Southern Pediatric Clinic, LLC
Charlene C. Blache, M.D.
Pediatrics and Adolescent Medicine

406-M Northside Drive
Valdosta, GA 31602
Ph. 229 • 241 • 0059
Fax 229 • 241 • 2088

PATIENT

Last Name	First Name	MI	Date of Birth

PARENT/GUARDIAN

Last Name	First Name	MI

Patient Eligibility Screening Record

Vaccines for Children Program

Provider: Southern Pediatric Clinic

A record must be kept in the healthcare provider's office that reflects the status of all children 18 years of age or younger, who receive immunizations with vaccines supplied by state programs. The record my be completed by the parent, guardian or individual of record, or by the healthcare provider. The same record may be used for all subsequent visits s long as the child's eligibility status has not changed. **While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine(s).**

NOTE: IF you do not have health insurance or if your insurance carrier does not cover vaccines, you can receive a vaccine provided by the Vaccines for Children Program. A fee of $21.93 per shot will be charged at the time of service. Only children 18 years and younger are eligible for this program.

Check only ONE (1) box. My child…		
(A) is enrolled in Medicaid (Peach**State**, WellCare, AmeriGroup, CareSource or SSI Medicaid).	◯	OR
(B) is American Indian or Alaskan Native.	◯	OR
(C) does not have health insurance.	◯	OR
(D) has health insurance that does not pay for vaccines.	◯	OR
(E) is enrolled in PeachCare (Peach**Care** will be listed as Managed Care Provider).	◯	OR
(F) has health insurance that pays for vaccines.	◯	

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Parent/Guardian Name (print) Signature Date

PATIENT NAME: _____ DATE: _____

Please print.

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE
15 THROUGH 17 YEAR VISITS FOR PARENTS

To provide you and your teen with the best possible health care, we would like to know how things are going. Please answer all the questions. Thank you.

WHAT WOULD YOU LIKE TO TALK ABOUT TODAY?

Do you have any concerns, questions, or problems that you would like to discuss today? ○ **No** ○ **Yes,** describe:

TELL US ABOUT YOUR TEEN.

What excites or delights you most about your teen?

Does your teen have special health care needs? ○ **No** ○ **Yes,** describe:

Have there been major changes lately in your teen's or family's life? ○ **No** ○ **Yes,** describe:

Have any of your teen's relatives developed new medical problems since your last visit? ○ **No** ○ **Yes** ○ **Unsure** If yes or unsure, please describe:

Does your teen live with anyone who smokes or spend time in places where people smoke or use e-cigarettes? ○ **No** ○ **Yes** ○ **Unsure**

YOUR GROWING AND DEVELOPING TEEN

Check off all the items that you feel are true for your teen.

- ☐ My teen does things that help her have a healthy lifestyle, such as eating healthy foods, being physically active, and keeping herself safe.
- ☐ My teen has at least one adult in his life who cares about him and knows he can go to if he needs help.
- ☐ My teen has at least one friend or a group of friends who she feels comfortable around.
- ☐ My teen helps others by himself or by working with a group in school, a faith-based organization, or the community.
- ☐ My teen is able to bounce back when things don't go her way.
- ☐ My teen feels hopeful and self-confident.
- ☐ My teen is becoming more independent and making more decisions on his own as he gets older.

PATIENT NAME: _____ DATE: _____

Please print.

