For Office Use:

☐ New Patient

☐ Update to Current Patient

Staff Initials:

ADULT PATIENT DEMOGRAPHICS

These forms must be completed exclusively by the patient.

Please Note: Your insurance card and driver's license are required upon check-in at each visit.

Patient Information:

Full Name (First, Middle, Last): ______________________________

Nickname : ____________________ **Gender:** ☐ Male ☐ Female **Date of Birth:** _____/_____/_____ **Age:** _____

Address: ______________________________ **City:** ____________________

State:_________ **Zip Code:**______________ **Email Address:** ______________________________

In case of a medical emergency, who would you like us to contact?

Name:______________________________ **Phone:**______________________________

Patient Portal Information:

Your parent/guardian will no longer have automatic access to your patient portal. Therefore, you will receive an email invite to set up your own account and can then grant proxy access to them, if you so choose. The security code will be your 4-digit year of birth.

(Primary Insurance Policy Holder)

Full Name of Policy Holder (as it appears on insurance card): ______________________________

Address of Policy Holder ______________________________

Policy ID #:______________________________ **Group #:**____________________

Gender: ☐ Male ☐ Female **Relationship to Patient:** ____________________ **Phone #:** ____________________

Date of Birth: _____/_____/_____

Other Information:

Please check your first preference for provider:

☐ Dr. Badaracco ☐ Dr. Conger ☐ Dr. Kelkar ☐ Dr. Sias

☐ Leigh Gistinger, NP ☐ Missy Nicholson, NP ☐ Sarah Caudle, PA

Revised 10/31/16

For Office Use:
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Staff Initials:

ADULT ANNUAL CONSENT & NOTIFICATION

Patient Name ______________________________ **DOB** ____/____/____

Consent for Medical Treatment. I do hereby give permission for Kids First Pediatrics and its physicians, nurse practitioners, physician assistants or their designee(s) to examine and treat my condition, injury or illness as is necessary in their judgement. I voluntarily consent to procedures which include but may not be limited to diagnostic evaluation, medical or surgical treatment, or other forms of necessary treatment. I also acknowledge that the practice of medicine is not an exact science and no guarantees have been made to me as the result of treatments, procedures or examinations by Kids First Pediatrics. I further understand that all options will be discussed prior to the administration of such treatments, procedures, or examinations. **Patient Initials: ______**

Communication Authorization for Protected Health Information (PHI). I authorize Kids First Pediatrics to communicate my Protected Health Information according to the methods checked below.

Primary Ph #: ____________	Secondary Ph #: ____________	Tertiary Ph #: ____________
Contact Name: ____________	Contact Name: ____________	Contact Name: ____________
☐ **Leave message with contact number only**	☐ **Leave message with contact number only**	☐ **Leave message with contact number only**
☐ **Leave message with detailed information**	☐ **Leave message with detailed information**	☐ **Leave message with detailed information**
☐ **Do not leave message**	☐ **Do not leave message**	☐ **Do not leave message**

Notice of Privacy Practices. I acknowledge that Kids First offered me a written copy of their Notice of Privacy Practices. I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions. **Patient Initials: ______**

By signing below I acknowledge that I have read and understand the statements contained in this document.

______________________________ ______________________________
Adult Patient Signature Date

Revised 04/01/19

For Office Use:

☐ New Patient

☐ Update to Current Patient

Staff Initials:

Adult Authorization to Release Private Health Information

[This form is to allow your parent(s), or another emergency contact, to have access to your medical records until a specified date]

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name: ______________________ DOB: ______________________

I authorize the following individual(s) to receive the above named individual's health information:

Name/Relation: ______________________ Phone #: ______________________

Name/Relation: ______________________ Phone #: ______________________

Please initial next to each of the following you choose for release of information:

_______ Complete Medical Record(s)*

_______ Immunizations

_______ Patient Visit Summary

_______ Detailed Progress Notes

_______ X-Ray/ Imaging Report(s)

_______ Laboratory/Pathology Report(s)

**This includes any and all information we have on file, including records from other physicians and/or health organizations.*

☐ Yes, I consent to the release of this information.

☐ No, I do not consent to the release of this information.

I understand the information released is for the specific purpose slated above. Any other use of the information without the written consent of the patient is prohibited. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Kids First Pediatrics. I understand the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date/event/or condition:

______________________ (If I fail to specify an expiration date/event/ or condition, this authorization will expire in 12 months)

I hereby acknowledge that Kids First Pediatrics is not required to agree to the restrictions requested. I understand that if I choose to revoke this consent, it must be in writing. I also acknowledge that if I have any questions about disclosure of my health information, I may contact Kids First Pediatrics at (972) 317-6000.

______________________ Patient Signature

______________________ Date

Revised 10/31/16

Notice Regarding Nurse Practitioners and Physician Assistants

Kids First has Pediatric Nurse Practitioners and Physician Assistants on staff to assist in the delivery of medical care. A pediatric nurse practitioner (PNP) and physician assistant (PA) are not doctors. A PNP has a Bachelor of Science degree in Nursing, two to three years advanced training in pediatrics and a Master's degree in child health. Our PNPs are Missy Nicholson and Leigh Gistinger.

PAs are licensed health care professionals who typically have a four year undergraduate degree before entering into a physician assistant program associated with a medical school. They have a Master's degree as a Physician Assistant after attending two and a half years of both classroom and hands-on clinical training in both outpatient and inpatient settings. Our PA is Sarah Caudle.

PNPs/Pas are qualified to perform a majority of general pediatric duties. They are trained to obtain health histories, perform physical examinations, order and interpret lab and diagnostic studies, diagnose health problems and develop treatment plans. Providing health education and counseling on an array of childhood issues is also an integral part of a PNP/PA role.

Supervision does not require the constant physical presence of a supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.

I have read the above and hereby consent to the services of a pediatric nurse practitioner or physician assistant for my future health care needs. However, I also understand when scheduling an appointment, I can refuse to see the pediatric nurse practitioner or physician assistant and request to see a physician.

________________________________ _______________

Parent/Guardian Date

Medication History

For New Patients, Age 5 and Older

Today's Date:______________________

Patient Name: ____ **DOB:** ______________________________

Please take a few minutes to fill out this form on past medications your child has taken. Thank you for your time.

Please circle what your child has previously tried for allergy nose spray

Flonase Nasacort Nasonex Omnaris Veramyst QNasal Dymista Astelin Patanase
Rhinocort Zetonna None

Please circle what your child has previously tried for asthma controller

Symbicort Flovent Dulera Q-Var Advair Alvesco Asmanex Aerospan Arnuity None

Please circle what your child has previously tried for heart burn or reflux

Nexium Prilosec Prevacid Zantac Aciphex None

Please circle what your child has previously tried for allergies

Zyrtec Claritin Allegra Xyzal Clarinex Singulair None

Please circle what your child has previously tried for ADD/ADHD

Vyvanse Concerta Adderall Adderall XR Focalin Focalin XR Quillivant XR Quillichew ER
Ritalin Ritalin LA Metadate CD Strattera Daytrana Patch Evekeo None

Please list any problems or side effects from the circled medications:

____

____

____

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