Legacy
Community Health Services

PEDIATRIC CLIENT INTAKE FORM

Date: _____ **Chart #:** _____ **Age:** _____

Legacy Community Health Services is a Community Health Center and all information requested is for statistical purposes. All information is strictly confidential to the full extent permitted by law. No identifying information will be released without your consent. The information requested allows Legacy to evaluate each client for eligibility for our programs; therefore, we request you complete this document in its entirety.

Patient's Information

NAME		PREFERRED NAME (IF APPLICABLE)	
ADDRESS	**CITY/STATE**	**ZIP CODE**	**COUNTY**
MAIN PHONE NUMBER	**OTHER PHONE NUMBER**	**DATE OF BIRTH**	**GENDER**
			☐ Male ☐ Female
SOCIAL SECURITY #	**BIRTH STATE**	**PREFERRED LANGUAGE**	
		☐ English ☐ Spanish ☐ Other _____	

ARE YOU HOMELESS?	ETHNICITY	RACE		
☐ Yes ☐ No	☐ Non-Hispanic	☐ White	☐ Black/African American	☐ Pacific Islander
	☐ Hispanic	☐ Asian	☐ Hawaiian	☐ American Indian/Alaska Native
		☐ Multiracial	☐ Unknown	☐ I do not wish to report

Parent/Guardian Information (please indicate one)

NAME: PARENT LEGAL GUARDIAN		ADDRESS (IF DIFFERENT FROM CHILD)	
MAIN PHONE NUMBER	**OTHER PHONE NUMBER**	**EMAIL ADDRESS**	
			☐ N/A
PREFERRED METHOD OF CONTACT			
Telephone: ☐ Yes ☐ No [Okay to leave a message: ☐ Yes ☐ No]		Mail: ☐ Yes ☐ No	☐ No Contact
DATE OF BIRTH	**GENDER**	**RELATION TO THE PATIENT**	**SOCIAL SECURITY #**
	☐ Male ☐ Female		
FAMILY SIZE (# OF PERSONS LIVING IN YOUR HOME)		**TOTAL FAMILY HOUSEHOLD INCOME**	

Primary Caregiver (Person responsible for providing day-to-day care for the patient.)

☐ Same as parent/guardian	NAME	RELATIONSHIP	PHONE NUMBER

Health Care Proxy (Person appointed to make health care decisions in place of parent/legal guardian.)

☐ Same as parent/guardian	NAME	RELATIONSHIP	PHONE NUMBER

Patient Name: _____

Please provide an emergency contact that does not live with your child.

NAME	RELATIONSHIP	PHONE NUMBER	ADDRESS
Does this person know that this child is a patient of Legacy Community Health Services? ☐ Yes ☐ No			

Medical Information

NAME OF PRIMARY CARE PROVIDER	ADDRESS	PHONE NUMBER
NAME OF PREFERRED PHARMACY	**ADDRESS**	**PHONE NUMBER**

Complete the insurance questions below.

DO YOU OR ANYONE IN YOUR HOUSEHOLD HAVE MEDICAID, MEDICARE, CHIP, V.A., OR OTHER INSURANCE COVERAGE?

☐ Yes ☐ No If yes, who? _____

WHAT TYPE OF HEALTH INSURANCE DO YOU HAVE?

☐ None / Self Pay ☐ Military ☐ Medicare Plan ☐ Medicaid Plan ☐ Private Insurance

Plan #: _____ Group #: _____

Private Insurance Company: _____

PCP Provider if HMO Policy: _____

INSURED/POLICY HOLDER'S INFORMATION	INSURED EMPLOYER'S INFORMATION
Name: _____	Name: _____
Date of Birth: ____/____/____	Address: _____
Social Security #: ____-____-____	Phone: (____) ____ - ____

Marketing

HOW DID YOU LEARN ABOUT OUR SERVICES?

☐ Friend/Relative ☐ In Print ☐ On Radio/TV ☐ Internet ☐ Referral ☐ Community Event ☐ Other

By signing this form, I attest that all the statements I have made, including my answers to all questions are true and correct to the best of my knowledge and belief. I agree to give the eligibility staff any information necessary to prove statements about my eligibility. I understand that giving false information could result in disqualification and repayment. Should my income or number of people in my family change, I will tell the eligibility staff.

_____ _____

Signature of Client or Parent / Guardian or Power of Attorney Date

_____ _____

Signature of Person Who Helped Complete this Form Date

Legacy
Community Health Services

Date: ____/____/_____

Name:

PATIENT DATA

Initial History Questionnaire

Household:
Please list those living in the child's home:

Name	Relationship to child	D.O.B.	Health Problems

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

If the mother and father are not living together or the child does not live with parents, what is the child's custody status?

