**Initial Demographics**

|  |
| --- |
| **Patient Information** -*Thank you for choosing our office. In order to serve you properly and accurately bill your insurance company, we need the following information. Please print. All information is kept confidential.* |
| Child’s Name­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\**if child has ever used another last name, please provide* | Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Physical Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| City, State, Zip code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Mailing Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Guardian/Legal Caregivers\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \*Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Relationship to Child\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Preferred Pharmacy\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| May we leave messages on identifiable answering system regarding appointment/lab results?⁭Y ⁭ N **Initials\_\_\_\_\_\_\_** |
| Whom can we contact in case of emergency AND leave protected health information? |
| Name & Relation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| I have received a copy of the Privacy Rules from Cornerstone Pediatrics and authorize the above named people to receive my child’s Protected Health Information. I may revoke this at any time by giving written notification to Cornerstone Pediatrics. |
| **Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **\*Race**  | **\*Ethnicity** |
| * American Indian or Alaska Native
* Native Hawaiian or Other Pacific Islander
 | * Asian
* White
 | * Black or African American
* Other Race
 | * Hispanic or Latino
* Not Hispanic or Latino
 |
| Primary Insurance Information– Insurance card required at time of appointment. |
| Name of Insurance company (network)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Policy # or AHCCCS #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Name of Insured (not child)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Relationship to Child\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Insured’s Social Security #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Insured’s Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Secondary Insurance Information- Insurance card required at time of appointment. |
| Name of Insurance company (network)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Policy # or AHCCCS #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Name of Insured (not child)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Relationship to Child\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Insured’s Social Security #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Insured’s Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Responsibility Statement -Your insurance is a method for you to receive reimbursement for fees you have paid to the physician for services rendered. Having insurance is not a substitute for payment. It is your responsibility to pay co-pays, deductibles, co-insurance, and any other balances not paid by your insurance. We will assist you in receiving reimbursement, but you are still responsible for your bill. I agree to be financially responsible for all charges. I have read this information and understand it. I authorize the release of all medical information necessary to process this claim and that is pertinent to my child’s medical care and related benefits. I authorize payment of all insurance benefits to Cornerstone Pediatrics, P. C. This assignment will remain in effect until revoked by me in writing. A photocopy or facsimile of this assignment is considered to be as valid as the original. I also understand that by signing below, I authorize use of the above named patient’s personal health information to be used for providing necessary treatment, payment, and other healthcare operations. Any other use of this information will require a separate release authorizing such use.Your signature is necessary for us to process insurance claims and to ensure payment for services rendered. |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Parent / Legal Guardian Date** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_Witness Initial** |

**0-4 Years Health History Form**

\**Government Requirement*

|  |  |  |
| --- | --- | --- |
| Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Male Female | DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Previous Last Name (if different than above)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Mother’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Father’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | DOB\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_ | Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Please list all the people in your household other than the patient: |
| *Name* | *Date of Birth* | *Relationship to Patient* |
| *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| **Birth History** |  |
| Place of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Birth Weight\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| During pregnancy did mother use alcohol or street drugs? | No Yes *Explain*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Were there any problems during pregnancy or delivery? | No Yes *Explain*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| How many weeks pregnant were you when your baby was born? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| How many days was the baby in the hospital? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Past Medical History***Please list any conditions in and explain.* |
| Has child had any surgical procedures? No Yes *Explain*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Has child been hospitalized *overnight* for any condition? No Yes *Explain*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Does child have any allergies? No Yes *Explain*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Has child been diagnosed with any chronicmedical problems, serious acute illnesses or injuries or ever been hospitalized? No Yes *If yes, with whom and where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Has child been diagnosed with any *behavioral* problems? No Yes *\_\_\_\_\_\_\_\_*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Does child currently take any medications daily? *(Prescription OR over the counter)* | No Yes *\_\_\_\_\_\_\_\_*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Does child have any problems with Vision Hearing Speech ­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Family History***Please mark any conditions in childs’ family AND explain. (Parents, grandparents, aunts, uncles, cousins, and siblings)*  |
|  Allergies Asthma Lung disease Tuberculosis | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  Birth defect Cancer | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  Diabetes Kidney disease Thyroid disease | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  Alcohol use Alcohol abuse Illegal drug use | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  Heart attack Heart disease | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  High blood pressure High cholesterol | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  Mental Illness Depression | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  Obesity Overweight | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  Seizures Epilepsy | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*Page 1* |
| **Family History *continued****Please mark any conditions in childs’ extended family AND explain. (grandparents, aunts, uncles, cousins, sibling)* |
| Have any of the child’s siblings died? |  Yes No | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Any family member under the age of 50 who died suddenly of causes other than *accident OR violence?* | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Social History** |
| Relationship of Parents  |  Married Divorced Separated |
|  |  Not married but living together Not married, not living together |
| Do you attend a church and have a religious preference? |  Yes No | If yes, what?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Will child go to daycare or a babysitter regularly? |  Yes No | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Does anyone smoke in the home? |  Yes No |  Inside Outside  |
| **Safety** |
| Does your child use a car seat in cars?  |  Yes No |  |
| Is your home child proofed? |  Yes No |  |
| Is there a gun/firearm/weapons in the house |  Yes No |  |
| Is there verbal /physical fighting occuring in the house? |  Yes No |  |
|  |  |
|  |  |
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|  |  |
|  |  |

