Parent/Guardian:

Your child has been scheduled for a New Patient Appointment in Primary Care Clinic. We are located at 1601 4th Ave South, Children's Park Place Clinics, Ground Floor. Park in the 5th Avenue parking deck (1600 5th Avenue South) and take the elevators to the ground floor. Be sure to bring your parking ticket to clinic to be validated for free parking. Complete the enclosed registration forms and bring to your appointment with you. **Please arrive 30 minutes early for registration**.

- **Medical Information/Immunization Records:** In order to provide the best service possible, please furnish us with medical records from your previous pediatrician. Please have records mailed to Primary Care Clinic, 1600 7th Ave South, CPPII G60, Birmingham, AL 35233. Fax number 205-638-2181. Please find the attached Release of Information to assist you in obtaining medical records. ***You will need to bring your child's immunization records with you to your visit.***

- **Medications**: Please bring a list of your child's current medications (name, dose, when taken) or you may bring the medications with you.

- **Insurance Card and Photo ID**: Please bring your child's insurance card and photo ID of the Parent/Legal Guardian.

- **Parent/Legal Guardian Present**: Parent/Legal Guardian **must** be present at first appointment. If you are the legal guardian, bring any custody/legal paperwork with you.

If you have questions, need to reschedule, or cancel your appointment, please call 205-638-9096.

Thank you for allowing us to assist you with your health care needs.

Primary Care Clinic

Appointment Date: _____

Appointment Time: _____

Appointment with: _____

Primary Care Clinic

Patient's Full Name _____
(Child's name as it appears on Birth Certificate)

Date of Birth _____/_____/_____ Male _____ Female _____ Race_____ SS# _____-_____-_____

Address _____
Street Apt #

_____
City State Zip County

Home Phone _____ Cell Phone _____ Alternate Phone _____

Parent/Guardian Information

Parent/Guardian's Name_____

Relationship to Child _____

SS# _____-_____-_____ DOB _____/_____/_____

Address _____

City_____ State_____Zip_____

Home Phone _____ Work Phone_____

Employer_____

Parent/Guardian's Name_____

Relationship to Child _____

SS# _____-_____-_____ DOB_____/_____/_____

Address _____

City_____State_____Zip_____

Home Phone_____ Work Phone_____

Employer_____

Email Address _____
(To be used for Patient Portal Access)

Insurance Information

Name of Insurance Co _____ Policy # _____

Group #_____ Insurance Appears in Whose Name?_____

Secondary Insurance Co _____ Policy # _____

Group #_____ Insurance Appears in Whose Name?_____

Person Responsible for Bill_____

Emergency Contact

Name_____ Relationship to Patient_____

Phone Number _____ Alternate Phone Number _____

Address to Parking Deck: 1600 5th Avenue South Birmingham Al 35233.

Please visit www.childrensAL.org/MapsDirections to print directions or take an interactive or video tour of Children's.

