Lakeside Health Clinic, P.C.

Patient Information Sheet (MINOR) **Welcome to our Practice**

PATIENT INFORMATION (PLEASE PRINT)

First Name _____ **MI** _____ **Last Name** _____

Preferred Name _____

Social Security # _____ - _____ - _____ **Sex** M F Date of Birth _____/_____/_____

Gender Identity (please circle one): Male Female Transgender (FTM/MTF) Non-Binary Choose not to disclose

Sexual Orientation (please circle one): Heterosexual Homosexual Bisexual Choose not to disclose

Race (please circle one): Asian Black/African American Native American/Alaskan Caucasian Hispanic Native Hawaiin/Pacific Islander Unknown/Declined

Home Phone (_____) _____ - _____ Would you like to receive texts from us

Mobile Phone (_____)_____ - _____→ reminding you of your appointments? YES NO

Preferred Contact Method (please circle one): **CALL TEXT EMAIL POSTAL**

☐ **Consent to leave automated text/voice messages on the phone numbers listed above**

Street Address _____

City _____ **State** _____ **Zip** _____

Mailing Address (if different) _____

City _____ **State** _____ **Zip** _____

Email Address _____

Would you like to receive e-mails from Lakeside Health Clinic reminding you of your appointments? YES NO

Would you like access to our Patient Portal? YES NO *REQUIRES EMAIL ADDRESS

Name of Pharmacy _____ **Location of Pharmacy** _____

Mother's Maiden Name _____

RESPONSIBLE PARTY INFORMATION (PLEASE PRINT)

Relation to Patient: MOTHER FATHER OTHER(specify): _____

First Name _____ **MI** _____ **Last Name** _____

Date of Birth _____/_____/_____ **Sex: M F Social Security #:** _____ - _____ - _____

Phone #: (_____) _____ - _____

Physical Address _____

City _____ **State** _____ **Zip** _____

Employer _____ **Employer Phone #:** (_____) _____ - _____

EMERGENCY CONTACT (PLEASE PRINT)

Full Name _____ **Relation** _____

Physical Address _____

City _____**State** _____ **Zip** _____

Home Phone (_____) _____ - _____ Mobile Phone (_____)_____ - _____

Do we have consent to contact the above listed person with medical information and appointment information if we are not able to get in contact with you? YES NO

Has your child had any of the following?	Please describe and give details, dates, and/or age onset
Serious Illness (specify)	
Head Injuries	
Seizures or Convulsions	
Surgery/Hospitalizations	
Diabetes (please specify type 1 or type 2)	
History of ear infections	
Allergies and/or asthma	
Vision problems	
Hearing problems	
Trouble sleeping/sleeping too much (circle one)	
Frequent nightmares and/or bed wetting	
Heart complications	
Speech or language problems (stuttering, articulation, etc)	
Emotional problems (depression, anxiety, mood swings, etc)	
Poor attention span	
Other Health Problem: (specify)	
Other Health Problem: (specify)	

SOCIAL HISTORY
(Minor Birth-17)

Do you Smoke? NEVER CURRENT 2ND HAND PRIOR USE
PACKS PER DAY: _____ QUIT DATE: _____

Exposed to cigarette smoke in the home? YES NO

Who does the child live with? BOTH PARENTS MOTHER FATHER OTHER (SPECIFY)

Caffeine Use NEVER OCCASIONAL DAILY

Are biological parents of the child: MARRIED SEPERATED DIVORCED NEVER MARRIED

If separated or divorced, who has legal custody? MOTHER FATHER SHARED OTHER (SPECIFY)

FAMILY HISTORY

TO HELP US UNDERSTAND ANY SPECIAL CIRCUMSTANCES FOR YOUR FAMILY, WE NEED TO KNOW IF ANY OF YOUR FAMILY HAS HAD ANY OF THE FOLLOWING. PLEASE CHECT THE APPROPRIATE BOXES. IDENTIFY ALL ILLNESSES OR CONDITIONS IN WHICH YOU KNOW HAVE OCCURED IN YOUR BLOOD RELATIVES.

USE "✓" TO INDICATE POSTIVE HISTORY

	FATHER	MOTHER	SISTER	BROTHER	GRANDMOTHER	GRANDFATHER	SON	DAUGHTER
HIGH BLOOD PRESSURE								
HEART PROBLEMS								
STROKE								
OBESITY								
DIABETES								
ALCOHOLISM								
DRUG ABUSE								
DEPRESSION								
HEPATITIS								
CANCER PLEASE SPECIFY THE TYPE IN THE BOX OF THE AFFECTED PERSON								
SEIZURES								
ASTHMA								
ANEMIA								
HIGH CHOLESTEROL								
BLEEDING DISORDER								
OSETOPOROSIS								
ARTHRITIS								

MEDICATION NAME	DOSAGE **(MG, McG, mL, etc)**	FREQUENCY (How many pills do you take a day & how many times a day)

Medication Allergies	Type of Reaction

Food Allergies	Type of Reaction

Enviromental Allergies	Type of Reaction

Lakeside Health Clinic, P.C.

