The Kidz Care Klinic Information Update Form

Please fill the form out completely.

Today's Date: _____

Patient and Sibling Information:

1. Name: _____ DOB: _____
   Sex: M/F Race: _____ SSN: _____
2. Name: _____ DOB: _____
   Sex: M/F Race: _____ SSN: _____
3. Name: _____ DOB: _____
   Sex: M/F Race: _____ SSN: _____
4. Name: _____ DOB: _____
   Sex: M/F Race: _____ SSN: _____
5. Name: _____ DOB: _____
   Sex: M/F Race: _____ SSN: _____
6. Name: _____ DOB: _____
   Sex: M/F Race: _____ SSN: _____

Parent/Guardian 1 Information *Relationship to Patient:* Mother Father Other: _____

Full Name: _____ DOB: _____ SSN: _____
Address: _____ City, State, Zip: _____
Cell#: _____ E-mail: _____
Preferred Contact Method: text call email

Parent/Guardian 2 Information *Relationship to Patient:* Mother Father Other: _____

Full Name: _____ DOB: _____ SSN: _____
Address: _____ City, State, Zip: _____
Cell#: _____ E-mail: _____
Preferred Contact Method: text call email

Insurance Information:

Primary
Insurance Name: _____ Policy #: _____
Police Holder's Name: _____ DOB: _____ SSN: _____

Secondary
Insurance Name: _____ Policy #: _____
Police Holder's Name: _____ DOB: _____ SSN: _____

Emergency Contact:

Full Name: _____ Relationship to Patient: _____

Primary Number: _____ Preferred Contact Method: text call

Initial History Questionnaire

Name

ID NUMBER

FORM COMPLETED BY | DATE COMPLETED

BIRTH DATE | AGE ☐ M ☐ F

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names, ages, and where they live. _____

What is the child's living situation if not with both biological parents?
☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody
☐ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

Birth History ■ Don't know birth history

Birth weight _____ Was the baby born at term? _____ OR _____ weeks

Were there any prenatal or neonatal complications?
☐ Yes ☐ No Explain _____

Was a NICU stay required? ☐ Yes ☐ No Explain _____

During pregnancy, did mother
Use tobacco ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No
Use drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins
What _____ When _____

Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, why?

Was initial feeding ☐ Formula ☐ Breast milk How long breastfed? _____

Did your baby go home with mother from the hospital?
☐ Yes ☐ No Explain _____

General DK = don't know

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ DK Explain _____

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ DK Explain _____

Has your child had any surgery? ☐ Yes ☐ No ☐ DK Explain _____

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ DK Explain _____

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ DK Explain _____

Do you feel your family has enough to eat? ☐ Yes ☐ No ☐ DK Explain _____

Biological Family History DK = don't know

Have any family members had the following?

Childhood hearing loss	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Asthma	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tuberculosis	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Heart disease (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
High cholesterol/takes cholesterol medication	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Anemia	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bleeding disorder	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Dental decay	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Cancer (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

(Biological Family History continued on back side.)

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Initial History Questionnaire

Biological Family History (Continued from front side.) DK = don't know

Liver disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Kidney disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Diabetes (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bed-wetting (after 10 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Obesity	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Epilepsy or convulsions	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Alcohol abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Drug abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Mental illness/depression	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Developmental disability	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tobacco use	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

Additional family history _____

Past History DK = don't know

Does your child have, or has your child ever had,

Chickenpox	☐ Yes	☐ No	☐ DK	When _____
Frequent ear infections	☐ Yes	☐ No	☐ DK	Explain _____
Problems with ears or hearing	☐ Yes	☐ No	☐ DK	Explain _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Explain _____
Problems with eyes or vision	☐ Yes	☐ No	☐ DK	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	☐ DK	Explain _____
Any heart problem or heart murmur	☐ Yes	☐ No	☐ DK	Explain _____
Anemia or bleeding problem	☐ Yes	☐ No	☐ DK	Explain _____
Blood transfusion	☐ Yes	☐ No	☐ DK	Explain _____
HIV	☐ Yes	☐ No	☐ DK	Explain _____
Organ transplant	☐ Yes	☐ No	☐ DK	Explain _____
Malignancy/bone marrow transplant	☐ Yes	☐ No	☐ DK	Explain _____
Chemotherapy	☐ Yes	☐ No	☐ DK	Explain _____
Frequent abdominal pain	☐ Yes	☐ No	☐ DK	Explain _____
Constipation requiring doctor visits	☐ Yes	☐ No	☐ DK	Explain _____
Recurrent urinary tract infections and problems	☐ Yes	☐ No	☐ DK	Explain _____
Congenital cataracts/retinoblastoma	☐ Yes	☐ No	☐ DK	Explain _____
Metabolic/Genetic disorders	☐ Yes	☐ No	☐ DK	Explain _____
Cancer	☐ Yes	☐ No	☐ DK	Explain _____
Kidney disease or urologic malformations	☐ Yes	☐ No	☐ DK	Explain _____
Bed-wetting (after 5 years old)	☐ Yes	☐ No	☐ DK	Explain _____
Sleep problems; snoring	☐ Yes	☐ No	☐ DK	Explain _____
Chronic or recurrent skin problems (eg, acne, eczema)	☐ Yes	☐ No	☐ DK	Explain _____
Frequent headaches	☐ Yes	☐ No	☐ DK	Explain _____
Convulsions or other neurologic problems	☐ Yes	☐ No	☐ DK	Explain _____
Obesity	☐ Yes	☐ No	☐ DK	Explain _____
Diabetes	☐ Yes	☐ No	☐ DK	Explain _____
Thyroid or other endocrine problems	☐ Yes	☐ No	☐ DK	Explain _____
High blood pressure	☐ Yes	☐ No	☐ DK	Explain _____
History of serious injuries/fractures/concussions	☐ Yes	☐ No	☐ DK	Explain _____
Use of alcohol or drugs	☐ Yes	☐ No	☐ DK	Explain _____
Tobacco use	☐ Yes	☐ No	☐ DK	Explain _____
ADHD/anxiety/mood problems/depression	☐ Yes	☐ No	☐ DK	Explain _____
Developmental delay	☐ Yes	☐ No	☐ DK	Explain _____
Dental decay	☐ Yes	☐ No	☐ DK	Explain _____
History of family violence	☐ Yes	☐ No	☐ DK	Explain _____
Sexually transmitted infections	☐ Yes	☐ No	☐ DK	Explain _____
Pregnancy	☐ Yes	☐ No	☐ DK	Explain _____
(For girls) Problems with her periods	☐ Yes	☐ No	☐ DK	Explain _____

