Patient Information

Patient Name: _____ **Date of Birth:** _____ **Sex:** M / F

Address: _____

Primary Number: _____

Primary Care Physician: _____ **PCP Phone #:** _____

Race (check all that apply): ___Asian ___African American/Black ___Caucasian/White ___Decline

Ethnic Group: ___Non-Hispanic/Latino ___Hispanic/Latino ___Decline

Parent/Guarantor Information

Name: _____ **Date of Birth:** _____ **Sex:** M / F

Address (If different from above): _____

City: _____ **State:** _____ **Zip:** _____

Phone Number: _____

Insurance Information

Insurance Company: _____ **Policy #:** _____

Subscriber Name: _____ **Subscriber DOB:** _____

Secondary Insurance Company: _____ **Policy #:** _____

Subscriber Name: _____ **Subscriber DOB:** _____

Pharmacy Name & City: **Phone Number:**

I understand that I am responsible for paying directly any applicable deductible/copayment. This is a mandatory requirement when receiving healthcare services. I understand that if I do not fulfill this requirement, my provider may notify my insurance carrier and seek alternative methods of collection. Failure to meet my financial obligations is a violation of my agreement/contract with my insurance carrier. I also understand that if I have unpaid deductibles or copayments owed to my provider longer than 90 days, my provider may terminate the doctor/patient relationship as a result, subject to the requirements of state and/or federal law.
I understand that my insurance card is required at each visit and if my insurance is not in effect at the time of visit, I understand that I am responsible for payment.

I have read the HIPAA medical information disclosure and understand the above.

Guardian Signature: _____ **Date:** _____

Signed off by: _____ **(Office Staff Only)**

Authorization For Release of Medical Information

Just Kids RI Sick Care

Patient Name: _____ **Date of Birth:**_____

I hereby authorize Just Kids RI Sick Care to release my medical records to my current pediatrician for continuity of care.

Release To: _____

Information Requested:

____ All Visit Notes

____ Laboratory Tests

____ X-Ray Results

____ Other: _____

I understand that this information is for use by the recipient named above only. It cannot be given to any other individuals or agency without my signed consent. This authorization can be revoked by me at any time. I have a right to receive a copy of this authorization.
I understand that information disclosed may contain matter that is protected by Federal and State laws, including information which may be related to ALCOHOL, DRUGS, PYSCHIATRIC TREATMENT, AIDS AND/OR HIV TESTING AND/OR OTHER SEXUALLY TRANSMITTED DISEASES.
I understand this information will be released unless I specifically request that it be withheld.

Signature of Patient/Guardian: _____

Date _____ **Relationship** _____

JUST KIDS RI SICK CARE
Family History

Name: _____

DOB: _____

Please List those living in the child's home:

Name	DOB	Relation	Health Problems

Birth History

Was the baby born at term? _____ Early? _____ Late? _____

Was the delivery: ☐ vaginal ☐ cesarean If cesarean, why:_____

Did your baby have any problems right after birth? _____

General

Do you consider your child to be in good health? ☐yes ☐no Explain_____

Does your child have any serious illness or medical condition? ☐yes ☐no Explain_____

Has your child had any serious injuries or accidents? ☐yes ☐no Explain_____

Has your child had any surgery? ☐yes ☐no Explain_____

Has your child ever been hospitalized? ☐yes ☐no Explain_____

Is your child allergic to any medicine or drugs? ☐yes ☐no Explain_____

Is your child vaccinated? ☐yes ☐no Explain_____

Does your child have any developmental delays? ☐yes ☐no Explain_____

Past History

Does your child have, or have they ever had:

Asthma, Bronchitis, Bronchiolitis or pneumonia ☐yes ☐no Explain_____

Any heart problem or heart murmur ☐yes ☐no Explain_____

Anemia or bleeding problem ☐yes ☐no Explain_____

Bladder or kidney infection ☐yes ☐no Explain_____

Any chronic or recurrent skin problem ☐yes ☐no Explain_____

Convulsions or other neurologic problem ☐yes ☐no Explain_____

Diabetes ☐yes ☐no Explain_____

Thyroid or other endocrine problem ☐yes ☐no Explain_____

Any other significant problem ☐yes ☐no Explain_____

Family History

Mother	☐ High Blood Pressure	☐ Diabetes	☐ Cancer	☐ Nasal Allergies	☐ Asthma	☐ Heart Disease	☐ Other (Please Specify)
Father	☐ High Blood Pressure	☐ Diabetes	☐ Cancer	☐ Nasal Allergies	☐ Asthma	☐ Heart Disease	☐ Other (Please Specify)
Grandmother (Maternal)	☐ High Blood Pressure	☐ Diabetes	☐ Cancer	☐ Nasal Allergies	☐ Asthma	☐ Heart Disease	☐ Other (Please Specify)
Grandmother (Paternal)	☐ High Blood Pressure	☐ Diabetes	☐ Cancer	☐ Nasal Allergies	☐Asthma	☐ Heart Disease	☐ Other (Please Specify)
Grandfather (Maternal)	☐ High Blood Pressure	☐ Diabetes	☐ Cancer	☐ Nasal Allergies	☐ Asthma	☐ Heart Disease	☐ Other (Please Specify)
Grandfather (Paternal)	☐ High Blood Pressure	☐ Diabetes	☐ Cancer	☐ Nasal Allergies	☐ Asthma	☐ Heart Disease	☐ Other (Please Specify)