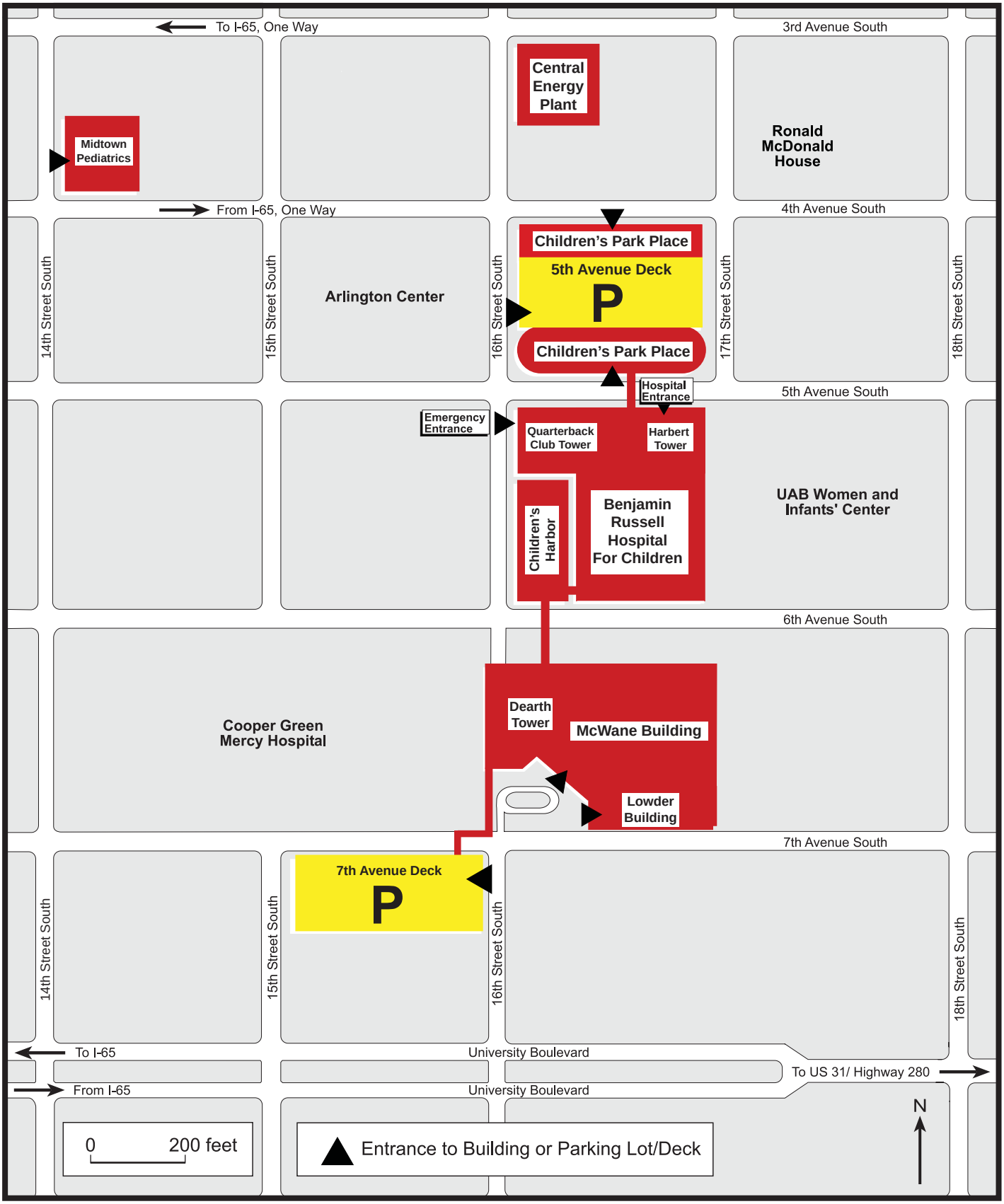
- **From the South on I-65 to Children's of Alabama - 5th Avenue Parking Deck**. Take the University Boulevard/8th Avenue South (Exit 259). Travel approximately one block to 13th Street South. Turn left on 13th Street. Travel four blocks and turn right on 4th Avenue South (one way street). Travel approximately three blocks to 16th Street South and turn right. Children's 5th Avenue Parking Deck is located on the left.

- **From the North on I-65 to Children's of Alabama - 5th Avenue Parking Deck**. Take the 4th Avenue South (Exit 259B). Travel approximately four blocks on 4th Avenue South and turn right on 16th Street South. Children's 5th Avenue Parking Deck is located on the left.

- **From the East/South on Hwy 280/31 North – Elton B. Stephens Expressway/Red Mountain Expressway to Children's of Alabama - 5th Avenue Parking Deck**. Exit onto 8th Avenue South/University Boulevard. At traffic light at end of ramp turn right onto 8th Avenue South/ University Boulevard. Travel seven blocks (approx. ¾ mile) and turn right onto 18th Street South. Travel three blocks and turn left onto 5th Avenue South. Travel approximately two blocks and turn right on 16th Street South. The Children's 5th Avenue Parking Deck entrance is located on the right.

- **From the West Hwy 280/31 South – Elton B. Stephens Expressway/Red Mountain Expressway to Children's of Alabama 5th Avenue Parking Deck**. Take the 3rd/4th Avenue South exit. At end of ramp turn right and take the first left onto 3rd Avenue South (one way street). Travel approximately 10 blocks to 16th Street South. Turn left on 16th Street South. The Children's 5th Avenue Parking Deck entrance is located on the left.

Children's of Alabama



Please Complete Both Sides

Initial History Questionnaire

Name

ID NUMBER

FORM COMPLETED BY

DATE COMPLETED

BIRTH DATE

AGE

☐ M ☐ F

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names, ages, and where they live. _____

What is the child's living situation if not with both biological parents?

☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody

☐ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

Birth History ☐ Don't know birth history

Birth weight _____ Was the baby born at term? _____ OR _____ weeks

Were there any prenatal or neonatal complications?

☐ Yes ☐ No Explain _____

Was a NICU stay required? ☐ Yes ☐ No Explain _____

During pregnancy, did mother

Use tobacco ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No

Use drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins

What _____ When _____

Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, why?

Was initial feeding ☐ Formula ☐ Breast milk How long breastfed? _____

Did your baby go home with mother from the hospital?

☐ Yes ☐ No Explain _____

General DK = don't know

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ DK Explain _____

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ DK Explain _____

Has your child had any surgery? ☐ Yes ☐ No ☐ DK Explain _____

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ DK Explain _____

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ DK Explain _____

Do you feel your family has enough to eat? ☐ Yes ☐ No ☐ DK Explain _____

Biological Family History DK = don't know

Have any family members had the following?

Childhood hearing loss	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Asthma	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tuberculosis	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Heart disease (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
High cholesterol/takes cholesterol medication	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Anemia	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bleeding disorder	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Dental decay	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Cancer (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

(Biological Family History continued on back side.)

American Academy of Pediatrics
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Biological Family History *(Continued from front side.)* DK = don't know

Liver disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Kidney disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Diabetes (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bed-wetting (after 10 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Obesity	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Epilepsy or convulsions	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Alcohol abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Drug abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Mental illness/depression	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Developmental disability	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tobacco use	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

Additional family history _____

Past History DK = don't know

Does your child have, or has your child ever had,

Chickenpox	☐ Yes	☐ No	☐ DK	When _____
Frequent ear infections	☐ Yes	☐ No	☐ DK	Explain _____
Problems with ears or hearing	☐ Yes	☐ No	☐ DK	Explain _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Explain _____
Problems with eyes or vision	☐ Yes	☐ No	☐ DK	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	☐ DK	Explain _____
Any heart problem or heart murmur	☐ Yes	☐ No	☐ DK	Explain _____
Anemia or bleeding problem	☐ Yes	☐ No	☐ DK	Explain _____
Blood transfusion	☐ Yes	☐ No	☐ DK	Explain _____
HIV	☐ Yes	☐ No	☐ DK	Explain _____
Organ transplant	☐ Yes	☐ No	☐ DK	Explain _____
Malignancy/bone marrow transplant	☐ Yes	☐ No	☐ DK	Explain _____
Chemotherapy	☐ Yes	☐ No	☐ DK	Explain _____
Frequent abdominal pain	☐ Yes	☐ No	☐ DK	Explain _____
Constipation requiring doctor visits	☐ Yes	☐ No	☐ DK	Explain _____
Recurrent urinary tract infections and problems	☐ Yes	☐ No	☐ DK	Explain _____
Congenital cataracts/retinoblastoma	☐ Yes	☐ No	☐ DK	Explain _____
Metabolic/Genetic disorders	☐ Yes	☐ No	☐ DK	Explain _____
Cancer	☐ Yes	☐ No	☐ DK	Explain _____
Kidney disease or urologic malformations	☐ Yes	☐ No	☐ DK	Explain _____
Bed-wetting (after 5 years old)	☐ Yes	☐ No	☐ DK	Explain _____
Sleep problems; snoring	☐ Yes	☐ No	☐ DK	Explain _____
Chronic or recurrent skin problems (eg, acne, eczema)	☐ Yes	☐ No	☐ DK	Explain _____
Frequent headaches	☐ Yes	☐ No	☐ DK	Explain _____
Convulsions or other neurologic problems	☐ Yes	☐ No	☐ DK	Explain _____
Obesity	☐ Yes	☐ No	☐ DK	Explain _____
Diabetes	☐ Yes	☐ No	☐ DK	Explain _____
Thyroid or other endocrine problems	☐ Yes	☐ No	☐ DK	Explain _____
High blood pressure	☐ Yes	☐ No	☐ DK	Explain _____
History of serious injuries/fractures/concussions	☐ Yes	☐ No	☐ DK	Explain _____
Use of alcohol or drugs	☐ Yes	☐ No	☐ DK	Explain _____
Tobacco use	☐ Yes	☐ No	☐ DK	Explain _____
ADHD/anxiety/mood problems/depression	☐ Yes	☐ No	☐ DK	Explain _____
Developmental delay	☐ Yes	☐ No	☐ DK	Explain _____
Dental decay	☐ Yes	☐ No	☐ DK	Explain _____
History of family violence	☐ Yes	☐ No	☐ DK	Explain _____
Sexually transmitted infections	☐ Yes	☐ No	☐ DK	Explain _____
Pregnancy	☐ Yes	☐ No	☐ DK	Explain _____
(For girls) Problems with her periods	☐ Yes	☐ No	☐ DK	Explain _____