*Page 2*

7875 East Florentine Road, Suite A

Prescott Valley, AZ 86314

Phone: (928) 443-5599

Fax: (928) 443-5376

# Authorization for Medical Records Release

|  |  |  |
| --- | --- | --- |
| Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| I, the undersigned parent or legal guardian, request, for ongoing health care, and authorize the release of a copy all medical records in your possession, regarding the above-named patient, to the office of Cornerstone Pediatrics.  Unless otherwise stated the medical records should include all confidential HIV related information (as defined in A. R. S 36-663), confidential communicable disease related information (as defined in 42cfr2.1, et seq.), confidential behavior or mental health diagnosis/treatment information. I understand that a photocopy of this authorization is considered acceptable in lieu of the original.  This authorization will expire in 12 months from date of signature, and I reserve the right to revoke it in the interim by written request. |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name of Previous Clinic or Child’s Healthcare Provider |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address, City, State, Zip |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone # |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax # |
| ***We must have either the telephone number or fax number to expedite the transfer of records!*** |
| I understand Cornerstone Pediatrics is covered by the federal privacy regulations (HIPAA) and is bound by law to only use the information received for ongoing medical care.   I do not authorize the further release to any third party and release Cornerstone Pediatrics and its physicians and employees from any and all liability arising directly from such re-disclosure.  I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or eligibility for benefits.  I understand that I may inspect or obtain a copy of any information used or disclosed under this authorization for a fee.  I understand that all confidential records (as noted in paragraph above) will be transferred unless I specifically state below which ones to withhold.    |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Parent/Legal Guardian Signature |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Today’s Date |
|  |
| **OFFICE USE ONLY****To Previous Clinic or Healthcare Provider** – Please fax the requested records to (928) 443-5376, If unable to fax, please mail the requested information to the above address. Thank you. |
| ⁭ All Records ⁭ Vaccine Record ⁭ Growth Chart ⁭ None Needed ⁭ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Requested By: \_\_\_\_\_\_\_\_\_\_ |

7875 East Florentine Road, Suite A

Prescott Valley, AZ 86314

Phone: (928) 443-5599

Fax: (928) 443-5376

**Permission to Treat**

   ***\*Please only list one person per form\****

|  |
| --- |
| I, the undersigned parent, hereby give permission for the following adult (*name and relationship to child*) **\***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_who is over 18 years of age to bring my child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (*child’s name*) whose date of birth is \_\_\_\_\_\_\_\_\_\_\_\_.  By my signature, I authorize the **ADULT** named above to sign for any medical treatment, office procedures, injections of vaccines or medications, and physical assessments of health or illness effective from (*today’s date*) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.   |
| ***This Permission to Treat expires one year from date signed*** |
|  This Permission to Treat can only be revoked with my signature.   I, the parent/guardian, understand that I must grant this permission annually.  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_( ) Mother ( ) Father ( ) Legal Guardian  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date |
| Witness Signature |  |  |

7875 East Florentine Road, Suite A

Prescott Valley, AZ 86314

Phone: (928) 443-5599

Fax: (928) 443-5376

**Patient Eligibility Screening /Release of Vaccination Information**

*Vaccines for Children Program AZ State Immunization Information System*

Today’s Date \_\_\_\_\_\_\_\_\_\_\_

Child’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Last Name, First Name Middle Initial)*

Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **This child qualifies for vaccination through the VFC Program*** Is American Indian or Alaskan Native
* Is enrolled in Kids Care
* Is enrolled in AHCCCS
* Does not have health insurance
 | *or* | **This child DOES NOT qualify for vaccination through the VFC Program*** **Has** health insurance that DOES pay for vaccines
* **Has** health insurance that DOES NOT pay for vaccines – ***child must go to the county health department***
 |

Please be advised, if your insurance company does not cover immunizations and you do not let us know at the time of the visit, it is your responsibility to pay the cost involved. We cannot make Vaccines for Children Program retroactive and you are only eligible for VFC at the time of the visit.

 If you are unsure if immunizations and well check-ups are covered, please contact your insurance company.

**My signature below indicates that the above statements apply and are true until revoked by me in writing.**

|  |  |  |
| --- | --- | --- |
| **Parent (legal guardian) Date** |  | **Witness Initials** |