Southeast Pediatrics
Columbus Regional Health Network
36 McNeill Plaza, Whiteville, NC 28472
(P) 910-640-4064 (F) 910-640-4063

FAMILY INFORMATION FORM

PATIENT NAME:

FIRST MIDDLE LAST NICKNAME DATE OF BIRTH SOCIAL SECURITY # GENDER Circle One Boy / Girl

CHILD'S ADDRESS: _____
PO BOX OR AND STREET ADDRESS CITY STATE ZIP CODE

Main Adult Contact for Child	**Alternate Adult Contact for Child**
Name:	Name:
Relation to Child: ☐ Mother ☐ Father ☐ Other:	Relation to Child: ☐ Mother ☐ Father ☐ Other:
Address: ☐ Same as child's address Street Address: _____ City: State: Zip:	Address: ☐ Same as child's address Street Address: _____ City: State: Zip:
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Social Security #: Date of Birth:	Social Security #: Date of Birth:
Email:	Email:
Employer:	Employer:
Work Phone:	Work Phone:

PHARMACY: _____ RACE: _____

FOSTER CHILD? ☐ Yes ☐ No FOSTER GUARDIAN: _____

DSS CUSTODY? ☐ Yes ☐ No ASSIGNED CONTACT: _____

The child's parents are:

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Living together, not married ☐ Widowed ☐ unknown ☐ Child is adopted

IN CASE OF AN EMERGENCY, THE OFFICE SHOULD CALL _____ PHONE #: _____
Name & Relationship

As a parent, I understand that I must give permission for my child to receive medical treatment. If at all possible, I will come with my child for every appointment at Southeast Pediatrics.

If I cannot come with my child, I agree to let _____ **and/or** _____
seek medical treatment for my child. (Name & Relationship) (Phone #) (Name & Relationship) (Phone #)

Examples of persons to name here may be stepparent, grandparent, sitter, etc.

If my child comes with anyone other than myself or the persons listed above, I agree to send with them a written note, with my signature giving permission for treatment.

Are there any court orders or legal documents involving your child that we should know about? ☐ Yes ☐ No

Signature of adult completing this form: _____ **Print Name:** _____

CHILD'S NAME: _____ DATE OF BIRTH: _____

PATIENT and FAMILY HISTORY

1. What medical problems does the child have? What medical problems do people in the child's family have?

Medical Problems:	Who has the medical problem (please circle):
Birth Defects	Child Mother Father Brother/Sister PGM PGF MGM MGF
Obesity (Overweight)	Child Mother Father Brother/Sister PGM PGF MGM MGF
Congenital Hearing Loss/ Hearing Problems	Child Mother Father Brother/Sister PGM PGF MGM MGF
Mental Retardation	Child Mother Father Brother/Sister PGM PGF MGM MGF
Migraine Headaches	Child Mother Father Brother/Sister PGM PGF MGM MGF
Allergies	Child Mother Father Brother/Sister PGM PGF MGM MGF
Asthma (Trouble Breathing)	Child Mother Father Brother/Sister PGM PGF MGM MGF
Heart Disease/Heart Problems (Murmur, Hole in Heart)	Child Mother Father Brother/Sister PGM PGF MGM MGF
Sudden Death of Infant/Baby	Child Mother Father Brother/Sister PGM PGF MGM MGF
Arthritis (Pain in the Joints)	Child Mother Father Brother/Sister PGM PGF MGM MGF
AIDS	Child Mother Father Brother/Sister PGM PGF MGM MGF
Cancer	Child Mother Father Brother/Sister PGM PGF MGM MGF
Thyroid Problems	Child Mother Father Brother/Sister PGM PGF MGM MGF
Diabetes (Sugar)	Child Mother Father Brother/Sister PGM PGF MGM MGF
Muscular Dystrophy	Child Mother Father Brother/Sister PGM PGF MGM MGF
Cystic Fibrosis	Child Mother Father Brother/Sister PGM PGF MGM MGF
Anemia (Low Iron in the Blood)	Child Mother Father Brother/Sister PGM PGF MGM MGF
Sickle Cell Disease	Child Mother Father Brother/Sister PGM PGF MGM MGF
Epilepsy	Child Mother Father Brother/Sister PGM PGF MGM MGF
Crohn's Colitis (Stomach or Bowel Problems)	Child Mother Father Brother/Sister PGM PGF MGM MGF
ADD/ADHD (Trouble Paying Attention or Sitting Still)	Child Mother Father Brother/Sister PGM PGF MGM MGF
Skin Problems (Acne, Flaking, Rashes)	Child Mother Father Brother/Sister PGM PGF MGM MGF
Cerebral Palsy	Child Mother Father Brother/Sister PGM PGF MGM MGF
Other (Please List):	Child Mother Father Brother/Sister PGM PGF MGM MGF

