A Place To Grow Pediatrics

Patient Registration

Dr. Trinity Loveless, MD
Dr. Diana Farrow, MD
Elisa Thompson, APRN-CNP

Patient Name:_____ Middle:_____ Last:_____
DOB:_____ Sex: M F
Address:_____City:_____ State:____ Zip:_____

Parent Information:

Mothers Name:_____ Last:_____ DOB:_____
Occupation:_____ Work Phone:_____
Home Phone:_____ Cell Phone:_____

Fathers Name:_____ Last:_____ DOB:_____
Occupation:_____ Work Phone:_____
Home Phone:_____ Cell Phone:_____

Patients Family Members:

Sibling Name:_____ DOB:_____ Relation:_____
Sibling Name:_____ DOB:_____ Relation:_____
Sibling Name:_____ DOB:_____ Relation:_____

Laboratory Information:

It is the patient's responsibility to know which lab, diagnostic facility, or specialist is in their insurance network. If the patient does not provide the office staff with the correct information, all lab orders will be sent to Diagnostic Laboratory of Oklahoma (DLO) with the exception of patients with United Healthcare, which will be sent to Laboratory Corporation of America (LabCorp). Any additional charges will be patient responsibility. If you are not in network with DLO or LabCorp please list the lab you are in network with below.

Name of Lab:_____

Insurance Authorization Assignment:

I hereby authorize Dr. Trinity Loveless, Dr. Diana Farrow, and/or Elisa Thompson APRN-CNP to furnish information to insurance carriers concerning my child's illnesses and treatments, and hereby assign to the doctor all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Parent/Guardian Signature:_____ Date:_____

I have received a Notice of Privacy Practices from the office of Dr. Trinity Loveless, Dr. Diana Farrow, and Elisa Thompson MSN APRN-CNP.

Patient/Guardian Signature:_____ Date:_____

A Place to Grow Pediatrics

CHILD REGISTRATION AND HISTORY RECORD

To be filled out by parent or guardian

Child's name _____ Date of Birth_____

Sex ____M ____F City of birth/delivery hospital _____

Pregnancy and Birth

		Yes	No
1.	Were there any problems during the mother's pregnancy?	☐	☐
2.	Mother's age at birth _____		
3.	Did the mother use any cigarettes, alcohol or medications during pregnancy?	☐	☐
4.	Did the baby come more than 2 weeks early or 2 weeks late?		
5.	What was the baby's birth weight? _____		
6.	Were there any problems during labor or delivery Vaginal ☐ C-section ☐	☐	☐
7.	Anesthesia _____		
8.	Were there any problems during the nursery stay?	☐	☐
9.	Other Problems _____		
10.	Number of days in the hospital _____		

Feeding and Digestion

		Yes	No
1.	Has the child had any unusual feeding problems?	☐	☐
2.	Have there been any problems with diarrhea or constipation?	☐	☐
3.	Is your drinking water fluoridated?	☐	☐
4.	Does the child ever eat dirt, plaster, or paint?	☐	☐
5.	How many meals does the child eat per day? _____		
6.	Does the child take vitamins, fluoride, iron or other supplements?	☐	☐
7.	Was/is the child breast ☐ or bottle ☐ fed? If discontinued, when? _____	☐	☐
8.	Has the child ever required oxygen? IV?	☐ ☐	☐ ☐

Developmental and Behavioral Issues

		Yes	No
1.	Does your child go to a sitter, or attend daycare or preschool? If yes, where? _____	☐	☐
2.	Did the child sit alone by 7 months?	☐	☐
3.	Did the child walk alone by 14 months?	☐	☐
4.	Did the child say 3 words by 15 months?	☐	☐
5.	Is the child doing well in school?	☐	☐
6.	Does the child get along well with Other children?	☐	☐
7.	Check off any of the following problems which the child has: ☐ Nightmares/sleep problems ☐ Irritable/bad temper ☐ Discipline problems ☐ Speech problems ☐ Thumb sucking ☐ Bed wetting ☐ Toilet training problems ☐ Breath holding		

Health and Safety

		Yes	No
1.	Are there any guns in the child's house?	☐	☐
2.	Does the child use a toothbrush daily?	☐	☐
3.	Does the child use a car seat or seat belt at all times?	☐	☐
4.	Are there smoke detectors in the child's home?	☐	☐
5.	Is the hot water temperature less than 125°?	☐	☐
6.	Do you have rules/limits for television viewing?	☐	☐
7.	Are medicines and potential poisons out of reach?	☐	☐
8.	Do you have syrup of ipecac?	☐	☐
9.	Do you know child resuscitation or choking management?	☐	☐

Name of current school _____

Current grade in school _____

Usual grades made in school _____

Illnesses- Check ☑ where the child or members of the child's family (parents, siblings, grandparents, aunts, uncles) have had the following illnesses or problems.

