Lifespan Family Healthcare
80 River Road
Newcastle, ME 04553
(207) 563-3366   Fax (207) 563-3393

Patient Information (Pediatric Form)

Patient Name (Last, First, Middle)			Social Security # ____-____-____ Date of Birth ___/__/____
Male__ Female__	Marital Status: S____M____W____D____O____		Name of Spouse:
Street Address		City & State	Zip Code
Occupation	Employer Name: Address:		
Student Status F___ / P ___	School Name:		
Home Phone ( )	Work Phone ( )		Other ( )

Insurance Information: Please provide a copy of your insurance card(s)

Name of Company:			
Plan	Group Number		Policy Number
Subscriber's Name (who holds the insurance?)		Relation to Patient (circle one) Self Spouse Parent Employer Other	
Subscriber's Social Security #	Subscriber's Street address City & State Zip Code		
Subscriber's Home Phone ( )	Subscriber's Work Phone ( )	Date of Birth	M ___ F___
Subscriber's Employer	Employer's Street address City & State Zip Code		
Effective Date	Expiration Date	Is Patient covered by additional Insurance Yes___ No____	
Medicaid Number	Medicare Number	Co-Pay Amount	

Emergency Contact Information

In case of Emergency contact	Relationship to Patient	Emergency Phone Number ( )

If this patient is a minor or student: Please indicate how you would like statements addressed if you do not want them addressed directly to the patient.

PATIENT NAME: ____ AGE _____ DATE _________

Present Health Concerns: ____

Medicines/Vitamins: ____

Herbs/Home remedies: ____

Allergies or Reactions to Medicines/Vaccines: ____

Pregnancy & Birth:

Is the child yours by ❒ birth ❒ adoption ❒ stepchild ❒ other

Any medical problems during pregnancy? ❒ None or Explain: _______________________

Delivered by ❒ vaginal birth ❒ caesarean If caesarean, why? _______________________

Birth weight _______ birth length _______ APGAR score _______1min ________5min

Any problems during baby's newborn period? ❒ No ❒ Yes If premature, how early? _____

Other problems: ____

Nutrition & Feeding:

Was your child breastfed? ❒ No ❒ Yes If so, how long? _________

Has your child had any unusual feeding or dietary problems? ____________________________

Milk intake now: ❒ Formula: Type: _______ ❒ Cow's milk ❒ Soy milk

Average ounces per day (8onces in 1 regular size cup): ___________________

Sleep

Hours per night ________ Naps (number and length) _________________

Development

At what age did your child: sit alone ____ walk alone ____ say words ____ toilet train ____

Girls only: Age of first menstrual period ______

Dental History: Has child been seen by a dentist? ❒ Yes ❒ No Date of last dental visit ___________

Immunizations/Infectious Diseases: Please bring your child's immunization records to the appointment

Has your child had: ❒ chickenpox ❒ measles ❒ mumps ❒ rubella ❒ meningitis ❒ TB

Exposure/Habits: Any concerns about lead exposure? (old home/plumbing/peeling paint) ❒Yes ❒ No

Do any household members smoke? ❒Yes ❒ No

TV - Hours per day ______ Computer - Hours per day ____ Video games - Hours per day ____

Past Medical History: Please describe any major medical problems and the dates of occurrence:

____

____

Hospitalizations/operations (with dates):

Broken bones or severe injuries:

____

Family History: Please circle if anyone in the family has any of the following conditions

Asthma/hay fever/eczema | Bleeding/clotting problems | Birth defects
Attention deficit disorder | Inherited/genetic diseases | Alcohol/drug problems
Heart disease or stroke | High blood pressure | Psychiatric problems | Kidney stones
Thyroid disease | Seizures

Social History:

Who lives at home? ____

Are the child's parents ❒ Married ❒ Unmarried ❒ Separated ❒ Divorced ❒ How long?___

Parents' occupation: Mother __________________ Father ________________________

Who cares for the child during the day? __________________________________

Is violence at home a concern? ❒ No ❒ Yes Are there guns in the home? ❒ No ❒ Yes

School History

Did/does your child attend preschool? ❒ No ❒ Yes

Current or upcoming grade in school: ______ Name of school _____________________

Any concerns about school performance? ❒ No ❒ Yes

Sports/exercise: Type ___________________________ How often: _________________

Review of Organ Systems: Does your child currently have any of the following symptoms?

Constitutional/Endocrine
❒ Fever/chills/sweating
❒ Unusual weight loss/gain

Eyes
❒ Squinting/crossed eyes
❒ Difficulty seeing

Ears/Nose/Throat
❒ Problems hearing
❒ Mouth breathing/snoring
❒ Frequant runny nose
❒ Problem with teeth/gums

Respiratory
❒ Coughing/wheezing

Cardiovascular
❒ Tires easily with exercise
❒ Shortness of breath
❒ Fainting

Gastrointestinal
❒ Abdominal pain
❒ Nausea/vomiting/diarrhea
❒ Constipation
❒ Blood in bowel movement

Genitourinary
❒ Bedwetting
❒ Painful urination
❒ Penile/vaginal discharge

Neurological
❒ Headaches
❒ Weakness
❒ Clumsiness

Musculoskeletal
❒ Muscle or joint pain

Allergy
❒ Hay fever/itchy eyes

Skin
❒ Rashes
❒ Unusual moles

Psychiatric/Emotional
❒ Speech problems
❒ Anxiety/stress
❒ Sleep problems/nightmare
❒ Nail biting/thumb sucking
❒ Bad temper/breath holding
❒ Depression

Blood/lymph
❒ Unexplained lumps
❒ Easy bruising/bleeding

To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the doctor of any changes in my child's medical status.