PGM = Paternal Grandmother MGM = Maternal Grandmother
PGF = Paternal Grandfather MGF = Maternal Grandfather

2. Check all the people that the child lives with:

☐ Mother ☐ Father ☐ # Brothers _____ ☐ # Sisters _____

☐ Other family members (list: _____)

☐ Friends or other people (list: _____)

☐ Animals: ☐ Dogs ☐ Cats ☐ Other animals (list: _____)

3. Has your child ever been a **patient in a hospital** (other than a few days after birth)?
   ☐ No
   ☐ Yes (Explain why and when below):

My child was in the hospital because:	**When:**
Example: *Bike Accident*	*5 years old*

4. Is your child taking any **prescription medicines**?
   ☐ No, my child does not take any prescription medicines.
   ☐ Yes – Please list the child's medicines below or ☐ I brought my child's medicines

Name of Medicine:	**Amount/ Size of Pill**	**How many pills or doses does your child take at:**
Example: *Dexedrine*	10 mg	____ morning ____ noon ____ dinner ____ bedtime
		____ morning ____ noon ____ dinner ____ bedtime
		____ morning ____ noon ____ dinner ____ bedtime
		____ morning ____ noon ____ dinner ____ bedtime

5. What **over-the-counter** medicines does your child take?
   ☐ Vitamins
   ☐ Herbal Medicines (Please list: _____)
   ☐ Other (Please list: _____)
   ☐ None – my child does not take any other-the-counter medicines

6. Does your child have any allergic reactions (bad effects) from any of the following? Check all that apply:
   ☐ Outdoor or indoor allergies (for example: grass, pollen, cats, bee stings, etc.)
   ☐ Food allergies (for example: milk, peanuts, wheat, etc.) Please list below.
   ☐ Medicines or shots (immunizations). Please list below.
   ☐ No, my child has no allergies that I am aware of.

Medicine or food that child is allergic to:	**What happens when the child eats that food or takes that medicine?**
Example: *Penicillin*	*Big red spots on skin (hives)*

7. Does the child go to **school or daycare**?
   ☐ No ☐ Yes (Name of school or daycare facility: _____)

8. Does the child live with anyone who smokes? ☐ Yes ☐ No
   ☐ Inside ☐ Outside

9. Does the child smoke? ☐ Yes ☐ No

10. What type of water is used in the child's house? ☐ City Water ☐ Well Water

11. When was your child's last well child examination? _____

ABOUT MOM WHEN PREGNANT

The next questions are about the mother of the child during pregnancy and birth.
If you do not know about the pregnancy of the mother, check here ☐.

12. Did the mother use any of the following **during pregnancy**?
    - ☐ Cigarettes
    - ☐ Alcohol
    - ☐ Illegal drugs (which ones? _____)
    - ☐ Prescription drugs (which ones? _____)
    - ☐ None of these were used by the mother during pregnancy

13. Did the mother have any of these **conditions or problems during pregnancy**?
    - ☐ Preeclampsia (High Blood Pressure)
    - ☐ Diabetes (Sugar)
    - ☐ Emotional Stress
    - ☐ Injury or Serious Illness
    - ☐ Unexpected Bleeding or Spotting
    - ☐ Other _____

14. **Was the birth:**
    - ☐ On the due date
    - ☐ Before the due date (by how much? _____)
    - ☐ After the due date (by how much? _____)

15. **Was the baby born by C-Section** (surgical cut in the tummy)? ☐ Yes ☐ No

16. Were there any problems during the birth? ☐ Yes ☐ No

    If yes, please explain: _____

17. Siblings? ☐ Yes ☐ No

    If yes,

Names (please list)	Date of Birth
_____	_____
_____	_____
_____	_____

18. 4 digit security code: _____ (to obtain authorized patient access)

Columbus Regional HEALTH NETWORK

Consent for Communication for Involvement of Care

I, the undersigned, do hereby consent and request that Southeast Pediatrics communicate with or release health information concerning me, if communication is in my best interest and is only information that is directly relevant to designated individual's involvement with my healthcare and treatment decisions.

Patient's Name _____ Date of Birth _____

1. Name and address of person who I want to have health information as outlined above.

Name _____ Relationship to Patient _____

Address _____

_____

Phone # _____

2. Name and address of person who I want to have health information as outlined above.

Name _____ Relationship to Patient _____

Address _____

_____

Phone # _____

3. Name and address of person who I want to have health information as outlined above.

Name _____ Relationship to Patient _____

Address _____

_____

Phone # _____

_____ _____

Signature of Patient or Authorized Party/Date Printed Name

I do not grant consent for anyone to be given information regarding my healthcare or treatment except required by law.