15 THROUGH 17 YEAR VISITS FOR PARENTS

RISK ASSESSMENT

Anemia	Does your teen's diet include iron-rich foods, such as meat, iron-fortified cereals, or beans?	O Yes	O No	O Unsure
	Has your teen ever been diagnosed with iron deficiency anemia?	O No	O Yes	O Unsure
	Does your family ever struggle to put food on the table?	O No	O Yes	O Unsure
	If your teen is female, does she have excessive menstrual bleeding or other blood loss?	O No	O Yes	O Unsure
	If your teen is female, does her period last more than 5 days?	O No	O Yes	O Unsure
Dyslipidemia	Does your teen have parents, grandparents, or aunts or uncles who have had a stroke or heart problem before age 55 (males) or 65 (females)?	O No	O Yes	O Unsure
	Does your teen have a parent with an elevated blood cholesterol level (240 mg/dL or higher) or who is taking cholesterol medication?	O No	O Yes	O Unsure
Hearing	Do you have concerns about how your teen hears?	O No	O Yes	O Unsure
Oral health	Does your teen's primary water source contain fluoride?	O Yes	O No	O Unsure
Sexually transmitted infections/ HIV	Teens who are sexually active are at risk of acquiring sexually transmitted infections, including HIV. Teens who use injection drugs are at risk of acquiring HIV. Are you concerned that your teen might be at risk?	O No	O Yes	O Unsure
Tuberculosis	Is your teen infected with HIV?	O No	O Yes	O Unsure
	Was your teen or any household member born in, or has he or she traveled to, a country where tuberculosis is common (this includes countries in Africa, Asia, Latin America, and Eastern Europe)?	O No	O Yes	O Unsure
	Has your teen had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test result?	O No	O Yes	O Unsure
Vision	Do you have concerns about how your teen sees?	O No	O Yes	O Unsure
	Does your teen have trouble with near or far vision?	O No	O Yes	O Unsure
	Has your teen ever failed a school vision screening test?	O No	O Yes	O Unsure
	Does your teen tend to squint?	O No	O Yes	O Unsure

ANTICIPATORY GUIDANCE

How are things going for you, your teen, and your family?

YOUR FAMILY'S HEALTH AND WELL-BEING

Interpersonal Violence (Fighting and Bullying)				
Are there frequent reports of violence in your community or school?		O No	O Sometimes	O Yes
Is your teen involved in that violence?		O No	O Sometimes	O Yes
Has your teen ever been threatened with physical harm or been injured in a fight?		O No	O Sometimes	O Yes
Has your teen bullied others?		O No	O Sometimes	O Yes
Has your teen been suspended from school because of fighting, bullying, or carrying a weapon?		O No	O Sometimes	O Yes
Do you know your teen's friends and the activities they participate in or attend?		O Yes	O Sometimes	O No
If your teen is in a relationship, is it respectful?	O NA	O Yes	O Sometimes	O No
Would your teen tell you if someone pressured or forced her to have sex?		O Yes	O Sometimes	O No
Living Situation and Food Security				
Do you have concerns about your living situation?		O No	O Sometimes	O Yes
In the past 12 months, did you worry that your food would run out before you got money to buy more?		O No	O Sometimes	O Yes
In the past 12 months, did the food you bought not last, and you did not have money to buy more?		O No	O Sometimes	O Yes
Alcohol and Drugs				
Is there anyone in your teen's life whose alcohol or drug use concerns you?		O No	O Sometimes	O Yes

PATIENT NAME: _____ DATE: _____

Please print.

15 THROUGH 17 YEAR VISITS FOR PARENTS

YOUR FAMILY'S HEALTH AND WELL-BEING (*CONTINUED*)

Connectedness With Family and Peers			
Does your family get along well with each other?	O Yes	O Sometimes	O No
Does your family do things together?	O Yes	O Sometimes	O No
Does your teen have chores or responsibilities at home?	O Yes	O Sometimes	O No
Do you set clear rules and expectations for your teen?	O Yes	O Sometimes	O No
Connectedness With Community			
Does your teen have interests outside of school?	O Yes	O Sometimes	O No
Are there things your teen does that you are proud of?	O Yes	O Sometimes	O No
School Performance			
Does your teen get to school on time?	O Yes	O Sometimes	O No
Does your teen attend school almost every day?	O Yes	O Sometimes	O No
Do you recognize your teen's successes and support his efforts?	O Yes	O Sometimes	O No
Does your teen have plans for after high school?	O Yes	O Sometimes	O No
Coping With Stress and Decision-making			
Have you talked with your teen about ways to deal with stress?	O Yes	O Sometimes	O No
Do you help your teen make decisions and solve problems?	O Yes	O Sometimes	O No