	Child	Child's Family		Child	Child's Family
Bone Disease	☐	☐	Learning disorder/mental retardation	☐	☐
Birth Defects	☐	☐	Kidney/bladder problems or infections	☐	☐
Frequent ear infections	☐	☐	Seizures/convulsions	☐	☐
Cystic fibrosis	☐	☐	Heart disease	☐	☐
Croup	☐	☐	High blood pressure	☐	☐
Mumps, measles, chicken pox	☐	☐	High cholesterol	☐	☐
Wheezing/asthma	☐	☐	Lung disease/tuberculosis	☐	☐
Pneumonia	☐	☐	Sexually transmitted diseases/HIV	☐	☐
Eye problems	☐	☐	Alcohol/drug problems	☐	☐
Dental problems	☐	☐	Mental/emotional disorders	☐	☐
Hearing problems	☐	☐	Thyroid disease	☐	☐
Hay fever/allergies	☐	☐	Cancer	☐	☐
Eczema/skin problems	☐	☐	Migraines	☐	☐
Anemia/ blood problems	☐	☐	Other _____	☐	☐
Arthritis	☐	☐			
Ulcers/stomach problems	☐	☐			
Diabetes	☐	☐			

General Health				Health		
	First Name	Year of Birth	Sex	Good	Poor	(Explain)
Mother						
Father						
Brothers and Sisters						

Have any of the child's brothers or sisters died? No ☐ Yes ☐ Explain _____

Hospitalizations or Serious/Unusual Illnesses

Identify any serious and/or unusual illnesses or injuries which your child has experienced.

Date Serious/Unusual Illness/Injuries

_____ _____

_____ _____

_____ _____

_____ _____

Allergies

List allergies, including any allergic reactions to drugs.

_____

_____

_____

Parent/Guardian Comments

_____

_____

_____

_____

_____

A Place to Grow Pediatrics

Dr. Trinity Loveless, M.D.
Dr. Diana Farrow, M.D.
Elisa C. Thompson, APRN-CNP

Authorization of Treatment of Minor

Child's Name _____Birthdate _____

I _____ (Parent/Guardian), do hereby give permission for medical treatment from Dr. Trinity Loveless, M.D. and/or Dr. Diana Farrow, M.D. and/or Elisa C. Thompson, APRN-CNP of

_____(child's name).

The following person (s) have my permission to bring the child listed above:

	Name	Phone Number	Relationship
1.			
2.			
3.			

Parent/Guardian Name _____

Parent/Guardian Signature _____Date _____

A Place to Grow Pediatrics

Dr. Trinity Loveless, M.D.
Dr. Diana Farrow, M.D.
Elisa C. Thompson, APRN-CNP

Vaccination Policy Agreement

Child's Name_____

I, _____, understand that I must vaccinate my child according to the following schedule provided by Dr. Trinity Loveless, M.D., Dr. Diana Farrow, M.D., and Elisa C. Thompson, APRN-CNP. I understand that this is a private practice and the providers can choose to deny care to my child if I do not follow the attached schedule.

I understand that my child will receive the first set of vaccines at the 2 month well child check. If I choose to follow an alternate vaccine schedule I will provide a copy to my provider at our 2 month well child check. I understand that my alternate schedule will require approval by Dr. Trinity Loveless, M.D., Dr. Diana Farrow, M.D., or Elisa C. Thompson, APRN-CNP. I understand that the provider has a right to disagree with the alternate schedule that I have provided and can require my child to be vaccinated according to the attached schedule.

I understand that if I choose to not vaccinate my child at all, or choose to completely eliminate any vaccine from the schedule, my provider can refuse to provide services to my child. I also understand that there are vaccine information statements on file in the office for patient education, and I have the right to request and obtain said documents if I so desire.

Parent/Guardian Name _____

Parent/Guardian Signature_____ Date _____

A Place to Grow Pediatrics

812 South Mustang Road ~ Yukon, Ok 73099

HIPAA NOTICE OF PRIVACY PRACTICES

Effective April 25, 2013

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOUR CHILD(REN) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Who will follow this notice:

- Dr. Trinity Loveless, Dr. Diana Farrow & Elisa Thompson (nurse practitioner)
- All employees of A Place to Grow Pediatrics and those who provide services for A Place to Grow Pediatrics

Our pledge regarding health information: We understand that health information about your child's healthcare is personal. We are committed to protecting health information about them. We create a record of the care and services your child has receive from us. We need this record to provide your child with quality care and to comply with certain legal requirements. This notice applies to all of the records of your child's care generated by this health care practice, whether made by the doctor or others working in this office. This notice will tell you about ways in which we may use and disclose health information about your child.