Signature: ____ Date: _____________

Print Name: ____Relation to child: _________

FINANCIAL POLICY

As a courtesy to our patients we file most insurance. Please be aware that some or perhaps all of the services rendered may or may not be covered. If your insurance company denies payment, you will be billed and payment in full is due upon receipt.

We cannot file your insurance unless you have your card with you. Your insurance must be current and verifiable at the time of treatment. Payment assignment must be made to this office. If you wish to have the check sent to you, payment in full is due at the time of service. Co-pays and payment for non-covered items are due at the time of treatment. We accept cash, checks and major credit cards. Should it be necessary to utilize outside collection means for past due account, you are responsible for all cost, including attorney, court, and collection fees. A minimum $25.00 fee will be assessed on all returned checks.

I have read and understand the Financial Policies of Lifespan Family Healthcare, LLC and have completed this form to the best of my ability and will not hold Lifespan Family Healthcare, LLC responsible for my errors or omissions.

Signature____Date_____________

IF YOU HAVE MEDICARE OR MAINECARE PLEASE READ:

MEDICARE/MEDICAID AUTHORIZATION

I requested that payment of Authorized Medicare Benefits be made to Lifespan Family Healthcare, LLC for any services furnished to me by Michael H. Clark, MD. I authorize any holder of information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents information needed to determine benefits. If I have other insurance, my signature authorizes releases of information to that insurer or agency. In Medicare/Medicaid assigned cases, the physician agrees to accept the determination of the carrier as payment in full and the patient is responsible for deductibles, coinsurance, and non-covered services.

Beneficiary
Signature____Date____________

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Lifespan Family Healthcare, LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Lifespan Family Healthcare, LLC describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Lifespan Family Healthcare, LLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Office Manager, 80 River Road, Newcastle, ME 04553.

I have the right to request that Lifespan Family Healthcare, LLC restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

With this consent, Lifespan Family Healthcare, LLC **may call my home** or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others. □ **yes** □ **no**

With this consent, Lifespan Family Healthcare, LLC **may mail to my home** or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked “Personal and Confidential.” □ **yes** □ **no**

With this consent, Lifespan Family Healthcare, LLC **may e-mail to my home** or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.
□ **yes** □ **no**

The following person(s) may contact LifeSpan Family Healthcare, LLC inquiring in regards to my health information. You have my permission to release information to them.

Name ______________________________ Relationship __________________________

Name ______________________________ Relationship __________________________

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Lifespan Family Healthcare, LLC may decline to provide treatment to me.

____
Signature of Patient or Legal Guardian

_________________________________ ________________________
Print Patient’s Name Date

____
Print Name of Patient or Legal Guardian, if applicable

Lifespan Family Healthcare, LLC

AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT INFORMATION (Please Print):

Name: ____ Date of Birth: __________

Social Security Number: ________________________________ Phone: __________________________

Address: ____

City: _______________________________________ State: ______________ Zip Code: ___________

RELEASE MY MEDICAL RECORDS FROM:

DR. Name: __________________________________ Business Name: ___________________________

Address: ____

City: _______________________________________ State: _____________ Zip Code: ___________

Phone: _______________________ Fax: __________________________

SEND MY MEDICAL RECORDS TO:

Lifespan Family Healthcare, LLC
80 River Road
Newcastle, ME 04553

Phone: 207-563-3366
Fax: 207-563-3393

REASON: □ Selected new physician in the area □ Second opinion/Consult
□ Change of insurance □ Moving out of town
□ Other ______________

PORTION OF RECORDS TO BE RELEASED:

□ Entire Medical Record □ Other ____
____

Restrictions: I understand that the recipient of this information may not use this information except for the express purpose identified above, unless another authorization is obtained from me or unless such or disclosure is specifically required or permitted by law.

Notice: Unless specified below this authorization is for full disclosure of all records, including clinical findings, diagnoses, treatments, assessments, recommendations for further care, names of all health care personnel, dates of hospitalizations and ambulatory visits, charges and any information that may be related to drug, alcohol, psychiatric conditions, and/or sexually transmitted disease, including AIDS/HIV information.

Exclusions (please initial): ______ Drug/Alcohol ______ Sexually Transmitted Disease
______ HIV/AIDS ______ Mental Health/Psychiatric

Patient signature: ____ Date: ______________________

A photocopy of this release is as valid as the original

I understand that this consent is only for the specific purpose stated and may be revoked at any time. This consent expires automatically when its purpose has been accomplished.