YOUR GROWING AND CHANGING TEEN

Healthy Teeth			
Does your teen see the dentist regularly?	O Yes	O Sometimes	O No
Do you have trouble getting dental care?	O No	O Sometimes	O Yes
Body Image			
Do you have any concerns about your teen's weight, eating habits, or physical activity?	O No	O Sometimes	O Yes
Does your teen talk about getting fat or dieting to lose weight?	O No	O Sometimes	O Yes
Healthy Eating			
Do you think your teen eats healthy foods?	O Yes	O Sometimes	O No
Do you have any difficulty getting healthy food for your family?	O No	O Sometimes	O Yes
Do you eat meals together as a family?	O Yes	O Sometimes	O No
Physical Activity and Sleep			
Is your teen physically active at least 1 hour a day? This includes running, playing sports, or doing physically active things with friends.	O Yes	O Sometimes	O No
Are there opportunities to safely exercise outside in your neighborhood?	O Yes	O Sometimes	O No
Do you and your teen participate in physical activities together?	O Yes	O Sometimes	O No
How much time does your teen spend on recreational screen time each day?	_____ hours		
Does your teen have a TV, computer, tablet, or smartphone in his bedroom?	O No	O Sometimes	O Yes
Has your family made a media use plan to help everyone balance time spent on media with other family and personal activities?	O Yes	O Sometimes	O No
Does your teen have a regular bedtime?	O Yes	O Sometimes	O No
Do you think your teen gets enough sleep?	O Yes	O Sometimes	O No

YOUR TEEN'S EMOTIONAL WELL-BEING

Mood and Mental Health			
Have you noticed any changes in your teen's weight, sleep habits, or behaviors?	O No	O Sometimes	O Yes
Is your teen frequently irritable?	O No	O Sometimes	O Yes
Do you have concerns about your teen's emotional health, such as being frequently sad or depressed?	O No	O Sometimes	O Yes
Do you think your teen worries too much or appears overly anxious?	O No	O Sometimes	O Yes

PATIENT NAME: _____ DATE: _____

Please print.

15 THROUGH 17 YEAR VISITS FOR PARENTS

YOUR TEEN'S EMOTIONAL WELL-BEING (*CONTINUED*)

Sexuality			
Have you talked with your teen about relationships, dating, and sex?	O Yes	O Sometimes	O No
Have you talked with your teen about his sexuality?	O Yes	O Sometimes	O No
Do you have house rules about curfews, parties, dating, and friends?	O Yes	O Sometimes	O No
Do you know where your teen's friends are and what they're doing?	O Yes	O Sometimes	O No

HEALTHY BEHAVIOR CHOICES

Sexual Activity			
Are you worried about sexual pressures on your teen?	O No	O Sometimes	O Yes
Substance Use			
Have you talked with your teen about alcohol and drug use?	O Yes	O Sometimes	O No
To your knowledge, is your teen currently using alcohol or drugs, or has she used them in the past?	O No	O Sometimes	O Yes
Have you discussed consequences if you discover your teen is using tobacco, alcohol, or drugs?	O Yes	O Sometimes	O No
Acoustic Trauma			
Does your teen often listen to loud music?	O No	O Sometimes	O Yes

SAFETY

Seat Belt and Helmet Use			
Does your teen always wear a lap and shoulder seat belt and bicycle helmet?	O Yes	O Sometimes	O No
Do you have rules or restrictions around driving?	O Yes	O Sometimes	O No
Sun Protection			
Does your teen use sunscreen?	O Yes	O Sometimes	O No
Gun Safety			
Is there a gun in your home or the homes where your teen spends time?	O No	O Sometimes	O Yes
If yes, is the gun unloaded and locked up?	O Yes	O Sometimes	O No
If yes, is the ammunition stored and locked up separately from the gun?	O Yes	O Sometimes	O No
Have you talked with your teen about gun safety?	O Yes	O Sometimes	O No

Consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 4th Edition

For more information, go to https://brightfutures.aap.org.