_____ _____

Signature of Patient or Authorized Party/Date Printed Name

Columbus Regional HEALTH NETWORK

ACKNOWLEDGEMENT FORM

Medical Records #: _____

Patient's Name: _____ Date of Birth: ____/____/____
Day Month Year

We are required by law to provide you with our Notice of Privacy Practices which explains how we use and disclose your health information. We are also required to obtain your signature acknowledging that this notice has been made available to you.

Signature: _____ Date: _____
(Patient or Authorized Representative)

Relationship to patient: _____ Self _____ Spouse _____ Other: _____

Reason Patient Unable/ Unwilling to Sign: _____

ACKNOWLEDGEMENT FORM

DOCUMENTO DE RECONOCIMIENTO DE COLUMBUS REGIONAL HEALTH NETWORK

Numero de Registro Medico: _____

Nombre del Paciente: _____ Fecha de Nacimiento: ____/____/____
Dia Mes Ano

La ley nos requiere que nosotros le proveamos a usted con nuestro Aviso de Practicas de Privacidad las cuales explican como podemos usar y divulgar su imformacion medica. La ley tambien nos requiere que obtengamos su firma, reconociendo que este aviso lo hemos hecho disponible para usted.

Firma: _____ Fecha: _____
(Paciente o Representate Authorizado)

Relacion al Paciente: _____ Mismo _____ Esposo (a) _____ Otro: _____

Razon Por la Cual El Paciente No Desea Firmar: _____

Columbus Regional
HEALTH NETWORK

PAYMENT POLICY & PATIENT STATEMENT OF RESPONSIBILITY TO OUR VALUED PATIENTS:

THANK YOU for choosing Columbus Regional Health Network for your healthcare services. We strive to provide the highest quality of care yet keep your healthcare costs as low as possible. These policies reflect our efforts to reduce healthcare costs. We appreciate your full cooperation.

FOR YOUR CONVENIENCE we accept any debit or credit card with the MasterCard, Visa, Discover, or American Express logo, as well as your personal check or cash.

PAYMENT (such as co-pays, deductibles & co-insurance) is required at the time of service. We request that you do not ask to be billed. Patients repeatedly asking for exceptions will be directed to a supervisor or practice manager.

INSURANCE CARDS must be presented at each visit. You may feel this is unnecessary, but insurance plans are becoming more complicated, and cards, policy numbers, and renewal dates are constantly changing. In order for us to file your claims with the appropriate plan, we must have the most recent card presented. **If you arrive without your card**, you will be responsible for all charges until the billing office has received complete, current, and accurate insurance information. Most plans require we file your claim within 90 days from the date of service. If we have not received your information within that time, you will remain responsible for all charges incurred up to the date you provide us with your insurance information and we receive payment from the insurance plan. Any balance you owe should be paid within thirty days.

MEDICARE PLANS are more numerous and complicated. Columbus Regional Health Network participates with **Traditional Medicare {Part A & Part B**) and a limited number of Private Fee-for-Service (PFFS) Medicare Advantage Plans. We do not accept any Non Private Fee-for- Service Plans except for emergency situations. Please notify the front office immediately if you have recently changed Medicare plans. Medicare deductibles and co-insurance are expected at the time of service. As a participating provider with Medicare and a limited number of PFFS, we will file your claim to Medicare and if applicable, to your secondary insurance carrier.

MANAGED CARE PLANS have a network of participating providers. We participate with most major plans, but please contact your plan or check their website or call our office for confirmation before your visit. Applicable co-pays, co-insurance and deductibles are expected at time of service. You will also be billed for any non-covered services for which you are liable after your insurance pays their share. If you have a managed care plan that we do not participate with, you will be expected to pay the bill in full at the time of service.

OTHER INSURANCES are those plans we do not participate in. You may be responsible for payment in full at the time of service. As a courtesy, we will file your claim.

WORKER'S COMPENSATION may or may not be accepted by your provider. Please check with your provider before making an appointment. If your provider accepts Worker's Compensation, you will be seen upon approval and authorization by your employer with the proper documentation.

Columbus Regional HEALTH NETWORK

MEDICAID may not be accepted by your provider. Please check with your provider's office before making an appointment. If your provider does accept Medicaid, **you will need to bring your current Medicaid Identification Card to each visit.** Failure to bring the current card may result in your appointment being rescheduled. If there is a co-pay with your plan, you will be expected to pay it at the time of service.

HEALTH SAVINGS ACCOUNTS/HEALTH REIMBURSEMENT ACCOUNTS are being promoted so that patients can have more control over managing their health care spending. These accounts will be patient specific so it is important you are aware of all benefits, deductibles, and co-payments. The deductible and co-payment will be expected at the time of service.

