Barg Family Clinic

Pediatric Patient Information Form

☐ New Patient

☐ Established Patient

ACCOUNT NUMBER

Is this work or accident related? ☐ **NO** ☐ **YES** **Date of Injury** _____

PATIENT INFORMATION			
PATIENT NAME (LAST) FIRST			HOME PHONE
ADDRESS			CELL PHONE
CITY, STATE	ZIP	D.O.B.	SOCIAL SECURITY
EMAIL ADDRESS	GENDER	RACE	MARITAL STATUS
EMPLOYER	EMPLOYER ADDRESS		
EMPLOYER PHONE	EXT	REFERRING PHYSICAN	
SPOUSE NAME		PHONE NUMBER	
EMERGENCY CONTACT	RELATIONSHIP TO PATIENT		PHONE NUMBER

GUARANTOR/RESPONSIBLE BILLING PARTY INFORMATION			
GUARANTOR	SOCIAL SECURITY	PHONE NUMBER	
BILLING ADDRESS			
CITY, STATE	ZIP	EMPLOYER	
EMPLOYER ADDRESS			EMPLOYER PHONE

INSURANCE INFORMATION (Please present your insurance cards/forms to receptionist)			
PRIMARY INSURANCE	POLICY HOLDER	D.O.B.	SSN
ADDRESS			PHONE
POLICY NUMBER	GROUP NUMBER		
SECONDARY INSURANCE	POLICY HOLDER	D.O.B.	SSN
ADDRESS			PHONE
POLICY NUMBER	GROUP NUMBER		
TERTIARY INSURANCE	POLICY HOLDER	D.O.B.	SSN
ADDRESS			PHONE
POLICY NUMBER	GROUP NUMBER		

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 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 ARKANSAS FAMILY CARE NETWORK DOCTORS 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 MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT THIS AUTHORIZATION WILL REMAIN IN EFFECT FOR AS LONG AS MY DEPENDENTS OR I REMAIN A PATIENT.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

DATE

Updated 8/17/2022

Barg Family Clinic

New Pediatric Patient Medical History Form

(This information is confidential and will not be released without your consent.)

Child's Name: _____
First *Middle* *Last*

Today's Date: _____/_____/_____ Date of Birth: _____/_____/_____
Month *Day* *Year* *Month* *Day* *Year*

Child's Legal Guardian(s): _____ Preferred Pharmacy: _____

_____ _____

Is your child covered by Medicaid? ☐ Yes ☐ No Child's Medicaid Number: _____

Reason for today's visit: _____

_____

FAMILY INFORMATION

Parent's Name: _____ Parent's Name: _____

Phone: _____ Phone: _____

Address:_____ Address: _____

_____ _____

Occupation: _____ Occupation: _____

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

_____

_____

_____

PREGNANCY AND BIRTH

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

   If yes, what kind?

   _____

   _____

PAST MEDICAL HISTORY

1. Where has your child gone for check-ups until now? _____
2. Date of last checkup? _____
3. Date of last dental checkup? _____
4. Has your child had reactions to any immunizations? ☐ Yes. ☐ No. Which ones?_____
   _____
5. Any hospitalizations other than for birth? ☐ Yes. ☐ No. What for? _____
   _____
6. Any serious injuries? ☐ Yes. ☐ No. What kind? _____
   _____
7. List all medications taken regularly. Include prescriptions, over the counter, and herbal.

Medication:	Dose:

Medication:	Dose:

8. List any allergies (medications, food, insects) and reactions (rash, hives, throat swelling, anaphylaxis).

Allergy:	Reaction:

Allergy:	Reaction:

FAMILY HISTORY

1. List the age, gender, and general health of the following family members:

Family Member	Age	Gender	General Health
Parent			
Parent			
Sibling			
Sibling			
Sibling			

2. Have any of your child's blood relatives ever been diagnosed with any of the following conditions? If so, who?

☐	Anemia		☐	Hepatitis	
☐	Anxiety/Depression		☐	High Blood Pressure	
☐	Arthritis		☐	Kidney Disease	
☐	Asthma		☐	Migraines	
☐	Cancer		☐	Seasonal Allergies	
☐	High Cholesterol		☐	Sleep Apnea	
☐	Congestive Heart Failure		☐	Thyroid Disease	
☐	COPD/Emphysema		☐	*Other (please specify)*	
☐	Diabetes		☐	*Other (please specify)*	
☐	Gout		☐	*Other (please specify)*	
☐	Heart Attack		☐	*Other (please specify)*	

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 problems during the first 3 months?
   ☐ Yes. ☐ No.
4. Do any foods disagree with him/her?
   ☐ Yes. ☐ No.
5. For the first 6 months, is/was he/she bottle fed, breast fed, or both (check both boxes)?
   ☐ Bottle fed. ☐ Breast fed.
6. If still on formula, which one do you use?

