WESTBROOK MEDICAL CENTER REGISTRATION FORM

PATIENT INFORMATION: (Please use full legal name, no nicknames please)

Last Name: _____ First Name: _____ Middle Name _____

Date of Birth: _____ Social Security Number: _____ MALE [ ] FEMALE [ ]

Race: American Indian Asian Black Caucasian Other Decline

Ethnicity: Hispanic Non-hispanic Declined

Child's Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Preferred Pharmacy: _____

Child Lives with: Both Parents Father Mother Other: Specify _____

Mother's First & Last Name: _____

DOB: _____ SS#: _____ Mother's Cell # _____

Mother's Address: _____

Mother's Employer: _____ Mother's Work # _____

Father's First & Last Name: _____

DOB: _____ SS#: _____ Father's Cell # _____

Father's Address: _____

Father's Employer: _____ Father's Work # _____

Are there any legal restrictions that would prevent the non-custodial parent(s) from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? YES [ ] or NO [ ]
If Yes, provide a copy of any legal paperwork that supports this restriction.

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)

PRIMARY INSURANCE

Policy Holder Name: _____ Relationship to Patient: _____

Policy Holder DOB: _____ Policy Holder SS#: _____

Insurance Name: _____ Policy/ Member #: _____ Group#: _____

SECONDARY INSURANCE

Policy Holder Name: _____ Relationship to Patient: _____

Policy Holder DOB: _____ Policy Holder SS#: _____

Insurance Name: _____ Policy/ Member #: _____ Group#: _____

Westbrook Medical Center, PLLC

Your answers on this form will help your child's health care provider better understand your child's medical concerns and conditions. If you are uncomfortable with any questions, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Patient's Name: _____ Date or Birth:___/___/_____ Date: _____

Person completing form: _____ Relationship: _____

BIRTH HISTORY

Did the mother have problems during the pregnancy (high blood pressure, high sugar, etc)? Yes ☐ No ☐

Did the mother take any medicines, drugs, or smoke cigarettes during pregnancy? Yes ☐ No ☐

If yes, please explain:

Where was the child born? ☐ Home ☐ Hospital ☐ Other:

Length of pregnancy? **Length of labor?**

Delivery type? Vaginal ☐ C-Section ☐ **Days in hospital?** **NICU?** Yes ☐ No ☐

If in NICU, list reasons why:

Birth Weight: **Birth Length:**

Problems at or soon after birth:

Jaundice Yes ☐ No ☐ Unknown ☐
Birth Defects Yes ☐ No ☐ Unknown ☐
Breathing Problems Yes ☐ No ☐ Unknown ☐
Was the newborn screen ("PKU") done? Yes ☐ No ☐ Unknown ☐
Any problems with the PKU?

Did the mother receive antibiotics during delivery? Yes ☐ No ☐ Don't know ☐

Did the mother test Group B Strep positive? Yes ☐ No ☐ Don't know ☐

Did the baby receive the Hepatitis B shot in the hospital? Yes ☐ No ☐ Don't know ☐

DEVELOPMENTAL HISTORY

Please list the age at which this child:

Started cooing _____ Sat without help _____ Started to say words _____

Pulled up on furniture _____ Started to walk _____

Do you have any concerns about the child's behavior or development? Yes ☐ No ☐

If yes, please describe:

SOCIAL HISTORY

Who lives in the child's home?

Name / Relationship_____ Age____ Occupation_____

Name / Relationship_____ Age____ Occupation_____

Name / Relationship_____ Age____ Occupation_____

Name / Relationship_____ Age____ Occupation_____

Name / Relationship_____ Age____ Occupation_____

Does anyone smoke? Inside ☐ Outside ☐ None ☐ **What kind of water does your child drink?** Well ☐ City ☐ Bottled ☐

School/Day Care Provider:

Do you have any pets? Yes ☐ No ☐ If so, what kind?

