



PATIENT INFORMATION

Name: _____ Date of Birth: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Primary Phone: (____) _____ Secondary Phone: (____) _____ Other Phone: (____) _____
 SS#: _____ - _____ - _____ Race: _____ Ethnicity: _____ Preferred language: _____
 Emergency contact: _____ Phone: (____) _____ Relationship: _____
 Preferred pharmacy: _____ Location: _____

INSURANCE INFORMATION

Policy holder: _____ DOB: _____
 Holder's SSN#: _____ - _____ - _____ Relationship to Patient: _____

Financial Responsibility/Assignment of Benefits

As a courtesy to you, our office will file insurance for all reimbursable services to both your primary and secondary insurance carriers. While we do our best to accurately predict your insurance coverage, sometimes our estimates are inaccurate due to circumstances beyond our control. Should your insurance not pay as we expect, or does not pay in a timely manner, you will be responsible for the unpaid portion of your charges.

I assign to C. Kelly Family Clinic, PA, any insurance, or other third party benefits available for health care services provided to me. I understand that C. Kelly Family Clinic, PA has the right to refuse or accept assignment of such benefits.

I have been given the opportunity to read the clinic's patient policies and procedures. The policies are available upon request.

Signature of Patient or Responsible Party: _____ Date: _____

HIPAA INFORMATION

Protected health information (PHI) will only be released from our practice with a properly executed authorization from the patient or his/her personal representative, except for treatment, payment, or health care operations and as otherwise required by law. Examples of some instances in which we are required to disclose your PHI include: Public health activities; information regarding victims of abuse, neglect, or domestic violence; health oversight activities; judicial and administrative proceedings; law enforcement purposes; organ donations purposes; research purposes under certain circumstances; national security and intelligence; and correctional institutions. **C. Kelly Family Clinic, PA** will only use or disclose PHI, except as noted above, consistent with the terms of the authorization.

I understand that I have the right to review the notice of Privacy Practices that provides a more complete description of information uses and disclosures.

Kelly Family Clinic may share my PHI with the following additional person(s): _____

Signature _____

Date _____



MOTHER'S INFORMATION

Name: _____ Date of Birth: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Primary Phone: (____) _____ Secondary Phone: (____) _____ Other Phone: (____) _____
 SS#: _____ - _____ - _____ Email Address: _____

FATHER'S INFORMATION

Name: _____ Date of Birth: _____
 SAME AS ABOVE
 Address: _____ City: _____ State: _____ Zip: _____
 Primary Phone: (____) _____ Secondary Phone: (____) _____ Other Phone: (____) _____
 SS#: _____ - _____ - _____ Email Address: _____

GUARANTOR INFORMATION – PERSON RESPONSIBLE FOR BILLING ACCOUNT

Name: _____ Date of Birth: _____
 SAME AS ABOVE
 Address: _____ City: _____ State: _____ Zip: _____
 Primary Phone: (____) _____ Secondary Phone: (____) _____ Other Phone: (____) _____
 SS#: _____ - _____ - _____ Email Address: _____

SOCIAL HISTORY

Parent's Marital Status: Single Married Widowed Separated Divorced
 Lives with: Both parents Mother Father Grandparents Other: _____
 Siblings (name and age): _____
 Mother's Occupation: _____ Father's Occupation: _____
 Guardian's Occupation: _____
 Day Care: Full time Part time None If none, who cares for your child during the day? _____
 School: _____



Medical History:

Has your child ever been admitted to the hospital? Yes No If so, when/ reason? _____

Surgical history/ Year/ Age: _____

List any known medical conditions: _____

Medication allergies, Adverse reactions, Other allergies

No Known Drug Allergies

Name	Reaction

Current Medications: (include over the counter medications and food supplements)

No Current Medications

Drug Name	Dose	How Often

Family History: Have any of your child's family members (mother, father, siblings, grandparents) had any of the following problems?

Condition	Family Member
Heart Condition	
Diabetes	
High Blood Pressure	
High Cholesterol	
Thyroid Disease	
Migraines	

Condition	Family Member
Asthma	
Seizure Disorder	
Depression	
Other Mental Illness	
ADD/ADHD	
Cancer: _____	

Any other illness in the family not listed? _____

Reason for Visit: _____



Physician Assistant Consent for Treatment

This facility has on staff a physician assistant to assist in the delivery of medical care.

A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by the Texas Medical Board. Under the supervision of a physician, a physician assistant can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care.

"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.

A physician assistant may provide such medical services that are within his/her education, training and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulate a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Assisting at surgery
- Offering counseling and education
- Supplying sample medications and writing prescriptions (where allowed by law)
- Making appropriate referrals

I have read the above, and hereby consent to the services of a physician assistant for my health care needs.

I understand that at any time I can refuse to see the physician assistant and request to see a physician.

Signature

Date



Immunization Intent

Please initial the following statements:

I understand Kelly Family Clinic will be my baby's pediatrician both in the hospital after delivery and for follow-up well child visits in the clinic.

I understand Kelly Family Clinic requires all patients to be fully immunized.

I agree my child will be immunized according to the schedule recommended by the CDC.

I understand if I choose to follow a different schedule or to not immunize my child, Kelly Family Clinic will not be able to treat my child for any healthcare.

Signature

Date