   _____

   _____
7. Does he/she take vitamins?
   ☐ Yes. ☐ No.

REVIEW OF SYSTEMS

Has your child ever experienced any of the following? Provide additional comments if needed.

☐	Anemia		☐	Frequent colds	
☐	Anxiety		☐	Frequent ear infections	
☐	Asthma		☐	Heart murmur	
☐	Behavioral problems		☐	Other heart issues	
☐	Bleeding disorders		☐	Hives	
☐	Cancer		☐	Nervous system issues	
☐	Constipation		☐	Pneumonia	
☐	Dental issues		☐	Recurrent cough	
☐	Depression		☐	Reflux	
☐	Developmental disorder		☐	Seasonal allergies	
☐	Diarrhea		☐	Seizures or epilepsy	
☐	Eczema		☐	Sore throats	
☐	Other skin issues		☐	Urination issues	
☐	Eye problems		☐	*Other (please specify)*	

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 1 ½ years old?

   ☐ Yes. ☐ No.

4. How does your child compare to others his or her age?

   _____

   _____

5. Does he/she have any trouble sleeping?

   ☐ Yes. ☐ No.

6. What grade is he/she in?

   _____

7. Has he/she had any trouble in school?

   ☐ Yes. ☐ No.

8. Does he/she get along with other children?

   ☐ Yes. ☐ No.

9. Does your child have any of the following?

   ☐ Nail biting
   ☐ Thumb sucking
   ☐ Bed wetting
   ☐ Problems with toilet training
   ☐ Bad temper
   ☐ Hyperactivity
   ☐ Nightmares
   ☐ Speech problems
   ☐ Problems with discipline
   ☐ Other: _____

SAFETY/ENVIRONMENT

1. Do you live in a (select one): ☐ Private house ☐ Apartment ☐ Mobile home ☐ Other
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? ☐ Yes. ☐ No.
6. Are there any problems with the condition of your home (peeling paint, insects, rats, mice, etc.)? ☐ Yes. ☐ No.
7. Does your child always wear a helmet when riding his/her bicycle, scooter, roller skates, etc.? ☐ Yes. ☐ No.
8. Are there pets in the home? ☐ Yes. ☐ No.

Do you have a record of your child's immunizations? ☐ Yes ☐ No

Barg Family Clinic

Clinic Policies and Procedures

Thank you for choosing Barg Family Clinic for your primary care needs. Below you will find a detailed description of our policies and procedures regarding office visits and other clinical services, late/missed appointments, and filling out paperwork such as FMLA forms.

Office Visits and Other Clinical Services

Insured patients will be expected to pay your coinsurance, any deductible not met, and/or copay every time you see your provider. You will be responsible for all non-covered charges (labs, procedures, etc.) not payable by your insurance company.

Self-pay patients will be expected to pay in full at the time of service. Self-pay patients who schedule an appointment at least 72 hours in advance will receive a good faith estimate (GFE) notification that outlines the expected charge(s) for the scheduled service.

Late Arrivals and Missed Appointments

If you have a phone that receives text messages and you are signed up to receive texts from us, we will send you a text reminder 1-2 days prior to your appointment time. However, we expect our patients to take responsibility for their appointments. If you are more than 15 minutes late for your appointment, your time slot is no longer guaranteed. We will make every effort to reschedule your appointment for another available slot later the same day. If you miss an appointment or did not call to cancel your appointment at least 24 hours in advance of your scheduled appointment time, you will be charged a "no-show" fee of $50. This applies to appointments scheduled and cancelled on the same day.

Forms and Letters

Please provide the front desk with any forms or letters requiring provider documentation after completing **your** portion of the form. We are unable to accept any forms left at the office without a name and date of birth. Please note that some forms may require you to be seen by a provider before completion. In this case you will be asked to schedule an appointment and will only be charged your co-pay. For forms that do not require an office visit, there will be a $25 fee that must be paid prior to form completion. Please allow five (5) business days for the office to complete your forms request.

Patient Name Patient Signature Date

Barg Family Clinic

A member of the Arkansas Family Care Network, P.A.

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 the following information.

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. _____