Are there guns in the home? Yes ☐ No ☐ Are they locked? Yes ☐ No ☐ Don't know ☐

PEDIATRIC NEW PATIENT FORM

PAST MEDICAL HISTORY

Are Immunizations (shots) up to date? Yes ☐ No ☐ Don't Know ☐

* Do you have a shot record? Yes ☐ No ☐ | Where have shots been given in the past?

Has the child ever had a high fever, screaming fit, or seizure after shots? Yes ☐ No ☐ Don't Know ☐

► Please list any allergies to medicine or food: ☐ No allergy to medication, food, latex or iodine

► Please list any medicine the child takes every day:

Has the child ever stayed in the hospital overnight? Yes ☐ No ☐ | If yes, please explain why:

Has the child ever had any surgeries? Yes ☐ No ☐ | If yes, please explain why:

Identify any medical problems the child has (example: asthma, allergies, or ADHD): None ☐

FAMILY HISTORY

Indicate who has had the problem: M = mother, F = father, C = child, S = sister, B = brother, MGF/MGM = maternal grandfather/grandmother, PGF/PGM = paternal grandfather/grandmother, MA/MU = maternal aunt/uncle, PA/PU= paternal aunt/uncle

- ☐ Asthma
- ☐ Allergies
- ☐ Trouble with anesthesia
- ☐ Birth defects (such as a hole in the heart, spina bifida, or Down Syndrome, etc.)
- ☐ Cancer _____
- ☐ High blood pressure
- ☐ Heart attack under age 50
- ☐ Diabetes
- ☐ Blood disorders (hemophilia/free bleeders, sickle cell disease, etc.)
- ☐ ADHD / learning problems
- ☐ Mental retardation
- ☐ Cystic fibrosis
- ☐ Tuberculosis (TB)
- ☐ Stomach disease (crohn's, ulcerative colitis, celiac disease, etc.)
- ☐ Thyroid problem
- ☐ Seizures
- ☐ Rheumatologic disease (lupus; rheumatoid arthritis, etc.)
- ☐ Mental health issues (depression, anxiety, bipolar,etc.)
- ☐ Substance abuse (alcohol or drugs)
- ☐ Babies in the family die early of SIDS or other problems
- ☐ Passing out
- ☐ Sudden unexplained death
- ☐ Other

ASSIGNMENT – AUTHORIZATION & LIEN

I hereby irrevocably authorize and direct my insurance company, my attorney, and/or any third party payers to pay directly to the provider, Westbrook Medical Center, PLLC, all sums of money due for any and all services rendered to me (or a minor child for which I m responsible) by reason of accident, illness or any and all reasons. I further direct said insurance company, attorney, or third party payer to withhold such sums from any payment, including but not limited to health and accident benefits, disability benefits, workers' compensation benefits, medical payment benefits, no fault benefits, foundation grants, government or agency benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately provide for any financial obligation owed this office and assignees.

I further agree that this agreement acts as an assignment of my rights and benefits to the extent this office rendered services; therefore if my insurance company and/or attorney obligated to make payment to me for the charges incurred at this office refuse to make such payment, I hereby assign and transfer to this office and assignee any and all causes of action that I might have or that might exist in my favor against such company and authorize this office and assignee to prosecute said cause of action either in my name or in the assignee's name. This office is also authorized to settle or otherwise resolve said claim or cause of action as they see fit. I understand that this does not relieve me of my personal responsibilities for all such charges in the event there is no recovery or if the recovery is insufficient to satisfy such charges. I hereby agree to give a full lien to said office against any and all insurance benefits named herein, or any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of injuries or illness for which I have been treated by said office and assignees. I further agree that the assignee's right for payment shall not be bound by a statute of limitations until a reasonable time has lapsed after either negotiations or litigation between third parties and myself are resolved. A photocopy of this assignment shall be considered as effective and valid as the original. I voluntarily waive the statute of limitations regarding my doctors and/or this office's rights to recover and, and I agree to be held fully responsible for all debts I incur in this office.