Patient Authorization Form

Advance Directives

Patient Authorization:

1. I consent to treatment necessary for the care of the below named patient.
2. I authorize the release of all medical records to the referring and family physicians and to my insurance company if applicable.
3. I will allow fax transmittal of my medical records, if necessary.
4. I understand that payment of charges incurred is due at the time of service unless definite financial arrangements have been made prior to the treatment.
5. In the events the charges incurred are not paid in full when due and collection is instituted whether by collection agency, attorney, or both, I agree to be responsible for and to pay in addition to the charges for services and treatment received to all costs associated with such collection activity including, but not limited to, reasonable agency fees, attorney's fees, and court costs.
6. I further authorize and request that insurance payments be made directly to the provider.
7. I have read and fully understand the above consent for treatment and financial responsibility, and release of information.
8. I consent to have my prescription history retrieved from my pharmacy, my health insurer, and my other healthcare providers.
9. I acknowledge full financial responsibility for services rendered by Lakeside Health Clinic, P.C.
10. I consent to appointment reminders in the form of text, emails, or phone calls.
11. I consent to leave automated text and voice messages on the phone numbers listed in my files.
12. I agree with all the above with the exception of number(s) _____

_____ _____

Patient's Name Date

_____ _____

Parent/Guardian Signature Date

_____ _____

Lakeside Employee Signature Date

Advance Directive:

Do you have a living will or durable power of attorney? YES NO

If you have a durable power of attorney, please identify:

First Name _____ MI _____ Last Name _____

Relationship _____ Social Security # _____ - _____ - _____

Address _____

Phone #: (_____) _____ - _____ Email Address _____

SIGNATURE REQUIRED EVEN IF YOU MARK "NO"

_____ _____

Patient's Name Date

_____ _____

Parent/Guardian Signature Date

_____ _____

Lakeside Employee Signature Date

Lakeside Health Clinic's Financial Policy

Lakeside Health Clinic would like to thank you for entrusting us in yours and your family's healthcare needs.

INSURED PATIENTS: Copays, deductibles, and co-insurance are *YOUR* responsibility. Your appointment may be rescheduled if not paid. If you are Out of Network with your insurance, you may responsible for your higher deductibles, copays, and co-insurance. We will not have a total cost of you visit until a claim has been made and your insurance has paid. If you owe anything after the insurance payment, you will receive a bill.

SELF PAY OR UNINSURED PATIENTS: A **$50.00 deposit** is required ***before*** you are seen by a provider in our clinic. The $50.00 is strictly for the office visit. If you receive any shots or have your blood drawn - you will be charged extra. Your appointment may be rescheduled if not paid. If we are Out of Network with your insurance, you may be considered self-pay.

If you do not provide us with the correct insurance information or if your insurance information has changed without our knowledge, you will be charged for your visit.

YOU are responsible for providing us with your new insurance information.

I, _____, have been advised by Lakeside Health Clinic that it is considered "Fraudulent" to not provide ALL of my insurance information at the time of service. I am fully aware that I can be penalized by law through termination of my insurance coverage, fines, and/or imprisonment if the information I provide is false.

I understand that I will be responsible for any charges that were filed, denied, or recouped under false pretense due to my negligence to provide all insurance benefits.

By signing this form, I acknowledge the following:

- **I have provided ALL of my insurance coverage information to Lakeside Health Clinic, P.C.**
- **I am fully aware that I can be penalized by law should I fail to provide all insurance coverage information to Lakeside Health Clinic.**
- **I WILL BE RESPONSIBLE FOR ANY CHARGES THAT WERE FILED, DENIED, OR RECOUPED UNDER FALSE PRETENSE.**
- **I understand Lakeside Health Clinic, P.C. CAN and WILL report any individual who may be guilty or insurance fraud to the Office of Inspector General (OIG).**

If you have any financial questions please contact (731) 924-2000. We will be glad to assist you!

_____ _____

Patient's Name Date

_____ _____

Parent/Guardian Signature Date

_____ _____

Lakeside Employee Signature Date

Lakeside Health Clinic, P.C

Peter Gardner, MD
Lisa Hubbard, PA-C
813 E Wood St
Paris, TN 38242
(731) 924-2000 P
(731) 653-0053 F

Medical Record Release Form

This form allows us to receive medical records from your most recent **Primary Care Provider** or **Specialists**.

_____ _____

Patient's Name **Date of Birth**

I hereby authorize the below listed facility to release my medical information to Lakeside Health Clinic, P.C.:

Facility: _____ Telephone #: _____

Facility Address: _____ Fax #: _____

_____

Please release information specified below:

_____ Entire Medical Records

_____ Specified records from _____ to _____

_____ Immunizations and Physical Examinations

_____ Imaging Reports

_____ Laboratory Reports

_____ EKG, EEG, EMG

_____ PMH/Family History

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Lakeside Employee Signature Date

This release authorizes the disclosure of records for one year from the date signed above. I understand that these records are protected under federal and/or state law and cannot be disclosed without written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, if applicable, include: diagnosis, prognosis, and treatment from physical and/or mental health illnesses, including treatment of alcohol or substance abuse, auto-immune deficiency syndrome (AIDS), AIDS released complex (ARC), or human immunodeficiency virus (HIV) infection for any admissions. I understand that I have the right to revoke this consent at any time unless the facility, which is to make the disclosure information, has already done so in compliance to the consent.

Lakeside Health Clinic, P.C

Peter Gardner, MD
Lisa Hubbard, PA-C

813 E Wood St
Paris, TN 38242

(731) 924-2000 P
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CONSENT FOR TREATMENT OF MINOR CHILD

_____ _____

Patient's Name Date of Birth

_____

Legal Parent/Guardian

I give permission to the person(s) listed below to bring my child to Lakeside Health Clinic, P.C. to seek medical treatment. I also give permission of Lakeside Health Clinic, P.C. to share any relevant health information with the person who is accompanying my child. I understand that it may be necessary to perform diagnostic tests such as x-rays and blood draws during the office visit. I agree to accept any charges incurred during this visit.

Person 1

Name _____ Relation to Child _____

Street _____ Home Phone Number _____

City/State/Zip _____ Work Phone Number _____

Person 2

Name _____ Relation to Child _____

Street _____ Home Phone Number _____

City/State/Zip _____ Work Phone Number _____

_____ _____

Parent/Guardian Signature Date

_____ _____

Lakeside Employee Signature Date