BARG FAMILY CLINIC

A Member of Arkansas Family Care Network, P.A.

PATIENT INFORMATION

Print Clearly

PAYMENT IS EXPECTED AT THE TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE
****A COPY OF YOUR INSURANCE CARD WILL NEED TO BE OBTAINED FOR OUR RECORDS****

Child's Name ____
First Name Middle Last Name

Sex________ Age ________ Birthdate ______________ Social Security # ____________________

Mailing Address: ____
Street City State Zip

Child's Legal Guardians ____________________ Home #______________ Cell#______________

Family Information

Father's Name ______________________

Address ______________________

____

Home #______________ Cell#______________

Employer ______________________

Soc. Sec. #______________ Birthdate ______________

Does this person carry insurance coverage for this Child? ______ Yes ______ No

Insurance Name ______________________

Phone # ______________________

Address ______________________

____

Policy ID #______________________

Group #______________________

Mother's Name ______________________

Address ______________________

____

Home #______________ Cell #______________

Employer ______________________

Soc. Sec. # ______________ Birthdate ______________

Does this person carry insurance coverage for this Child? ______ Yes ______ No

Insurance Name ______________________

Phone # ______________________

Address ______________________

____

Policy ID #______________________

Group #______________________

Is your child covered by Medicaid? ______ Yes ______ No Child's Medicaid #______________________

In case of emergency, whom should we contact other than the parents?

Name ______________________ Relationship ______________ Phone # ______________

ALL SERVICES RENDERED ARE THE FINANCIAL RESPONSIBILITY OF THE PATIENT AND NOT THE INSURANCE COMPANY. OUR OFFICE WILL BILL YOUR INSURANCE COMPANY AS A COURTESY. YOUR FINANCIAL RESPONSIBILITY IS TO ENSURE THAT THE ARKANSAS FAMILY CARE NETWORK IS PAID FOR SERVICES RENDERED. THIS INCLUDES LIABILITY COVERED INJURIES, AS BILLS WILL NOT BE POSTPONED IN ANTICIPATION OF LEGAL SETTLEMENT. INFORMATION WILL BE PROVIDED TO YOU TO FILE YOUR OWN INSURANCE AND SUPPLIED TO YOUR ATTORNEY UPON REQUEST.

I HEREBY AUTHORIZE THE DOCTORS OF THE BARG FAMILY CLINIC TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE DOCTOR ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MY DEPENDENTS OR MYSELF. I UNDERSTAND THAT THIS AUTHORIZATION WILL REMAIN IN EFFECT FOR AS LONG AS MY DEPENDENTS OR I REMAIN A PATIENT

(SIGNATURE) OF PATIENT OR GUARDIAN X______________________________

DATE______________________________

I,______________________________, HEREBY CONSENT TO ALLOW THE FOLLOWING PERSON(S) ACCESS TO INFORMATION ON MY ACCOUNT THAT WOULD OTHERWISE BE CONSIDERED PROTECTED HEALTH INFORMATION:______________________________

NEW PATIENT QUESTIONNAIRE

BARG FAMILY CLINIC

Name: ____________________ Mother's Name: ____________________

Birthdate: ____________________ Occupation: ____________________

Today's Date: ____________________ Father's Name: ____________________

Mother's Maiden Name ____________________ Occupation: ____________________

If adults in the household work outside the home, what child care arrangements are made for this child?

____

A. PREGNANCY AND BIRTH

1. Mothers' age at birth? ______
2. Did mother have any illness during pregnancy? No Yes
3. Did she take any medicines other than vitamins & iron? No Yes
4. Was the baby on time? Yes No
5. What was the birth weight? ______
6. Did the baby have any trouble starting to breathe? No Yes
7. Did the baby have any trouble in the hospital? No Yes
   (jaundice, infections, other?)
   What kind? ______

B. PAST MEDICAL HISTORY:

1. Where has your child gone for check-ups until now? ______
2. Date of last check-up? ______
3. Date of last dental check-up? ______
4. Has your child had allergic reaction to any medications, foods, insect bites? No Yes
   Which ones? ______
5. Has your child had reactions to any immunizations? No Yes
   Which ones? ______
6. Any hospitalizations other than for birth? No Yes
   What for? ______
7. Any serious injuries? No Yes
   What kind? ______
8. Are any medications taken regularly? No Yes
   Which ones? ______

