



Faith Family Wellness
207 Aberdeen Parkway Panama City, FL 32405
PH: (850) 788-3120 / FAX: (850) 788-3125

What is the reason for your visit today?

How did you hear about our office/who can we thank?

Patient Information

Child's Legal Name	Birth Date	Age	Birth Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Name of Previous Provider:			Phone#
Mailing Address		City, State, Zip	
Current Grade Level and School:		Parents Email	
Special Needs:			
Extracurricular Activities			
Preferred Language			Ethnicity: Hispanic or Latino Not Hispanic or Latino
Race <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other _____ <input type="checkbox"/> Prefer not to answer			

Guarantor/Responsible Party

Legal Name of Responsible Party	Birth Date	Relationship to Patient
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Medical Insurance (Please present ID & insurance card to the front desk)

PRIMARY Insurance Company Name	Policy Number/Member ID	Group Number
Policy Holder Name	Insured Date of Birth	Patient Relationship <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent
SECONDARY Insurance Company Name	Policy Number/Member ID	Group Number
Insured Name	Insured Date of Birth	Patient Relationship <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent

Emergency Contact

Contact Name	Phone Number	Relationship to Patient
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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Faith Family Wellness or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date



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PATIENT MEDICAL HISTORY

HEIGHT:	WEIGHT:
ALLERGIES (include medication, food latex and environmental allergies) <input checked="" type="checkbox"/> No Known Allergies <input type="checkbox"/>	

Allergy to 1. _____ 2. _____ 3. _____

Severity/Reaction _____

CURRENT MEDICATION/SUPPLEMENTS (May provide detailed list or bring in bottles) <input checked="" type="checkbox"/> No Current Medication <input type="checkbox"/>		
Medication Name	Dose	Frequency
Preferred Pharmacy :		

HOSPITALIZATIONS/PROCEDURES/SURGERIES	NONE <input type="checkbox"/>
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Date Surgery Date Surgery

HEALTH MAINTENANCE CHECK RECENT TEST - Give month/year of last exam
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Routine Physical: _____ Dental Exam: _____

Eye Exam: _____

Vaccination Status (please check): _____ Up to date _____ Delayed _____ Not Immunized

If delayed or not immunized explain: _____

PAST MEDICAL HISTORY

Check one for each box....Yes or No

Condition	Y	N	Condition	Y	N	Condition	Y	N
ADHD			Fractures			Scoliosis		
Allergies			Intestinal Disorder			Seizure Disorder		
Asthma			Joint Disorder			Thyroid Disorder		
Acne			Kidney/Urinary Disease			List others below:		
Chicken Pox			Liver Disease					
Ear Infections			Meningitis					
Developmental Problems			Mental Illness					
Diabetes			Mononucleosis					
Eczema			Neurologic Disorder					
Eye Disease			Reflux					



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Please provide any additional details regarding those condition(s) above where you marked "yes":

Please list below any specialists you see/have seen, contact information if possible:

FAMILY HISTORY: Is there an history your family of? check all that apply
NO Significant Family History is Known

	Mother	Father	Brother/ Sister	Grandmother (Maternal)	Grandmother (Paternal)	Grandfather (Maternal)	Grandfather (Paternal)
High Cholesterol							
Heart Attack							
Diabetes							
Prostate Cancer							
Kidney Cancer							
High Blood Pressure							
Kidney stones							
Other significant disease?							



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FINANCIAL AND CONSENT FOR TREATMENT AUTHORIZATION FORM

Please carefully review and initial the following rules and regulations related to our office. Please always try to follow these regulations as they are intended to make the workflow in our office more efficient and practical. If you have any questions about these, please do not hesitate to ask one of our office staff members.

AUTHORIZATION FOR MEDICAL CARE AND TREATMENT: Consent for Treatment I consent freely and voluntarily to participate in the treatment that may be ordered by my health care provider. I understand that I may withdraw consent at any time. This may include but is not limited to Telemedicine services, outpatient treatment, and diagnostic procedures by the Faith Family Wellness as may be deemed necessary or advisable by my provider /or consultants. If I need additional treatments or procedures my consent will be obtained except in emergencies or unusual circumstances.