It is further agreed that I shall remain personally responsible for the total amount due this office and assignee for its services. I further understand and agree that this Assignment, Authorization, and Lien does not constitute any consideration for the office to wait for payment(s) and that they may demand full payment from me immediately and at any time upon rendering service at their option. Such option requires that I pay for all sums due and owing in full within ten (10) days of demand. I further understand that a monthly service charge is computed by a periodic rate of 1% per month which is an annual percentage rate of 12% applied to the previous balance after deducting current payments and that the service charge may change without notice. I understand that all money due this office will be paid in a timely manner with no amount of money due past 90 days from the date of service, regardless of attorney liens, representations of any attorney, pending settlement(s) or other matters unless approved in writing by this office in advance of the 90 day limit. I further agree and understand that, if the need arises, accounts delinquent may be placed for collection and that I am fully responsible for all court costs, filing fees, attorney costs, and all associated collection costs.

I further understand and agree that, as necessary, this office and its staff may submit, prepare or complete medical records, consultations, depositions and/or court appearances on my behalf which I understand must be paid in full in advance and are not considered part of my account. I authorize this office to release any information pertinent to my case to any insurance company, adjuster, attorney or legal service bureau to facilitate collections under the terms of this document. I agree that Westbrook Medical Center, PLLC is given full power of attorney to endorse and/or sign my name on any and all checks for payment of any indebtedness owed this office and assignee. I understand that this office, the doctors and the staff are accepting my case based on examination findings and believe the outlined treatment should produce change and/or improvement. However, as with any doctor's treatment, a guarantee of improvement or complete recovery cannot be made and it is even possible that no change will occur. I do agree that I am fully obligated to pay for all charges for all services rendered to me.

Print Name_____

Signature _____ Date _____

Westbrook Medical Center

"Consent for Purposes of Treatment, Payment & Healthcare Operations"

(In this document, "I" and "my" refer to the patient, and "facility" refers to Westbrook Medical.)

I consent to the use or disclosure of my protected health information by Westbrook Medical Center for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct the health care operations of Westbrook Medical Center. I understand that analysis, diagnosis or treatment of me by this facility may be conditioned upon my consent which is evidenced by my signature below. Diagnostic testing may be required so a thorough analysis can be completed.

I understand that payment is due at the time services are rendered unless other arrangements have been approved in advance by the staff. I understand that Westbrook Medical Center may accept insurance assignments when the insurance coverage is through a group with whom they participate. If applicable, my consent for an assignment of my benefits to Westbrook Medical Center is designated by my signature below. Deductibles and co-payments must be honored at the time services are rendered. A finance charge will be added to outstanding balances. I understand that Westbrook Medical Center accepts cash, Visa, and MasterCard.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Westbrook Medical Center is not required to agree to the restrictions that I may request. However, If Westbrook Medical Center agrees to a restriction that I request, the restriction is binding to the facility.

I have to right to revoke this consent, in writing, at any time, except to the extent that Westbrook Medical Center has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health condition.

_____ _____

Signature of Patient or Representative | Print Name of Patient or Representative

_____ _____

Date of Signing | Description of Representative's Authority

CONSENT FOR PATIENT TESTING AFTER HEALTHCARE WORKER EXPOSURE

Westbrook Medical Center health care workers handle blood and other body fluids for many reasons such as when performing lab tests and cleaning equipment. It is the policy of Westbrook Health Center to test a patient for Hepatitis B, Hepatitis C and HIV (the virus that causes AIDS) if any employee or health care worker is exposed to a patient's blood or other body fluid in such a way that transmission of these infections could occur. Should an accidental exposure occur, the tests would be conducted at no cost to you. We are requesting that you consent to these tests prior to treatment. My signature below indicates my consent to test my blood or body fluid for Hepatitis B. Hepatitis C, or HIV.

_____ _____

Signature of Patient or Representative | Date

I decline to authorize the above testing:

_____ _____

Signature of Patient or Representative | Date

Co-parenting

Children are sensitive and often very intuitive about tension or dissension between their parents, even from a young age. Navigation of the turbulent emotions surrounding separation and/or divorce is difficult for everyone, but co-parents can help their children understand and cope with the life change.