PATIENT NAME: _____ DATE: _____

Please print.

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE
15 THROUGH 17 YEAR VISITS FOR PATIENTS

To give you the best possible health care, we would like to know how things are going. Our discussions with you are private. We hope you will feel free to talk openly with us about yourself and your health. Information is not shared with other people without your permission unless we are concerned that someone is in danger. **Depression screening and Tobacco, Alcohol, or Drug Use assessment are also part of this visit.** Thank you for your time.

WHAT WOULD YOU LIKE TO TALK ABOUT TODAY?

Do you have any concerns, questions, or problems that you would like to discuss today? ○ **No** ○ **Yes,** describe:

TELL US ABOUT YOURSELF.

What are you most proud of about yourself?

Do you have any special health care needs? ○ **No** ○ **Yes,** describe:

Have there been major changes lately in your family's life? ○ **No** ○ **Yes,** describe:

Have any of your relatives developed new medical problems since your last visit? ○ **No** ○ **Yes** ○ **Unsure** If yes or unsure, please describe:

Do you live with anyone who smokes or spend time in places where people smoke or use e-cigarettes? ○ **No** ○ **Yes** ○ **Unsure**

GROWING AND DEVELOPING

Check off all the items that you feel are true for you.

- ☐ I do things that help me have a healthy lifestyle, such as eating healthy foods, being physically active, and keeping myself safe.
- ☐ I have at least one adult in my life who I know I can go to if I need help.
- ☐ I have a friend or a group of friends that I feel comfortable to be around.
- ☐ I help others.
- ☐ I am able to bounce back when life doesn't go my way.
- ☐ I feel hopeful and confident.
- ☐ I am becoming more independent and I make more of my own decisions.

PATIENT NAME: _____ DATE: _____

Please print.

15 THROUGH 17 YEAR VISITS FOR PATIENTS

RISK ASSESSMENT

Anemia	Does your diet include iron-rich foods, such as meat, iron-fortified cereals, or beans?	O Yes	O No	O Unsure
	Do you eat a vegetarian diet (do not eat red meat, chicken, fish, or seafood)?	O No	O Yes	O Unsure
	If you are a vegetarian (do not eat red meat, chicken, fish, or seafood), do you take an iron supplement?	O Yes	O No	O Unsure
	Have you ever been diagnosed as having iron deficiency anemia?	O No	O Yes	O Unsure
	Does your family ever struggle to put food on the table?	O No	O Yes	O Unsure
	For females: Do you have excessive menstrual bleeding or other blood loss?	O No	O Yes	O Unsure
	For females: Does your period last more than 5 days?	O No	O Yes	O Unsure
Dyslipidemia	Do you have parents, grandparents, or aunts or uncles who have had a stroke or heart problem before age 55 (males) or 65 (females)?	O No	O Yes	O Unsure
	Do you have a parent with an elevated blood cholesterol level (240 mg/dL or higher) or who is taking cholesterol medication?	O No	O Yes	O Unsure
	Do you smoke cigarettes or use e-cigarettes?	O No	O Yes	O Unsure
Oral health	Does your primary water source contain fluoride?	O Yes	O No	O Unsure
Sexually transmitted infections/ HIV	Have you ever had sex, including intercourse or oral sex? **IF NO, SKIP TO THE NEXT SECTION (HIV).**	O No	O Yes	O Unsure
	Are you having unprotected sex?	O No	O Yes	O Unsure
	Are you having sex with multiple partners or anonymous partners?	O No	O Yes	O Unsure
	Are you or any of your past or current sexual partners bisexual?	O No	O Yes	O Unsure
	Have you ever been treated for a sexually transmitted infection?	O No	O Yes	O Unsure
	Have any of your past or current sex partners been infected with HIV or used injection drugs?	O No	O Yes	O Unsure
	Do you trade sex for money or drugs or have sex partners who do?	O No	O Yes	O Unsure
	For males: Have you ever had sex with other males?	O No	O Yes	O Unsure
HIV	Do you now use or have you ever used injection drugs?	O No	O Yes	O Unsure
Tuberculosis	Are you infected with HIV?	O No	O Yes	O Unsure
	Were you or was any household member born in, or has he or she traveled to, a country where tuberculosis is common (this includes countries in Africa, Asia, Latin America, and Eastern Europe)?	O No	O Yes	O Unsure
	Have you had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test result?	O No	O Yes	O Unsure
Vision	Do you have concerns about your vision?	O No	O Yes	O Unsure
	Have you ever failed a school vision screening test?	O No	O Yes	O Unsure
	Do you have trouble with near or far vision?	O No	O Yes	O Unsure
	Do you tend to squint?	O No	O Yes	O Unsure

