South Sound PEDIATRICS

Date: _____

3516 12th Ave NE * Olympia, WA 98506 * 360-456-1600

Patients Information:

_____ _____ _____/_____/_____
First Name Middle Name Last Name Preferred Name Date of Birth

_____ _____ _____ _____
Street/PO Box City State Zip Code

Primary Contact Number (_____) _____ ☐ Home ☐ Mobile ☐ Other
Biological Sex: ☐ Male ☐ Female
Gender: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Nonbinary ☐ Other _____
Preferred Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other: _____

Patient's Demographics

Race:
☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific
☐ White
☐ Prefer Not to Answer

Ethnicity:

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Prefer Not to Answer

Preferred Language: _____
Secondary Language: _____

Other Children (seen as patients):

_____ _____/_____/_____ ☐ M ☐ F
First Name MI Last Name Date of Birth

_____ _____/_____/_____ ☐ M ☐ F
First Name MI Last Name Date of Birth

_____ _____/_____/_____ ☐ M ☐ F
First Name MI Last Name Date of Birth

_____ _____/_____/_____ ☐ M ☐ F
First Name MI Last Name Date of Birth

_____ _____/_____/_____ ☐ M ☐ F
First Name MI Last Name Date of Birth

Parent or Guardian Information: **SSN: ☐☐☐- ☐☐- ☐☐☐☐**

(Living in same household as patient)

Relationship to patient: ☐ Mother ☐ Father ☐ Grandparent ☐ Sibling ☐ Foster Parent ☐ Other _____

_____ _____/_____/_____
First Name MI Last Name Date of Birth

_____ _____ _____ _____
Street/PO Box City State Zip Code

Preferred Pronouns: ☐ He/Him ☐ She/her ☐ They/Them ☐ Other: _____

Primary Contact Number: (____) _____ ☐ Home ☐ Mobile ☐ Other

Other Contact Number: (_____) _____ ☐ Home ☐ Mobile ☐ Other

Marital Status: _____ Okay to Leave Detail Voicemail? ☐YES ☐NO

IS THE ABOVE ADDRESS THE CORRECT ONE FOR STATEMENT BILLING? ☐YES ☐NO

Parent or Guardian Information: **SSN: ☐☐☐- ☐☐- ☐☐☐☐**

(Other Contact)

Relationship to patient: ☐ Mother ☐ Father ☐ Grandparent ☐ Sibling ☐ Foster Parent ☐ Other _____

_____ _____/_____/_____
First Name MI Last Name Date of Birth

_____ _____ _____ _____
Street/PO Box City State Zip Code

Preferred Pronouns: ☐ He/Him ☐ She/her ☐ They/Them ☐ Other: _____

Primary Contact Number: (____) _____ ☐ Home ☐ Mobile ☐ Other

Other Contact Number: (_____) _____ ☐ Home ☐ Mobile ☐ Other

Marital Status: _____ Okay to Leave Detail Voicemail? ☐YES ☐NO

IS THE ABOVE ADDRESS THE CORRECT ONE FOR STATEMENT BILLING? ☐YES ☐NO

Emergency Contact Information: *(Relative/friend outside of the household)*

_____
First Name Last Name Contact Number Relationship to Patient

Contact information will remain in place until changed in writing by you

Primary Insurance:

_____ _____/_____/_____

Name of Plan Subscriber ID # Group # Effective Date

_____ _____/_____/____ _____

Subscriber's Name Date of Birth Employer

Relationship to Patient: ☐ Mother ☐ Father ☐ Self ☐ Other_____

Secondary Insurance:

_____ _____/_____/_____

Name of Plan Subscriber ID # Group # Effective Date

_____ _____/_____/____ _____

Subscriber's Name Date of Birth Employer

Relationship to Patient: ☐ Mother ☐ Father ☐ Self ☐ Other_____

Authorization for Treatment of a Minor:

I, _____, the parent/legal guardian of _____, hereby authorize the physicians of South Sound Pediatrics to provide medical care to the above name minor child.

_____

Signature Date Relationship to Patient

Financial Responsibility, Release of Information, and Assignments of Benefits:

I hereby authorize the release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the doctor or group indicated on the claim. I understand I am financially responsible for any balance not covered by my insurance company. A copy of this signature if just as valid as the original.

_____

Signature Date Relationship to Patient

Notice of Policy Regarding Disruptive Behavior:

South Sound Pediatrics is a family and patient centered healthcare clinic. We are committed to providing a safe and welcoming environment for all. Aggressive, threatening, intimidating or disruptive behavior will not be tolerated.

Examples of aggressive, intimidating or disruptive behavior include but are not limited to:
Verbal harassment – yelling, threatening or intimidating words or body language
Demanding, controlling or manipulative statements and requests
Abusive/offensive language or swearing
Physical violence or aggression
Threats of any kind

South Sound Pediatrics will not tolerate ANY form of aggressive or disruptive behavior. These types of behaviors will result in dismissal from the practice.

_____

Signature Date Relationship to Patient

South Sound PEDIATRICS

Date: _____

Notice of Privacy Practices

South Sound Pediatrics has a responsibility to protect the privacy of your health care information and to provide a Notice of Privacy Practices that describes how your health care information may be used and disclosed, how you can access your health care information, and whom to contact if you have questions, concerns or complaints.

We may change the Notice of Privacy Practices at any time, and you may contact our office manager at (360) 456- 1600 ext. 104 to obtain a current copy of the Notice of Privacy Practices or to ask questions.

By my signature below I acknowledge receipt of the Notice of Privacy Practice given to me by a representative of South Sound Pediatrics.

