

NEW CHILDREN REGISTRATION FORM

Patient's Legal Name: _____
Last First MI

Responsible Parent's Name _____
Last First MI

Mailing Address : _____
Address or PO Box City/State/Zip Code

Email Address: _____ Preferred Language: _____

Sex: _____ Male _____ Female DOB: _____

Parent Cell Phone: (_____) _____ Home Phone: (_____) _____

Preferred method of contact for the appointments, treatment, and billing information via:

Cell Phone: _____ Home Phone: _____ Work Phone: _____ Text to Cell Phone: _____ Email: _____ Any method listed: _____

I authorize information about my children's health to be provided to me via:

Cell Phone: _____ Home Phone: _____ Work Phone: _____ Text to Cell Phone: _____ Email: _____ Any method listed: _____

Primary Race: Hispanic _____ Black/African American _____ American Indian/Alaskan _____ Asian _____
Native Hawaiian/Pacific Islander _____ White _____

Secondary Race: Hispanic _____ Black/African American _____ American Indian/Alaskan _____ Asian _____
Native Hawaiian/Pacific Islander _____ White _____

Ethnicity: Hispanic or Latino _____ Non Hispanic or Latino _____ Decline to Provide this Information: _____

Student Status: Full-time _____ Part-time _____ School: _____

Preferred Pharmacy Name & Location: _____

Would you like Dr. Scott Lafferty to be your Primary Care Physician? Yes No, I have a primary care physician

How did you hear about Lafferty Family Care? TV Newspaper Social Media Friends Google Other: _____

Emergency Contact - Outside of Immediate Family Members

Name: _____ Relation: _____ Phone: _____

Insurance Information

Your insurance card will be scanned into the chart. Please provide the following information in order to file your insurance claims.

Name of person providing insurance coverage: _____

DOB: _____ Relationship to in Client: _____

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Patient Financial Responsibility

- I certify that the insurance information that I have provided is accurate, complete and current and that no other coverage or insurance exists. **Parent Initials:** _____
- I acknowledge that my co-pay or coinsurance is due at the time of service. **Parent Initials:** _____
- I knowledge that I am financially responsible, if my deductible is not met or for any service not covered by insurance. If my deductible is not met, I acknowledge that I will pay the allowed insurance amount at the time of service and will receive an email bill for the remainder.**
Parent Initials: _____
- I acknowledge that if my account is not paid or the office is called to make an arrangement within 45 days of bill that my account will be sent to collections. **Parent Initials:** _____
- If my account is turned over to collections for not making a payment toward my balance within 60 days, I acknowledge that my insurance will no longer be billed and I am a cash-only client. **Parent Initials:** _____

Assignment of Benefits

I request that payment of authorized benefits be made on my behalf to Dr. Scott Lafferty/Lafferty Family care (LFC) for services provided. I assign my right to receive these payments to LFC. I authorize LFC to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my insurance plan will not direct payment to LFC, I agree to forward all insurance payments to OUC. Initials: _____

HIPAA Consent

I acknowledge I was offered/ received a copy of the currently effective Notice of Privacy Practices for this healthcare facility. This Notice describes the types of uses and disclosures of my protected health information (PHI) that might occur in my treatment, payment of my bills, or in the performance of health care operations. This consent will be filed in my medical records.

Please **Print** parent/legal guardian name

Date

Please **Sign** parent legal guardian name

Please Print Patient's Name

Date

Legal Representative

Date

Description of Authority

I have additional requests for the use and disclosure of my personal health information. Please provide the REQUEST FOR RESTRICTIONS ON USE AND DISCLOSURE form. I will complete the appropriate form. **Initials:** _____

Office Use Only

An attempt was made to obtain the patient's or legal representative's signature on this Acknowledgement but did not because:

It was emergency treatment _____

Inability to communicate with patient _____

Patient refused to sign _____

Patient was unable to sign _____ Reason: _____

Other: _____

Privacy Officer Signature

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HEALTH HISTORY

Patient Name: _____ Date: _____

List any prescription medications with dosage you are currently taking:

1. _____ 3. _____
2. _____ 4. _____

Are you allergic to any prescription medicines: Yes No If yes, please list below:

1. _____ 3. _____
2. _____ 4. _____

Have you ever had a history of the following?

High Blood Pressure	Arthritis	Hepatitis	Kidney Disease
Heart Disease/Blockages	Pacemaker	Anemia	Heartburn
Diabetes	Ulcers	HIV	Migraines
Heart Attack	Cancer	Epilepsy/Seizures	Chronic Back Pain
Heart Murmur	Emphysema	Low Thyroid	Lupus
Irregular Heartbeat	Asthma	Kidney Stones	Depression/Anxiety

Please list any other diseases or conditions:

1. _____ 3. _____
2. _____ 4. _____

Please list all surgeries and/or hospitalizations:

1. _____ 3. _____
2. _____ 4. _____

Social History

Do you use alcohol?	Yes	No
Do you use tobacco?	Yes	No
Do you use illicit drugs?	Yes	No
Do you get significant exposure to the sun?	Yes	No
Do you exercise on a regular basis?	Yes	No
Are you currently sexually active?	Yes	No
Are you pregnant?	Yes	No

