LEWIS&CLARK COMMUNITY COLLEGE
Family Health Clinic

PEDIATRIC/ADOLESCENT PATIENT REGISTRATION

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Patient's Last Name:	First:	Middle:

Birth date: / /	Age:	Sex: ❑ M ❑ F	Social Security No.:	Phone : ( )

Street address/PO Box:	City:	State:	ZIP Code:

INSURANCE INFORMATION

Please give your insurance card (s) and photo ID to the receptionist. You must notify us if this is an accident or work related visit.

Type of Insurance Coverage: ☐ No Insurance ☐ Private Insurance ☐ Medicaid ☐ Medicare

Is this patient covered by insurance: ☐ Yes ☐ No **Email Address:**

Policy Holder's Name:	Policy Holder's SS#:	Policy Holder's Birth Date:	Co-Payment:

Policy Number:	Policy Group Number:

Patient's relationship to subscriber:

STATISTICAL INFORMATION (OPTIONAL)

The LC Family Health Clinic is grant funded and the following questions are for statistical purposes. Please complete the following information.

County of Residence:
☐ Greene ☐ Macoupin ☐ Jersey ☐ Calhoun
☐ Madison ☐ Other(Please Specify):
_____

Ethnicity:
☐ White/Non-Hispanic ☐ African American ☐ Hispanic ☐ Asian
☐ American Indian/Alaskan ☐ Hawaiian/Pacific Islander
☐ Other: _____

Do you reside in Public Housing: ☐ Yes ☐ No **Are you a veteran?** ☐ Yes ☐ No

Based on your family size, please circle the box that best describes your family income. You may choose <u>either</u> annual or monthly. Thank you.

Family Size	ANNUAL INCOME										
1	$11,770	$14,124	$15,6544	$15,890	$16,478	$17,066	$17,655	$20,598	$21,775	$23,540	>$23,540
2	$15,930	$19,116	$21,187	$21,506	$22,302	$23,099	$23,895	$27,878	$29,471	$31,860	>$31,860
3	$20,090	$24,108	$26,720	$27,122	$28,126	$29,131	$30,135	$35,158	$37,167	$40,180	>$40,180
4	$24,250	$29,100	$32,253	$32,738	$33,950	$35,163	$36,375	$42,438	$44,863	$48,500	>$48,500
5	$28,410	$34,092	$37,785	$38,354	$39,774	$41,195	$42,615	$49,718	$52,559	$56,820	>$56,820
6	$32,570	$39,084	$43,318	$43,970	$45,598	$47,227	$48,885	$56,998	$60,255	$65,140	>$65,140
7	$36,730	$44,076	$48,851	$49,586	$51,422	$53,259	$55,095	$64,278	$67,951	$73,460	>73,460
8	$40,890	$49,068	$54,384	$55,202	$57,246	$59,291	$61,335	$71,558	$75,647	$81,780	>$81,780

Family Size	MONTHLY INCOME										
1	$ 981	$1,177	$1,305	$1,324	$1,373	$1,422	$1,471	$1,716	$1,815	$1,962	>$1,962
2	$1,328	$1,593	$1,766	$1,792	$1,851	$1,925	$1,991	$2,323	$2,456	$2,655	>$2,655
3	$1,674	$2,009	$2,227	$2,260	$2,344	$2,428	$2,511	$2,930	$3,097	$3,384	>$3,384
4	$2,021	$2,425	$2,688	$2,728	$2,829	$2,930	$3,031	$3,536	$3,739	$4,042	>$4,042
5	$2,368	$2,841	$3,149	$3,196	$3,315	$3,433	$3,551	$4,143	$4,380	$4,735	>$4,735
6	$2,714	$3,257	$3,610	$3,664	$3,800	$3,936	$4,071	$4,748	$5,021	$5,428	>$5,428
7	$3,061	$3,673	$4,071	$4,132	$4,285	$4,438	$4,591	$5,356	$5,663	$6,122	>$6,122
8	$3,408	$4,089	$4,532	$4,600	$4,771	$4,941	$5,111	$5,963	$6,304	$6,815	>$6,815

The project is supported by the Health Resources and Services Administration (HRSA) UD7HP28529-01-00 for the Nurse Education, Practice, Quality, And Retention Program for an Interprofessional Collaborative Practice. Funds received for the three year project are 1,420,458.00. The information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any official endorsement be inferred by HRSA or the US Government.