ANTICIPATORY GUIDANCE

How are things going for you and your family?

HOW YOU ARE DOING

Interpersonal Violence (Fighting and Bullying)			
Do you feel safe at home?	O Yes	O Sometimes	O No
Do you feel safe at school and getting to and from school?	O Yes	O Sometimes	O No
Have you been bullied in person, on the Internet, or through social media?	O No	O Sometimes	O Yes
Do you have ways that help you deal with feeling angry?	O Yes	O Sometimes	O No
Have you been in a fight in the past 12 months?	O No	O Sometimes	O Yes

PATIENT NAME: _____ DATE: _____

Please print.

15 THROUGH 17 YEAR VISITS FOR PATIENTS

HOW YOU ARE DOING (*CONTINUED*)

Interpersonal Violence (Fighting and Bullying) (*continued*)			
Have you ever carried a weapon to school?	O No	O Sometimes	O Yes
Do you belong to a gang or know anyone in a gang?	O No	O Sometimes	O Yes
Have you ever been touched in a sexual way that made you feel uncomfortable?	O No	O Sometimes	O Yes
Have you ever been forced or pressured to do something sexual you didn't want to do?	O No	O Sometimes	O Yes
Have you ever been in a relationship with someone who threatened or hurt you?	O No	O Sometimes	O Yes
Food Security and Living Situation			
In the past 12 months, have you had trouble having enough food to eat or have concerns that you might not have enough?	O No	O Sometimes	O Yes
Alcohol and Drugs			
Is there anyone in your life whose tobacco, alcohol, or drug use concerns you?	O No	O Sometimes	O Yes
Connectedness With Family and Peers			
Do you get along with your family?	O Yes	O Sometimes	O No
Does your family do things together?	O Yes	O Sometimes	O No
Do you follow your family rules and limits?	O Yes	O Sometimes	O No
Do you get along with your friends and others at school?	O Yes	O Sometimes	O No
Connectedness With Community			
Do you have interests outside of school?	O Yes	O Sometimes	O No
Do you do things you are good at or that you are proud of?	O Yes	O Sometimes	O No
School Performance			
Have you missed more than 2 days of school in any month?	O No	O Sometimes	O Yes
Are you doing well in school?	O Yes	O Sometimes	O No
Are you having any problems in school?	O No	O Sometimes	O Yes
Do you have plans for what you will do after high school?	O Yes	O Sometimes	O No
Coping With Stress and Decision-making			
Do you have ways to deal with stress?	O Yes	O Sometimes	O No
Do you worry or feel stressed out much of the time?	O No	O Sometimes	O Yes

YOUR DAILY LIFE

Healthy Teeth			
Do you brush your teeth twice a day?	O Yes	O Sometimes	O No
Do you floss once a day?	O Yes	O Sometimes	O No
Do you see the dentist twice a year?	O Yes	O Sometimes	O No
Do you chew gum or tobacco?	O No	O Sometimes	O Yes
If you play contact sports, do you wear a mouth guard?	O Yes	O Sometimes	O No
Body Image			
Do you have any concerns about your weight?	O No	O Sometimes	O Yes
Are you currently doing anything to try to gain or lose weight?	O No	O Sometimes	O Yes
Have you ever been teased because of your weight?	O No	O Sometimes	O Yes
Healthy Eating			
Do you have access to healthy food options?	O Yes	O Sometimes	O No
Do you eat fruits and vegetables every day?	O Yes	O Sometimes	O No
Do you have milk, yogurt, cheese, or other foods that contain calcium every day?	O Yes	O Sometimes	O No
Do you drink juice, soda, sports drinks, or energy drinks?	O No	O Sometimes	O Yes

PATIENT NAME: _____ DATE: _____

Please print.