Has had first period ☐ Yes ☐ No Age of first period _____

Any other significant problem _____

This American Academy of Pediatrics Initial History Questionnaire is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 3rd Edition.

HE0328

9-223/0109

The Kidz Care Klinic
5440 Watkins Drive
Suite B
Jackson, MS 39206
Phone: (601) 364-2726 Fax: (601) 364-2731

Patient Name:_____
DOB: _____

AUTHORIZATION

Clinic Policy:

I am responsible for payment of services rendered to me by this clinic. (If the patient is under 18, the parent requesting treatment assumes responsibility of all charges.) Full payment is due at the time of service. I understand that if my account should ever require action by a collection agency or attorney in order to insure payment, the fees charged by these agents may be added to the balance due and unpaid on my account. I authorize The Kidz Care Klinic and all facilities, physicians, employees, and other personnel associated with The Kidz Care Klinic to have access to my existing and future medical records and copies thereof in connection with all medical services or treatment which I may now or hereafter receive from any of them. I understand that I must present the correct insurance information to be billed out on my child's behalf for services rendered by this physician and/or associate. In the event that improper insurance has been presented and billed to the wrong insurance company, I will be responsible for any fees for service by this physician and/or associate. I hereby acknowledge and accept the policies stated above.

_____ _____
Signature of Patient/Guarantor Date

Private Insurance:

I, the undersigned, authorized payment of medical benefits to the physician for any services furnished to me by the physician. I understand that I am financially responsible for any amount not covered by my insurance policy. I also authorize you to release to my insurance company information concerning health care advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluation and administering claims of benefits.

_____ _____
Signature of Patient/Guarantor Date

Medicaid:

I agree to be responsible for any service not covered by Medicaid. I request that payment of authorized Medicaid benefits be made on my behalf to this physician. I authorize any holder of medical or other information about me to release to the Division of Medicaid or its Fiscal Agent any information needed to determine these benefits payable for related services.

_____ _____
Signature of Patient/Guarantor Date

The Kidz Care Klinic
5440 Watkins Drive
Suite B
Jackson, MS 39206
Phone: (601) 364-2726 Fax: (601) 364-2731

Medical Authorization and Release

This form, or any photostatic copy, authorizes each and every physician, health care professional, hospital, and health care provider to release copies of any and all treatment records of _____ (patient name), DOB: _____, to The Kidz Care Klinic concerning past medical conditions in his/her possession, including but not limited to the following:

All documents concerning treatment, prescriptions, hospitalizations, and/or surgery including but not limited to your complete file, all hospital records, all office visit records, statement of account X-ray films, photographs, medical files, physicians' notes and reports, nurses' notes and reports, operative reports, anesthesiologists' prescriptions and reports, tissue slides, specimens, and inpatient and outpatient test results and reports.

This form further authorizes each and every physician, health care professional, hospital, and health care provider involved in the treatment plan to discuss the treatment, surgery, or otherwise of _____ with The Kidz Care Klinic.

Patient's Name: _____

Parent's Signature:_____ **Date:** _____

Please send all records to:
The Kidz Care Klinic
5440 Watkins Drive
Suite B
Jackson, MS 39206
Phone: (601) 364-2726 Fax: (601) 364-2731

The Kidz Care Klinic
5440 Watkins Drive
Suite B
Jackson, MS 39206
Phone: (601) 364-2726 Fax: (601) 364-2731

Patient Name:_____
DOB: _____

Receipt of Notice of Privacy Practices Written Acknowledgment Form

I, _____, have received a copy of The Kidz Care Klinic's Notice of Privacy Practices.

_____ _____
Signature of Patient/Guarantor Date

Communication Authorization

I give The Kidz Care Klinic permission to email information to the following email address: _____.

I give The Kidz Care Klinic permission to text/call information to the following phone number: _____.

- ☐ By providing my email address, I agree to receive email communications and other promotions from The Kidz Care Klinic.
- ☐ By providing my phone number, I agree to receive text/call communications and other promotions from The Kidz Care Klinic.

_____ _____
Signature of Patient/Guarantor Date

Social Media/Photo Consent

The Kidz Care Klinic would like your permission to use images taken of you/your child to showcase.

Please indicate below the following areas where you consent to the use of your/your child's picture.

Please circle all that apply.

TKCK Website TKCK Instagram TKCK Facebook TKCK Office Bulletin Board None

_____ _____
Signature of Patient/Guarantor Date