SELF PAY PATIENTS are those patients who **do not have insurance coverage**. Self pay patients will be given a 25% discount off the charges for services provided and are expected to pay a minimum of $50.00 at the time of service. This discount also does not apply to those patients who may have insurance, but we do not participate with their plan.

MEDICAL FORMS/MEDICAL LEAVE/DISABILITY FORMS will be completed **within 7 to 10 business days** upon receiving the form in the office. Please make sure you allow plenty of time for completion of these forms. Emergencies will be handled on a case by case basis. There may also be a fee for completion of these forms.

We thank you for taking time to read and understand our policies. Please let us know if you have any questions. Again, our office should be notified immediately of any changes in insurance coverage or primary care assignment.

I understand my responsibilities as outlined above and will abide by them.

Patient/Guardian Name _____

Patient/Guardian Signature _____ Date: _____

COLUMBUS REGIONAL HEALTHCARE SYSTEM – SOUTHEAST PEDIATRICS
36 McNeill Plaza Whiteville, North Carolina 28472
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Phone: 910-640-4064
Fax: 910-640-4063

Patient Information: I give permission to release the health information of:

Patient Name: _____ Date of Birth: _____
Street Address: _____ Last 4 Numbers of SSN: _____
City, State, Zip: _____ Telephone: ( )
Email Address: _____

Release Information From:

_____
(List applicable Facility(s) and/or Practices)

_____

_____
(Phone number) (Fax number)

Release Information To:

SOUTHEAST PEDIATRICS
36 MCNEILL PLAZA
WHITVILLE NC 28472

910-640-4064 (Phone number) 910-640-4063 (Fax number)

PURPOSE OF RELEASE (check one) ☐ Request of individual/personal ☐ Continued patient care ☐ Insurance
☐ Legal purpose including discussions and proceedings ☐ Other _____

Fill in dates of treatment for records to be release:
Treatment dates: From _____ To _____
Hospital Summary: May include history & physical, discharge summary, operative notes, consults, diagnostic test results, medication list, allergies.
Office/Clinic Summary: May include most recent office visits, physical exam, consults, diagnostic test results.

Hospital (check all that may apply):
☐ Hospital Summary
☐ Discharge Summary ☐ Emergency Record
☐ History and Physical ☐ Cardiac Reports/EKG
☐ Consultation Reports ☐ Other: _____
☐ Operative Reports _____
☐ Laboratory Reports _____
☐ Radiology/ X-Ray Reports _____
☐ Pathology Reports _____
☐ Entire record (Not including psychotherapy notes)

Office/Clinic (check all that may apply):
☐ Office/Clinic Summary
☐ Office Visit
☐ Physical Exam
☐ Laboratory Reports
☐ Radiology Reports
☐ Other: _____
_____
☐ Entire record (Not including psychotherapy notes)

FORMAT:
☐ CD (charges may apply)
☐ Email address noted above, where permitted
☐ Paper copy (charges may apply)
☐ Other: _____

DELIVERY METHOD:
☐ Reg. US Mail ☐ Pick-up ☐ Fax, where permitted
☐ Overnight/Express Mail Service, where permitted
☐ Secure email
☐ Other: _____ IF MORE THAN 25 PAGES, PELASE MAIL

PATIENT'S RIGHTS – I understand that:

- I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or practice names above. Any cancellation will apply only to information not yet released by facility or practice.
- This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases.
- Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.
- Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in health plan, or eligibility for benefits.
- CRHS will not share or use my health information without my permission other than by ways listed in CRHS's Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at crhealthcare.org.
- A fee may be charged for providing the protected health information.
- I have a right to receive a copy of this form upon request.

This permission expires one year after the date of my signature unless another date or event is written here: _____

Signature: _____ Print Name: _____ Date: _____

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form.
Note the relationship/authority if signature is not that of the patient (Written Proof May be Requested):
☐ Healthcare Agent/POA ☐ Guardian ☐ Executor/Administrator/Attorney in Fact ☐ Spouse
☐ Parent ☐ Adult Child ☐ Affidavit Next of Kin ☐ Other:

Note: If minor consented for their outpatient treatment for pregnancy, sexually transmitted disease or behavioral/mental health without parental consent, the minor must sign this authorization. When the patient is a minor being treated for substance abuse, the minor must sign this authorization, regardless of who consented for treatment.

Signature of Minor: _____ Print Name: _____ Date: _____

Authorization given to patient/Date of release: _____ via ☐ Mail ☐ Fax ☐ Other _____ ☐ ID Verified ☐ DL/Other ID _____

CRHS Employee Name & Title: _____ CRHS Employee Signature: _____ Date: _____