15 THROUGH 17 YEAR VISITS FOR PATIENTS

YOUR DAILY LIFE (*CONTINUED*)

Healthy Eating (*continued*)			
Do you ever skip meals?	○ No	○ Sometimes	○ Yes
Do you eat meals together with your family?	○ Yes	○ Sometimes	○ No
Physical Activity and Sleep			
Are you physically active at least 1 hour every day? This includes running, playing sports, or doing physically active things with friends.	○ Yes	○ Sometimes	○ No
How much time every day do you spend watching TV, playing video games, or using computers, tablets, or smartphones (not counting schoolwork)?	_____ hours		
Do you get 8 or more hours of sleep each night?	○ Yes	○ Sometimes	○ No
Do you have trouble sleeping at night or waking up in the morning?	○ No	○ Sometimes	○ Yes

YOUR EMOTIONAL WELL-BEING

Mood and Mental Health			
Do you harm yourself, such as by cutting, hitting, or pinching yourself?	○ No	○ Sometimes	○ Yes
Sexuality			
Have you talked with your parents about dating and sex?	○ Yes	○ Sometimes	○ No
Do you have any questions about your gender identity?	○ No	○ Sometimes	○ Yes

HEALTHY BEHAVIOR CHOICES

Romantic Relationships and Sexual Activity				
If you have been in romantic relationships, have you always felt safe and respected?	○ NA	○ Yes	○ Sometimes	○ No
Have you ever had sex, including oral, vaginal, or anal sex? *If no, skip to the next section.*		○ No	○ Sometimes	○ Yes
Are you currently having sex, including oral sex, with anyone?		○ No	○ Sometimes	○ Yes
Have you had multiple partners in the past year?		○ No	○ Sometimes	○ Yes
Do you and your partner use condoms every time?		○ Yes	○ Sometimes	○ No
Do you and your partner always use another form of birth control along with a condom?		○ Yes	○ Sometimes	○ No
Are you aware of emergency contraception?		○ Yes	○ Sometimes	○ No
Tobacco, E-cigarettes, Alcohol, and Prescription or Street Drugs				
Have you ever smoked cigarettes or used e-cigarettes?		○ No	○ Sometimes	○ Yes
Have you ever drunk alcohol?		○ No	○ Sometimes	○ Yes
Have you ever used drugs, including marijuana or street drugs?		○ No	○ Sometimes	○ Yes
Have you ever taken prescription drugs that were not given to you for a medical condition?		○ No	○ Sometimes	○ Yes
Acoustic Trauma				
Do you use earplugs or sound-canceling headphones to protect your hearing around loud noises or at concerts?		○ Yes	○ Sometimes	○ No
Do you often listen to loud music?		○ No	○ Sometimes	○ Yes

STAYING SAFE

Seat Belt and Helmet Use				
Do you always wear a lap and shoulder seat belt?		○ Yes	○ Sometimes	○ No
Do you always wear a helmet to protect your head when you are biking, skateboarding, or skating?		○ Yes	○ Sometimes	○ No
Do you always wear a life jacket when you do water sports?		○ Yes	○ Sometimes	○ No
If you have started driving, do you follow the safety rules for young drivers?		○ Yes	○ Sometimes	○ No
Do you have someone you can call for a ride if you feel unsafe driving yourself or riding with someone else?	○ NA	○ Yes	○ Sometimes	○ No

PATIENT NAME: _____ DATE: _____

Please print.