 I authorize the release of any medical or demographic information to determine medical benefits or to facilitate payment for such services.

 I understand that I am financially responsible to Faith Family Wellness and the clinic for any charges not covered by my healthcare benefits. It is my responsibility to notify the aforementioned provider of health coverage changes or additions in a timely fashion. I understand that if all or part of the balance is denied by insurance, I am responsible for the balance in full.

 I understand that payment for services are due in full at the time of service unless other arrangements have been made in advance. At the time of service, I will pay for my co-pay or co-insurance portion and/or deductible.

 By Appointment Only: Walk-ins are not accepted. In order to have your child seen you must have a scheduled appointment.

PRESCRIPTIONS

 Prescription refills take 72 hours to process and complete. Please allow yourself at least three business days to get the medication filled. Please plan ahead if the prescription is due on a weekend or holiday and give us enough time to prepare the prescription.

 I understand that Faith Family Wellness may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my provider and my pharmacy. I have been informed and understand that my provider using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my provider to see this health information.

LATE POLICY /NO SHOW POLICY

 If you are running late for your appointment, please contact our office. We will determine whether or not your appointment will need to be rescheduled. If you arrive more than 15 minutes late to your scheduled Appointment time, we will make an effort to accommodate you. However, your appointment may be rescheduled.

 We may charge you a \$25.00 "No Show" fee if you fail to cancel or reschedule your appointment at least 48 hours prior to your appointment date.

****** This Pediatric Intake Form has been completed to the best of my ability.******

Signature of Parent/Guardian: _____ Date: ___/___/___



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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION & MEDICAL RECORDS

I hereby authorize the release of my medical records and understand that may include information relating to sexually transmitted disease, AIDS, HIV, behavioral or mental services, and treatment for alcohol and drug abuse. I understand that I have the right to inspect and obtain a copy of the information to be disclosed. The cost of copying and releasing the medical records, if any, has been explained to me. Unless revoked, this authorization will expire in one year. I understand that the revocation will not apply to any information that has been released as a result of this authorization. The authorization to disclose health information is voluntary. I am aware that this information is subject to disclosure by the recipient and may no longer be protected by the Privacy Rule.

Patient Name: _____

_____ Patient Signature or Representative

_____ Date

_____ Relationship to Patient

_____ Date of Birth



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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Notice of Private Practices: You have the right to read our Privacy Practices before you decide whether or not to sign this consent. A copy of our Notice and/or this consent is available upon request. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we make of your protected health information. Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. I have been shown a copy of this office's Notice of Privacy Practices and have had full opportunity to read and consider its contents. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations. If this consent is signed by a personal representative on behalf of the patient, complete the following:

Patient Signature or Representative

Date

Relationship to Patient

DOB

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____ give *Faith Family Wellness* permission to release and/or discuss my medical records or conditions with the following individual(s):

NAME	Relationship to the patient

I understand that the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do it in writing.

Signature of Parent/Guardian: _____ Date: ____/____/____



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Authorization of Other Persons for Patient Treatment and Transport

I, the parent/legal guardian of the below named child:

Date of birth _____

Hereby authorize and consent to the examination and/or treatment of my child/children during office and facility visits by the physicians and clinical staff of Faith Family Wellness. In addition, I give permission for the following person(s) to bring my child to Faith Family Wellness in my absence and to act on my behalf in authorizing medical care and treatment. In the event of emergency or other illness, I understand that the provider and staff of Faith Family Wellness will deliver any medical care deemed necessary regardless of the accompanying adult. Unless we are notified in writing, Faith Family Wellness, will assume that a child's biological and/or legal parents are both legal guardians who have access to treatment options and medical information for that child. I (we) authorize the following people to bring my child/children in for treatment:

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Printed name (parent/guardian): _____

Signature of Parent/Guardian: _____ **Date:** ____/____/____