C. FAMILY HISTORY:

1. Are the child's parents both in good health? Yes No
2. Circle any diseases that this child's parents, grandparents, brothers, sisters, or aunts and uncles have had: anemia, asthma, allergies, diabetes, high blood pressure, heart trouble, tuberculosis, mental illness, drug problems, alcohol problems, inherited illness, venereal disease, cancer, AIDS, others
3. List age, sex and general health of brothers and sisters ______
4. Have any of your children died? No Yes

D. FEEDING AND NUTRITION:

1. Is your child's appetite usually good? Yes No
2. Is it good now? Yes No
3. Was there severe colic or any unusual feeding problem during the first 3 months? No Yes
4. Do any foods disagree with him/her? No Yes
5. For the first 6 months, is he/she (was he/she) breast fed or bottle fed? ______
6. If still on formula, which one do you use? ______
7. Does he/she take vitamins? Yes No

E. REVIEW OF SYSTEMS:

1. Has your child had frequent ear infections? No Yes
2. Any eye problems? No Yes
3. Any problems with teeth? No Yes
4. Frequent colds or sore throats? No Yes
5. Is there asthma, pneumonia, or recurrent cough? No Yes
6. Any heart murmur of heart problems? No Yes
7. Any problems with urination? No Yes
8. Any problems with diarrhea or constipation? No Yes
9. Have there been any convulsions or other problems with the nervous system? No Yes
10. Any eczema, hives or other skin conditions? No Yes
11. Has your child ever been anemic? No Yes
12. Please list any other medical problems: ______

F. DEVELOPMENT/BEHAVIOR:

1. At what age did your child sit alone? ______
2. At what age did he/she walk alone? ______
3. Did he/she say any words by the time he/she was 1½ years old? Yes No
4. How does this child compare to others his or her age? ______
5. Does he/she have any trouble sleeping? No Yes
6. What grade is he/she in? ______
7. Has he/she had any trouble in school? No Yes
8. Does he/she get along with other children? Yes No
9. Circle if your child has had any of the following: nail biting, thumb sucking, bed wetting, problems with toilet training, bad temper, hyperactivity, nightmares, speech problems, problems with discipline, others

G.SAFETY/ENVIRONMENT:

1. Do you live in a private house, apartment, mobile home, other? (CIRCLE)
2. Do you know the hottest temperature of the water in your pipes? Yes No
3. Is there a working smoke alarm on each floor in the house? Yes No
4. Does your child always use a car seat/seat belt when riding in a car? Yes No
5. Are there any smokers in the household? No Yes
6. Are there any problems with the condition of your home? (peeling paint, insects, rats, or mice) No Yes
7. Does your child always wear a helmet when riding his/her bicycle? Yes No

H. DO YOU HAVE A RECORD OF IMMUNIZATIONS? Yes No

ARKANSAS FAMILY CARE NETWORK

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of the Arkansas Family Care Network's Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time and that I may obtain a revised copy of the Notice at the Clinic location where I receive health care services.

Signature: ______________________________ **Date:** ________________

Print Name: ______________________________ **Date of Birth:** ___________

If you are not the patient, please fill out the following information:

Name: ____
Relationship to Patient: ______________________________________
Address: ____
Telephone: ____

Please furnish a copy of any conservator/guardianship papers with this form.

IF YOU WOULD LIKE SOMEONE ELSE TO HAVE ACCESS TO YOUR PROTECTED HEALTH INFORMATION PLEASE FILL OUT INFORMATION BELOW:

I, ______________________________, HEREBY CONSENT TO ALLOW THE FOLLOWING PERSON(S) ACCESS TO INFORMATION ON MY ACCOUNT THAT WOULD OTHERWISE BE CONSIDERED PROTECTED HEALTH INFORMATION:

1.__________________________ 3.__________________________

2.__________________________ 4.__________________________

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