15 THROUGH 17 YEAR VISITS FOR PATIENTS

STAYING SAFE (*CONTINUED*)

Sun Protection				
Do you use sunscreen?		O Yes	O Sometimes	O No
Do you visit tanning parlors?		O No	O Sometimes	O Yes
Gun Safety				
Have you ever carried a gun or knife (even for self-protection)?		O No	O Sometimes	O Yes
If there is a gun in your home, do you know how to get hold of it?	O NA	O No	O Sometimes	O Yes

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For more information, go to https://brightfutures.aap.org.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®

Southern Pediatric Clinic, LLC
Charlene C. Blache, M.D.
Kereese Gayle-Farias, M.D.
Pediatrics and Adolescent Medicine

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Date

Child's Name Date of Birth

PHQ-2

Over the last two weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	◯	◯	◯	◯
2. Feeling down, depressed, or hopeless.	◯	◯	◯	◯

STOP HERE if you ANSWERED "not at all" to the above 2 questions!

PHQ-9

Over the last two weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
3. Trouble falling or staying asleep, or sleeping too much.	◯	◯	◯	◯
4. Feeling tired or having little energy	◯	◯	◯	◯
5. Poor appetite or overeating.	◯	◯	◯	◯
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down.	◯	◯	◯	◯
7. Trouble concentrating on things, such as reading the newspaper or watching television.	◯	◯	◯	◯
8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	◯	◯	◯	◯
9. Thoughts that you would be better off dead or of hurting yourself in some way	◯	◯	◯	◯

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all	Somewhat difficult	Very difficult	Extrememly difficult

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Patient Name: _____ **Today's Date:** _____

Please answer the following questions by checking a box to the right of the question.

BULLYING	**YES**	**NO**
Do you ever feel afraid to go to school?		
Have you ever been bullied at school, in your neighborhood, or online?		
Have you seen other kids being bullied?		
Do you know who you can go to for help?		

SUICIDE RISK SCREENING	**YES**	**NO**
In the past few weeks, have you wished you were dead?		
In the past few weeks, have you felt that you or your family would be better off if you were dead?		
In the past week, have you been having thoughts about killing yourself?		
Have you ever tried to kill yourself? If yes, how?_____ When? _____		
Are you having thoughts of killing yourself right now? If yes, please describe: _____		

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Patient Demographics Form

Child's Name _____ Birthdate _____ Sex M / F
Address _____ Zip Code _____ Social Security
Race ☐ Black or African American
☐ White (Caucasian) ☐ Asian ☐ Other: _____

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other: _____
Preferred language ☐ English ☐ Spanish ☐ Other: _____

MOTHER/LEGAL GUARDIAN'S NAME: _____ Birthdate _____
Social Security # _____ Marital Status : _____ Email: _____
Address _____ Mobile Phone _____
Employer _____ Occupation _____ Work Phone _____

FATHER/LEGAL GUARDIAN'S NAME: _____ Birthdate _____
Social Security # _____ Marital Status: _____ Email: _____
Address _____ Mobile Phone _____
Employer _____ Occupation _____ Work Phone _____

EMERGENCY CONTACT OTHER THAN PARENT

Name: _____ Relationship _____ Mobile Phone Number: _____
Physical Address: _____

MEDICAL INSURANCE INFORMATION: PROVIDE A COPY OF EACH INSURANCE CARD		
Primary Insurance	Policy Number	Policy Holder's Name / Date of Birth / Sex (M/F)
Secondary Insurance	Policy Number	Policy Holder's Name / Date of Birth / Sex (M/F)

WE STRONGLY BELIEVE IN VACCINATING OUR PATIENTS ACCORDING TO THE RECOMMENDED AMERICAN ACADEMY OF PEDIATRICS AND CENTER FOR DISEASE GUIDELINES.
BY SIGNING BELOW, YOU ARE AGREEING TO ALLOW US TO VACCINATE YOUR CHILD.

