00 p.m. to 1:00 p.m. for lunch. All physician visits are by appointment only.

Insurance Billing: Hinton Healthcare Group accepts most major insurance policies. It is the patient's responsibility to check if our doctors are covered by your specific insurance plan. If one of our providers is not listed or covered, we are still able to see you out of network. Patients will be responsible for balance due. We do accept self-pay for patients with no medical insurance.

Medical Records and Confidentiality: Your medical records are confidential and require your written authorization before they can be released to other health care providers or other approved recipients. Medical records will be completed within 30 days from the date they are requested.

Appointment Cancellations and Late Policy: Hinton Healthcare Group has a "No Call, No Show and Cancellation Policy". We require a 24 hour cancellation notice for all appointments, failing to do so may result in a fee of $25.00. Please be aware that if you are more than 15 minutes late you may be asked to reschedule.

Protected Health Information: "Protected Health Information" (PHI) is information that identifies you and relates to your identify and your past, present or future medical history. It includes your medical records and personal information such as your name, social security number, address, and phone number.

Family and Medical Leave Act: The family and medical leave act (FMLA) paperwork will be an additional charge of $25.00 and will take up to 7 business days to complete. All FMLA paperwork will require a visit with a provider prior to completing the form.

Patient Fusion: All patients are automatically enrolled into our patient fusion program if an email is provided. Along with our appointment reminder/follow up text if a mobile number is given.

By my signature, I verify that the information I provided is correct and I acknowledge that I understand my rights as a patient concerning my protective health information. I authorize Hinton Healthcare Group to perform the necessary health care services I/My child may need.

X: _____ _____

Signature of Patient/Guardian Date