Co-parenting following separation/divorce or just personal choice can be difficult and frustrating, and we know it takes time to learn how to do it effectively. As a pediatric medical provider, our responsibility is to provide the best care for your child(ren) that we can. It is not our place to enter the co-parenting relationship with the parents.

If one parent brings the child(ren) to an appointment, we expect that parent to communicate with the other on the matters discussed. We operate under the premise that informing one parent informs both parents. Therefore, we do not make duplicate phone calls to parents who do not speak with one another. We do not assume responsibility for a lack of communication between co-parents.

Under Tennessee law, both parents have a right to the health information of their child(ren). If you have a legal ruling that states otherwise, please provide a copy of the court order for us to keep in your child(ren)'s medical chart. If we have been given no legal documents, we must assume either parent can bring th3e child to appointments, make medical decisions and be given all medical test results, etc.

Furthermore, the parent who accompanies the child to the appointment is responsible for payment of the deductible, co-pay, or co-insurance at the time of service regardless of which parent is ultimately responsible for medical bills. We expect co-parents to arrange this between one another in advance

Please sign below to signify your understanding of our co-parenting policy.

_____ _____

Print Child's Name Child's Date of Birth

_____ _____ _____

Parent # 1 Signature Parent # 1 Name (printed) Relationship to child

_____ _____ _____

Parent # 2 Signature Parent # 2 Name (printed) Relationship to child

Date_____

WESTBROOK MEDICAL CENTER
930 Adell Ree Park Lane
KNOXVILLE, TN 37909
(865) 769-2600
865/769-2616 FAX

CONSENT TO RELEASE/RECEIVE CONFIDENTIAL INFORMATION

I _____ authorize Westbrook Medical Center located at the address above to receive my medical history information or treatment records from any source needed to enhance my care with their facility.

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken in reliance on it. This consent will last while I am being treated by providers at this facility unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the facility specified above is otherwise notified by me.

I understand that the records to be released may contain information pertaining to confidential information about communicable diseases including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

Unless otherwise specified, please release ALL records related to my care.

Printed name of Patient	Patient Date of Birth	Patient Social Security Number

Patient Signature	Patient Signature Date

If you have received this form in error, please notify the above office immediately.

Please fax records as soon as possible unless noted otherwise.

Note: Faxed to _____ *at fax #* _____
FACILITY/PROVIDER *NUMBER*

WESTBROOK MEDICAL CENTER

Authorization for Medical Care

COMPLETE THIS SECTION IF PATIENT IS BELOW 18 YEARS OF AGE:

I _____authorize the following people to bring my child_____ Birthdate_____in for, and consent to, treatment, or to receive medical advice over the phone if they are taking care of my child in my absence. I understand telephone triage and advice services regarding direct patient care will be extended to the above persons only when the child is in their care. This does not allow them to have access to confidential health information that is not relevant for that particular visit. In the event of an emergency or other illness, I understand that the physicians and staff of Westbrook Medical Center will deliver any medical care deemed necessary regardless of the accompanying adult.

1) Name:_____

Relationship to patient:_____ Phone #:_____

2) Name:_____

Relationship to patient:_____ Phone #:_____

3) Name:_____

Relationship to patient:_____ Phone #:_____

If a document is to be picked up by a non-legal guardian, Westbrook must have written consent from the legal guardian. This authorization serves as consent for any medical treatment Westbrook deems medically necessary and appropriate. This will remain in effect until revoked by written consent.

_____ _____

Legal guardian signature Print Name

Date _____ _____

Relationship to patient

COMPLETE THIS SECTION, IF APPLICABLE, IF PATIENT IS 18 OR OLDER:

I _____ Birthdate_____authorize the following people to have access to my treatment information and appointment dates. This will remain in effect until revoked by written consent.

1) Name:_____

Relationship to patient _____Phone #_____

2) Name:_____

Relationship to patient _____Phone # _____