Family History

Father:	Alive	Deceased	Medical Conditions: _____
Mother:	Alive	Deceased	Medical Conditions: _____
Sisters:	Alive	Deceased	Medical Conditions: _____
Brothers:	Alive	Deceased	Medical Conditions: _____

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Comprehensive Review of Systems

Patient Name: _____

Date: _____

Please Circle Current Symptoms

CONSTITUTIONAL

Weight Change
Loss of Appetite
Chills
Fever
Weakness
Night Sweats*
Fatigue*
Decrease Energy Level*

HEENT

Nose Bleeds
Hearing Trouble
Vision Change
Mouth Sores
Sinus Pressure
Runny Nose
Eye Irritation
Eye Drainage
Change in Voice
Sore Throat
Difficulty Swallowing

CARDIOLOGY

Palpitations
Leg Pain w/Exercise
High Blood Pressure
Chest Pain
Shortness of Breath w/Activity
Leg Swelling

RESPIRATORY

Shortness of Breath
Chest Tightness
Cough
Wheezing
Congestion

UROLOGY

Difficulty Urinating
Blood in Urine
Urinary Frequency
Urinary Urgency
Urinary Incontinence*

HEMATOLOGY

Easy Bruising
Swollen Glands
Fatigue

DEMATOLOGY

Rash/Hives
Itching
Jaundice
Hair Loss
Lumps

GASTROENTEROLOGY

Blood in Stool
Diarrhea
Vomiting
Constipation
Nausea
Abdominal Pain
Change in Bowel Habits
Black/Tarry Stools

ENDOCRINOLOGY

Night Sweats*
Excessive Thirst
Excessive Sweating
Excessive Urination
Cold Intolerance
Heat Intolerance
Hot Flashes*

MUSCULOSKELETON

Joint Stiffness
Leg Cramps
Joint Pain*
Joint Swelling
Back Pain
Neck Pain
Muscle Aches*

NEUROLOGY

Headaches
Tingling or Numbness
Seizures
Dizziness
Focal Weakness
Migraines*

PSYCHIATRIC

Depression*
High Stress
Mood Swings*
Suicidal Thoughts
Anxiety*
Sleeping Difficulty*
Obsessive Compulsive
Difficulty Concentrating
Foggy Thinking
Loss of Memory

GENITOURINARY - MALE

Difficulty with Erections
Low Libido*
Penile Discharge
Painful Intercourse*

GENITOURINARY - FEMALE

Premenstrual Syndrome
Painful Periods
Frequent Yeast Infections
Vaginal Itching
Intermenstrual Bleeding
Pelvic Pain
Irregular Periods
Abnormal Vaginal Discharge
Painful Intercourse*

SLEEP APNEA SYMPTOMS

Snoring
Stop breathing during sleep
Wake up fatigued
High Blood Pressure

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REQUEST FOR RESTRICTION ON USE AND DISCLOSURE

Patient Name: _____ DOB: _____

I understand I have the right to request restriction(s) as to how my Protected Health Information may be used and/or disclosed to carry out treatment, payment or health care operations or disclosed to family members and others involved in my care. I understand that Lafferty Family Care is not required to agree to the restriction(s) requested but will accommodate reasonable requests whenever feasible. If we agree to a requested restriction, it will be binding except in the case of emergency treatment or as required by law. You may end the restriction(s) at any time by notifying us in writing. A signed, dated copy of this Request shall be as effective as the original.

List individuals you **want** information disclosed to: (1) _____

(2) _____ (3) _____

List any information you **want** disclosed: (1) _____

(2) _____ (3) _____

SIGNATURE OF PARENT OR LEGAL GUARDIAN

DATE

RELATIONSHIP TO PATIENT

DATE

FOR OFFICE USE ONLY

<input type="checkbox"/> Accepted <input type="checkbox"/> Denied <input type="checkbox"/> Delayed	If accepted, state which of the restriction(s) accepted:	
	If denied, state which restriction(s) were denied:	
Signature of Privacy Officer		Date

NEW CHILDREN REGISTRATION FORM

Consent to Treat a Minor When Parents/Legal Guardians are Absent

According to Arkansas regulations, the "mature minor doctrine" states that any person of ordinary intelligence and awareness sufficient to comprehend the need for, nature of and risks involved in medical care is competent to consent on his/her own. AR Code Ann. 20-9-602(7)(2011)

If the child does not meet the definition of a "mature minor", the undersigned parent/legal guardian of _____ grants temporary authority to the person(s) listed below to give consent to treat the
(Child's Name)
child, which may include, but not limited to x-ray, vaccines or other injections, and minor invasive procedures when I am not available.

I acknowledge that this consent is given in advance to any specific diagnosis or treatment and allows the physician/provider to diagnose and treat the child when the parent/ guardian is not present.

This Consent is effective until withdrawn in writing by the child's parent or guardian.

1. Person(s) authorized by the parent/legal guardian to consent to treatment (please print):

Name: _____ Relationship to Child: _____ Phone: _____

Name: _____ Relationship to Child: _____ Phone: _____

Name: _____ Relationship to Child: _____ Phone: _____

2. Medical concerns: _____

3. Known allergies: _____

Name of Parent/ Legal Guardian: _____
(Print Name)

Contact Number(s): _____

Address: _____

City, State, Zip: _____

Parent/Legal Signature: _____ Date: _____