_____

Signature Printed name Relationship to patient Date

Notice of No-Show Policy

South Sound Pediatrics has a responsibility to inform you of our no-show policy and the consequences of no-show appointments. While we realize that there may be a good reason for you to miss an appointment, we also hope you realize a specific time was set aside for your child's visit. Each time you miss an appointment you deprive another patient of the opportunity to see one of our providers.

If you are unable to keep your scheduled appointment, we would appreciate a 24-hour notice of cancellation so we may utilize this time for another patient. Established families are limited to 3 missed appointments within 365 days. New patients who missed an appointment, cancel at the last minute, or arrive late more than once will not be accepted as a new patient.

Please call to reschedule your appointment. Our office opens at 8 a.m. Monday through Saturday. South Sound Pediatrics and/or our answering service are always available to take your calls.

By my signature below I acknowledge receipt of the No-Show Policy given to me by South Sound Pediatrics.

_____

Signature Printed name Relationship to Patient Date

South Sound PEDIATRICS

Parental Advance Consent to Treat Minors

Authorization for South Sound Pediatrics:

I hereby authorize and consent to routine and emergency medical treatment for my child by qualified medical personnel at South Sound Pediatrics. I authorize and consent to emergency medical treatment when deemed necessary or advisable to safeguard my child's immediate health, and I cannot be reached within a reasonable time by reason of absence from the community or otherwise. I waive my right to informed consent to such treatment with the understanding what every attempt to contact me has been made.

_____

Signature Printed name Relationship to Patient Date

Other Authorization:

This is to certify that the person(s) **(not parents)** listed below has my permission to authorize necessary medical care for my child, if I am unable to accompany my child to their doctor's appointment. This authorization will be in effect until it is revoked in writing by me. I accept financial responsibility for necessary treatment and services.

_____

Name Relationship to Patient Phone number

_____

Name Relationship to Patient Phone number

Does the above-named person(s) have permission to speak with South Sound Pediatrics over the phone regarding your child's health care information? ☐YES ☐NO

_____

Signature Printed name Relationship to Patient Date

South Sound PEDIATRICS

Health Questionnaire

Please complete the following questions. Skip any that you can't answer or do not apply to your child.

Past Medical History (check all that apply)

Is your child on any medications? ☐Yes ☐No

If yes, please list medications:

NAME	DOSAGE	NAME	DOSAGE

Any allergies to medications or foods? ☐Yes ☐No

If yes, please list allergies including reaction type:

_____

_____

Does your child have any chronic medical problems (asthma, allergies, autism, anxiety, depression, behavioral concerns, diabetes, seizures etc.)? ☐Yes ☐No

If yes please list:

_____

_____

Has your child ever been hospitalized? ☐Yes ☐No If yes, please explain

_____

_____

Has your child ever had surgery? ☐Yes ☐No If yes, please explain

_____

_____

Any past injuries or broken bones? ☐Yes ☐No If yes, please explain

_____

_____

Health questionnaire cont.

Is your child up to date on immunizations? ☐Yes ☐No
Any previous reactions to immunizations? ☐Yes ☐No

If yes to previous reactions, please explain:
_____
_____

Social history
Is your child in daycare? ☐Yes ☐No

Does anyone in your home smoke? ☐Yes ☐No

Do you have pets at home? ☐Yes ☐No

If so what kind?
_____

Who lives at home with your child?
_____
_____

Family history
Does anyone in the immediate family (parents, siblings, maternal grandparents, paternal grandparents) have any of the following medical issues: (please check if applicable and list family member's relationship)

☐ ADHD _____ ☐ Diabetes _____

☐ Allergies _____ ☐ Hay fever _____

☐ Anemia _____ ☐ High Blood Pressure _____

☐ Anxiety _____ ☐ Kidney Disease _____

☐ Asthma _____ ☐ Learning Disability _____

☐ Autism _____ ☐ Liver Disease _____

☐ Cancer _____ ☐ Seizure _____

☐ Developmental Delay _____ ☐ Substance abuse _____

☐ Depression _____

☐ Heart Disease at early age? (Under age 55) _____

MY KIDS CHART SIGN UP AND AUTHORIZATION FORM

South Sound Pediatrics is pleased to announce our new patient portal: My Kids Chart. This portal will provide you with access to your child's chart wherever and whenever you need it.

With My Kids Chart you will be able to login and:

***Securely message your child's nurse**
***Access your child's immunization record**
***View your child's lab results**
*** Updates on referrals**
***View past and present appointments**
***View your child's current prescriptions**
***Access your child's visit summary**

I _____authorize South Sound Pediatrics to communicate via my email address that I have provided for the sole purpose of access to my patient e-chart.

_____ ____/_____/_____

**Signature Relationship Date

_____ ____/_____/_____ _____

Patient's Name Date of Birth Email

***** If patient is over 13 years of age, patient must sign for authorization AND provide their own email for access.*****

I _____ GIVE CONSENT FOR MY PARENT/GUARDIAN, _____, TO HAVE ACCESS TO MY MEDICAL CHART AND INFORMATION CONTAINED IN THE MY KIDS CHART PATIENT PORTAL. I UNDERSTAND THAT MY CONSENT IS IN EFFECT UNTIL I SO CHOOSE TO REVOKE IT EITHER IN PERSON, VIA TELEPHONE OR IN WRITING.

_____ _____

PT SIGNATURE SOUTH SOUND PEDIATRICS WITNESS

Where a minor has right to consent to medical treatment, he or she also has right to control information related to treatment. A minor patient's signature is required in order to release the following information: (1) conditions relating to the minor's reproductive care including, but not limited to, contraception, pregnancy and pregnancy termination, any age sexually transmitted diseases (age 13 and older) (2) alcohol and/or drug use (age 13 and older) (3) mental health (age 13 and older).

For office use:

Picture ID checked: _____ (initials) Name of parent/guardian verified in chart _____ (initials)

Login in created: _____(date) _____(initials)