We are required by law to:

- Make sure that health information that identified your child is kept private.
- Give you this notice of our legal duties and privacy practices with respect to the health information of your child.
- Follow the terms of this notice that is currently in effect.

How we may use and disclose health information about your child: The following categories describe different ways that we may use and disclose health information. For each category of uses and disclosures, we will explain what we mean and try to give some examples. Not every use or disclosure in a category is listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.

For treatment: We may use and disclose health information about your child so that treatment and services your child receives from us may be billed to and payment collected from you, an insurance company or a third party.

Appointment reminders: We may use and disclose health information to contact you as a reminder that your child has an appointment. Please let us know if you would like other means of notification.

Treatment alternatives: We may use and disclose protected medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you and your child.

Health Related Benefits and Services: We may use and disclose protected medical information to tell you about health related benefits or services that may be of interest to you or your child.

Individuals involved in your child's care and payment: We may release protected medical information about you to a friend or family member who is involved in your child's medical care. We may also give medical information to someone who helps pay for your child's care.

Research: Under certain circumstances, we may use and disclose protected medical information about you or your child for research purposes. We will always ask for specific permission if they will have access to your child's name, address or other information.

As required by law: We will disclose protected medical information about your child when required by federal, state, and local law.

Special situations and public health risks: We may disclose protected medical information for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability
- To report births and deaths
- To report a suspected crime
- To report child abuse or neglect
- To report vulnerable adult abuse
- To report reactions to medications and problems with products
- To notify the appropriate government authority if we believe patients have been the victim of domestic violence. We may only make this disclosure if you agree or when required by law.

Health Oversight Activities: We may disclose protected medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example: audits, investigations, and licensure. These activities are necessary for government programs and compliance of civil rights.

Lawsuits and disputes: If you/your child are involved in a lawsuit or dispute, we may disclose protected medical information about you/your child in a response to a subpoena (request to other lawful process by someone else involved in the dispute), but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested. We may release protected information if asked to do so by a law enforcement official:

- In response to a court order, warrant, summons or similar process.
- To identify, locate a suspect, fugitive material witness, or missing person.
- About the victim of a crime if unable to obtain the person's agreement
- About a death we believe may be a result of criminal conduct.
- In emergency situations to report a crime, the location of a crime and the identity of the person who committed the crime.

Medical examiners and funeral directors: We may release protected medical information to a medical examiner.

National Security and Intelligence Activities: We may release protected information about your child to authorized Federal officials for intelligence and other national security activities authorized by law.

Protected Services for the President and Others: We may discuss protected medical information about your child to authorized federal officials so they provide protection to the President and other authorized persons of foreign heads of state, or to conduct special investigations.

Inmates: If you are an inmate to a correctional institution or under custody of a law enforcement official, we may release protected medical information about you to the correctional institution or official.

Your Rights Regarding Medical Information about Your child: You have the right to inspect and copy your child's medical information that may be used to make decisions about your child's care. This does not include psychotherapy notes. To inspect and/or copy you must submit a request to a member of our office in writing. The charge by statute of Oklahoma is $0.25 per page plus the cost of postage. An x-ray image is $5.00 per image.

Right to Amend: If you feel your child's information is incorrect or incomplete, you may ask us to amend your information. This must be in writing and submitted to the office manager. In addition, you must provide a reason that supports your amendment request.

Right to an Accounting of Disclosures: You have a right to request an "accounting of disclosures." This is a list of the disclosures we have made of your medical information.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or a certain location. To request confidential communications, you will need to request in writing to our office manager.

Right to Request Restrictions: You have a right to request a restriction or limitation on the protected medical information we use or disclose about your child for treatment, payment, or health care operation. However, we must receive your restrictions in writing before we have made such decisions. We are not required to agree with your request. If we do not agree, we will comply with your request unless the information is needed for emergency treatment.

Right to Copy of the Notice: We reserve the right to change this notice. We reserve the right to make revisions or change information as we receive it in the future. We will post a current copy in our office and it will have the effective date at the top of the notice.

Complaints: If you believe your child's privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our office manager at 405-265-3900. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Other Use of Medical Information: Other uses and disclosures of protected medical information not covered by this notice or the laws that apply, will be made only with your written permission. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the care we have provided to your child.

I have received a Notice of Privacy Practices from the office of Dr. Trinity Loveless, Dr. Diana Farrow, and Elisa Thompson MSN APRN-CNP.

Patient/Guardian Signature:_____ Date:_____