Has had first period ☐ Yes ☐ No Age of first period _____

Any other significant problem _____

This American Academy of Pediatrics Initial History Questionnaire is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 3rd Edition.

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PLEASE RETURN TO: The Primary Care Clinic, 1600 7th Avenue South, CPPII 110, Birmingham, Alabama 35233
PHONE (205) 638-9096 FAX (205) 638-2181

HIPAA Authorization for Release of Information

Patient Information:

Patient Name (Last, First, MI):_____

Address:_____

Phone Number: (___)_____ **Date of Birth:**_____

This Authorization applies to the following Information:

I understand that the information may contain psychiatric/psychological, alcohol/drug abuse, AIDS/HIV information, and/or other sensitive health information and I expressly consent to the release of the information.

☐ Growth Charts	☐ Laboratory Records	☐ Birth Records
☐ Immunization Records	☐ Progress Notes	☐ Emergency Department Visit
☐ Clinic Notes	☐ Discharge Summary	☐ Teacher/Counselor Correspondence
☐ X-rays/X-ray Reports	☐ Other:_____	☐ **ALL** Records

Treatment Dates: from (month/day/year) ____/____/____ **to** (month/day/year)____/____/_____

The Information may be released as follows (Please provide address and phone number):

From (Person/Organization providing the information):_____

_____

To (Person/Organization receiving the information): UAB Primary Care Clinic -
1600 7th Ave S, CPP II, Suite G60, Birmingham, Al 35233 - Fax 205-638-2181

Purpose of the release:

☐ Continuity of Treatment ☐ Other *(Please specify):*_____

I understand the Information released will be limited to information necessary to fulfill the need or purpose for the disclosure. If I have authorized the disclosure of Information to a recipient who is not subject to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), then the recipient may re-disclose it and it may no longer be protected under HIPAA, a federal privacy law. This Authorization is valid for ninety (90) days from the date of signature, unless otherwise noted. This Authorization only applies to treatment occurring before the date of signature. I may decline to sign this Authorization. I understand I may revoke this authorization in writing at any time by completing a form available from the Primary Care Clinic. If I revoke this authorization, the revocation will not apply to information that has already been released in response to this authorization. I understand the patient's health care and the payment for the patient's health care will not be affected if I do not sign this form. I understand I may see and copy the Information described on this form if I ask for it, and I may receive a copy of this form after I sign it. Before requesting medical record copies, please ask about the copy fee by law that may apply. I represent that I have the authority to and voluntarily grant permission for the Information to be released as described above.

Patient/Parent/Legal Guardian Printed Name	Parent/Legal Guardian Signature Date
Patient Signature if 14 or older Date	Witness Signature for Patient/Parent/ Legal Guardian Date

DT0141

UAB MEDICINE
PEDIATRICS

Children's of Alabama

Consent for Medical Treatment of a Minor Child

When you are away from your child, the person entrusted with your child's care may be faced with an illness or injury to your child that cannot be treated promptly until your consent has been obtained. If you would like to give permission to your child's caretaker, or someone other than yourself to seek medical care in your absence, please complete the following form:

I_____ give permission to _____

_____

_____

To seek medical attention for _____ D.O.B. _____

To seek medical attention for _____ D.O.B. _____

To seek medical attention for _____ D.O.B. _____

To seek medical attention for _____ D.O.B. _____

To seek medical attention for _____ D.O.B. _____

At UAB Pediatrics Primary Care Clinic located in Children's Hospital. This permission will be valid for:

1) The duration of enrollment at UAB Pediatrics Primary Care Clinic

2) From _____ to _____

Signature of Parent or Guardian _____ Date _____

Signature of Witness _____ Date _____

Signature of Witness _____ Date _____