If one or both parents are not living in the house, how often does he/she see the parent/parents not it the home?

Birth History:

Birth weight: _____ ☐ Vaginal Delivery ☐ Cesarean Delivery

If Cesarean, why?

Was the baby born at term? ☐ Early ☐ Late If early, how many week's gestation? _____

Did your baby have any problems right after birth? ☐ Yes ☐ No
Explain:

During pregnancy, did mother: Smoke: □ Yes □ No Drink alcohol: □ Yes □ No
Use drugs or medications: □ Yes □ No If yes, What: _____ When: _____

Was initial feeding : □ Breast □ Bottle

Did your baby go home with mother from the hospital? □Yes □ No Explain_____

General	Yes	No	Comments
Does your child have any serious illness or medical condition?			
Has your child had any serious accidents?			
Has your child had any surgery?			
Has your child ever been hospitalized?			
Is your child allergic to any medication or drugs?			

Development	Yes	No	Comments
Does your child have physical developmental problems?			
Does your child have mental or emotional development problems?			
Does your child have problems with their attention span?			
If your child is in school:			
Does your child have behavioral problems in school?			
Has he/she failed or repeated a grade in school?			
Does your child have academic problems in school?			
Is he/she in special or resource classes?			

Does your child have any issue – See Below

Eyes:	Yes	No	Comments
Any problems with eyes?			
Do eyes looked crossed?			
Does the child wear glasses?			

Ears:	Yes	No	Comments
Any hearing problems?			
Three or more ear infections?			

Nose:	Yes	No	Comments
Does the child have frequent bouts of sneezing, rubbing his/her nose?			
Has the child had frequent nose bleeds?			
Does your child have trouble breathing at night due to snoring?			

Throat:	Yes	No	Comments
Does your child have three or more strep throat infections per year?			

Heart:	Yes	No	Comments
A heart murmur?			
High blood pressure?			
Heart defect?			

Lungs:	Yes	No	Comments
Bronchitis or pneumonia?			
Asthma/wheezing?			
Chronic cough?			

Abdomen:	**Yes**	**No**	**Comments**
Constipation?			
Blood in bowel/stool?			
Frequent abdominal pain?			
Frequent vomiting or diarrhea?			
Difficulty with eating/chewing/swallowing? If yes, please explain in “Comments” >>			

Kidney:	**Yes**	**No**	**Comments**
Has your child ever had a urinary tract infection?			
Is your child toilet trained?			
Does your child ever wet the bed?			

Skin:	**Yes**	**No**	**Comments**
Any sensitivity or allergy?			
Eczema or atopic dermatitis?			
Diagnosis of a skin condition?			

Extremities: Has your child:	**Yes**	**No**	**Comments**
Had weakness or paralysis of arms or legs?			
A persistent limp?			
Ever worn corrective shoes or braces?			

Neurological: Has your child ever had:	**Yes**	**No**	**Comments**
Frequent headaches?			
Convulsions or seizures?			
Dizziness?			
Fainting?			

Does your child receive any kind of therapy:	Yes	No	Comments
Occupational			
Speech			
Physical			
Behavioral			

Concerns:	Yes	No	Comments
Are there concerns about physical, sexual, or emotional abuse?			

Has your child ever been admitted to the hospital for any reason?
Please explain: _____

_____

Has your child seen any specialists? Please explain below:

Specialist ***Hospital***

_____

_____

Has your child ever had any Imaging studies?

Xray_____ Ultrasound _____

MRI_____ CT scan_____

Other _____

Any other concerns you would like to discuss? _____

Family Hx: _____

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PEDIATRIC
CONSENT & ACKNOWLEDGEMENT FOR SERVICES

Name: _____

CONSENT FOR TESTING AND TREATMENT

I voluntarily authorize and consent to such medical care, treatment, and diagnostic tests that Legacy Community Health Services believe are necessary for this patient. I understand that by signing this form, I am giving permission to the doctors, nurses, physician assistants, and other health care providers in this medical office to provide treatment to this child as long as this child is a patient in this office, or until I withdraw my consent.

I acknowledge that Legacy Community Health Services is required by state law to report information on patients who are diagnosed with tuberculosis (TB) or other diseases such as HIV or syphilis. This is to ensure that the patient and those around the patient have been properly treated for these illnesses. This report is submitted to the City of Houston, Department of Health & Human Services. The parent/guardian may be contacted by employees from the Department of Health and Human Services for further questions relating to the treatment of TB or other diseases that could be spread to others if needed. If you have any questions about this, please ask to speak a member of our medical staff before signing this form and being tested.