PATIENT INFORMATION

ALLERGIES to medicine/vaccines/food (list and describe reaction)

_____
_____
_____
_____
_____
_____
_____

Family History

Do any family members have any of the following conditions?

Condition	mother	father	sibling	grandparents
Asthma	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Heart problems	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Depression/anxiety	☐	☐	☐	☐

Please explain all positives:_____
_____
_____

Development/Nutrition

At what age did your child: sit alone_____
walk alone_____ say words ____ toilet train _____
1st period (females) age _____
Was your child breast fed_____ how long _____
Has your child had any unusual feeding/dietary problems?
Explain: _____
Are your child's immunizations up to date _____

Social History

Number of persons who lives in the household with the child _____ number of siblings'
_____
Child's parents ☐married ☐unmarried ☐divorced ☐other
Does your child go to daycare or is cared for by babysitter, family, friend? ☐ Yes ☐ No
Do any household members smoke? ☐Yes ☐No
How many hours per day does your child spend:
watching TV____ Computer ____ Video games ___
Any concerns regarding peer or teacher relationships _____
_____

Sports/exercise

☐Sedentary (No Exercise)
☐Mild Exercise (i.e. climb stairs, walk)
☐Occasional vigorous exercise (less than 4x/week for 30 min)
☐Regular vigorous exercise (4x/week for 30 min)

Diet

Are you concerned with your weight? ☐Yes ☐ No
How many times a week do you eat fast food? _____

Sexually Active

☐Yes
☐ No

Child's Past Medical History

What city and state was your child born_____
Is the child yours by: ☐ birth ☐ adoption ☐stepchild ☐other_____
Pregnancy complications _____
Delivered by: ☐C-section ☐vaginal birth
Was your child premature: ☐ Yes ☐ No
Birth weight _____ Length _____

Infancy/childhood/adolescence

Asthma or reactive airway disease_____
Wheezing, bronchitis, pneumonia_____
Seasonal allergies_____
Food allergies_____
Recurrent ear infections_____
Urinary tract infections_____
Genetic syndromes_____
Seizures_____
Anemia_____
Broken bones_____
Mentally challenged or learning disabilities/Autism:
_____
Depression/anxiety_____
Other chronic medical conditions_____
_____
_____
Has your child ever been hospitalized ? ☐Yes ☐No
Explain: _____
Any previous surgeries or procedures: ☐Yes ☐No
Explain: _____
List any other physicians your child is currently seeing and
Reason: _____
_____

Dental

Last Dental Exam: _____
Experiencing any pain in mouth? ☐Yes ☐No
Gums bleed when bushing or flossing? ☐Yes ☐ No

Vision

Last Vision Exam: _____
Any hearing loss? ☐Yes ☐No

Medications

List current medications and dose:
_____
_____
_____
_____
_____
_____
_____

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Consent for Care:

I, with my signature, authorize LC Family Health Clinic, and any employee working under the direction of the provider, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but not limited to) preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling assessment or review of physical/ mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with interprofessional healthcare students and other health care professionals for care and treatment.

Financial Policy:

We appreciate you choosing us for your healthcare. We will adhere to the following financial policy in order to consistently deliver high quality care and services. The patient/responsible party assumes responsibility to ensure that the financial obligation is fulfilled for the health care services received.

- I understand that I am responsible for all co-payments, amounts applied to deductible, and other amounts that may be deemed my responsibility by the payment source, as required by my contract with my insurance plan and state regulations.

- I understand that if I have an insurance co-payment, I am expected to make payment when checking in for my appointment.

- I understand that my contract with my insurance entity may or may not cover some services. All insurance policies are not the same. They vary by employer group. LC Family Health Clinic is not responsible or able to know every policy available. It is my responsibility to verify applicable coverage prior to receiving the services. If I seek care outside of the contract terms, I am aware that I may be responsible for all charges that are incurred.

Thank you for your understanding and cooperation with this policy. It is our privilege to provide your medical care.

Consent Agreement

I affirm that I have stated all my known medical conditions and answered all questions honestly.

I agree to keep the provider updated as to any changes in my medical profile and understand that there shall be no liability to *Lewis & Clark Community College Family Health Clinic or LCCC Health Services* should I fail to do so.

_____ _____

Signature of Guardian Date

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