_____(Initials)

ACKNOWLEDGMENT OF RECEIPT

By initialing, I acknowledge that Legacy Community Health Services has provided me with its: Notice of Privacy Practices, which explains how my health information will be handled in various situations; Client Rights and Responsibilities, which I agree to abide by; Grievance Policy and, for filing complaints and E-Prescribing Information Sheet.

_____(Initials)

FINANCIAL RESPONSIBILITY

By initialing below, I understand that if I qualify for services through a grant funded program such as Ryan White or the Department of State Health Services Family Planning (Title X) and Texas Vaccine for Children these resources are payers of last resort. Meaning that, if I currently or in the future have Medicare, Medicaid and/or third party insurance, I may not be eligible for services under these grants. Therefore, I agree to immediately report any changes in my financial status and/or insurance coverage to the Eligibility Specialist. If such changes have not been appropriately reported and if those changes in my status result in my ineligibility for services under a grant funded program at Legacy Community Health Services, I understand that I am fully responsible for the cost of services delivered by Legacy Community Health Services.

_____(Initials)

MEDICAID / MEDICARE / THIRD PARTY INSURANCE

By initialing below, I understand that if this child becomes eligible for Medicaid, Medicare and or third party insurance while a client of Legacy Community Health Services, I authorize Legacy Community Health Services to furnish Medicaid and/or Medicare and/or third party insurance all of the necessary medical information with my child's diagnoses including but not limited to his/her HIV status to process his/her claim.

_____ (Initials)

I hereby assign to Legacy Community Health Services all payments from Medicaid, Medicare and/or any other third party insurance for medical services provided. I understand that I am responsible for the cost of services delivered, not covered by my child's insurance. I also understand that I may be responsible for the co-pay which will be paid prior to my child being seen by a health care practitioner.

_____ (Initials)

DELEGATION OF CONSENT

I hereby authorize (when I am unavailable to give consent) the following individual(s), _____

whose relationship to this child is _____, to consent to any and all medical care and attention for this child which is deemed necessary and appropriate by a health care provider licensed in the state of Texas. This consent includes, but is not limited to, medical and surgical intervention, and elective as well as emergency care. This delegation shall be valid until I withdraw delegation of consent.

_____ (Initials)

TERMS OF CONSENT

By signing below, I agree to the terms and information above. I am giving this consent of my own free will. I fully release Legacy Community Health Services and the Harris County Public Health & Environmental Services, and Ryan White Grant Administration, as well as their Officers, Directors, Board Members, employees, and agents (i.e.: volunteers, students) harmless from any and all damages, losses, liabilities (joint or several), payments, obligations, penalties, claims, litigation, demands, defenses, judgments, suits, proceedings, costs, disbursements or expenses (including without limitation, fees, disbursements and expenses of attorney, and other professional advisors and of expert witnesses and costs of investigation and preparation) of any kind or nature whatsoever resulting from, relating to or arising out of my receipt of services.

I have had the opportunity to ask any questions and have had them answered in a language that I understand. I further agree to abide by the terms of this consent. I understand that this document remains in effect until I revoke my consent in writing. I also understand that I am free to revoke my consent at any time.

_____ _____
Client Name Printed Initials

_____ _____
Signature of Client or Parent / Guardian or Power of Attorney Date

_____ _____
Witness Signature Date

Legacy
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CONSENT & ACKNOWLEDGEMENT FOR OBTAINING E-PRESCRIBING HISTORY

Patient Name: _____ **Date of Birth:** _____

ACKNOWLEDGMENT OF RECEIPT OF E-PRESCRIBING INFORMATION SHEET

By initialing, I acknowledge that Legacy Community Health Services has provided me with its E-Prescribing Information Sheet, which explains the purpose and details on how my prescriptions and prescription refill history will be handled electronically. _____(Initials)

TERMS OF CONSENT

I understand that providing Legacy Community Health Services with a history of my current and past prescriptions will assist the agency in confirming the safety of my prescriptions and decreasing dangerous interactions with any other medications I may be taking.

☐ I hereby grant Legacy Community Health Services permission to obtain this medication history electronically from other health care organizations, including, but not limited to pharmacies.

☐ I **decline** the option of providing Legacy Community Health Services with a history of my current and past prescriptions.

By signing below, I agree that I am completing this consent of my own free will to consent as initialed above. I fully release Legacy Community Health Services, their employees, Board Members, and agents (i.e.: volunteers, students) harmless from any and all damages, losses, liabilities (joint or several), payments, claims, litigation, suits, proceedings, of any kind or nature whatsoever resulting from out of my receipt of this service.

I understand that this consent shall remain active until I withdraw my consent in writing at any time.

_____ _____
Client Name Printed Initials

_____ _____
Signature of Client or Parent / Guardian or Power of Attorney Date

_____ _____
Witness Signature Date