Parent/Guardian Printed Name Signature Date

Southern Pediatric Clinic, LLC
Charlene C. Blache, M.D.
Pediatrics and Adolescent Medicine

406-M Northside Drive
Valdosta, GA 31602
Ph. 229 • 241 • 0059
Fax 229 • 241 • 2088

Consent & Disclosure of PHI & Treatment of Patient & Statement of Persons Allowed to Accompany Patient to Office Visits

Patient Consent for Use and Disclosure of Protected Health Information (PHI) and for Treatment

Patient's Name: _____ Date of Birth: _____

MOTHER'S NAME WHO IS LEGAL GUARDIAN _____ Birthdate _____

FATHER'S NAME WHO IS LEGAL GUARDIAN _____ Birthdate _____

Southern Pediatric Clinic, LLC and employees., may use and disclose PHI about the said patient above to carry out treatment, payment and healthcare operations (TPO). Please review the Notice of Privacy Practices for full information regarding this statement.

1. I have reviewed the Notice of Privacy Practices for Southern Pediatric Clinic and I acknowledge that Southern Pediatric Clinic has the right to revise its Notice of Privacy Practices at any time and that I will have access to revisions.
2. I have read and understand the Notices of Privacy Practices that are in place and that I may contact the Privacy Officer listed for further questions.
3. Southern Pediatric Clinic, and all those associated, may call my home or other designated location and leave a message on voice mail or in person in reference that assist the practice in carrying out TPO, such as appointment reminders and patient statements.
4. Southern Pediatric Clinic may treat my child and order diagnostic tests and labs for diagnosis and treatment.
5. Southern Pediatric Clinic may disclose Individually Identifiable Health Information (IIHI) that will be used to carry out TPO as referred to above, to anyone specified below who brings my child(ren) to the office for treatment.
6. Southern Pediatric Clinic will not act as mediator in separation, divorced, and/or custody battles. We must abide by the laws set forth in court-ordered documents for your child. Please make sure we have a copy on file.

DUE TO HIPAA REQUIREMENTS, PATIENTS CAN ONLY BE ACCOMPANIED TO OFFICE VISITS BY PARENTS, LEGAL GUARDIANS OR PERSONS WHOSE NAMES ARE DOCUMENTED IN THE PATIENT'S CHART. PLEASE INDICATE BELOW FOR BOTH IIHI AND HIPPA COMPLIANCE.

Name	**Relationship to Patient**

I have the right to request that Southern Pediatric Clinic restricts how it uses or discloses my PHI to carry out TPO. However, the practices are not required to agree to my requested restrictions, but if it doesn't, it is bound by this agreement. By signing this form, I am consenting to the practice's use and disclosure of my PHI to carry out TPO. I my revoke my consent in writing, except to the extent that which the practice has already made disclosures upon my prior consent. If I do not sign this consent, providers for Southern Pediatric Clinic may decline to provide treatment for my child(ren).

I authorize Dr. Blache to release any medical information necessary to process an insurance claim for my son/daughter and request the insurance company to make payment to Dr. Blache. I also authorize Southern Pediatric Clinic, LLC staff and/or Dr. Blache to use the contact information listed above.

_____	_____	_____
Parent/Guardian Printed Name	Signature	Date

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Financial Consent

1. ASSIGNMENT OF BENEFITS/BILLING AUTHORIZATION CONSENT:

____ Private Insurance: The cost of our services will be billed to your insurance company. If your private insurance denies coverage, or does not pay within 90 days of billing, you are financially responsible and will be billed directly for services rendered. The amount of fees for services will vary depending on changes in the patient's medical condition, progress, and physician order(s). In the event that sick symptoms or concerns are discussed outside the health check your co-pay or co-insurance may apply once insurance has been billed.

____ Private Pay: You are financially responsible of all fees due at time of service. The amount of fees for services may vary depending on changes in the patient's medical condition, progress, and physician order(s).

____ State Insurance: The cost of our services will be billed to your insurance company. If your state insurance denies coverage, or retro disenrolls the patient, you are financially responsible and will be billed directly for services rendered. The amount of fees for services will vary depending on changes in the patient's medical condition, progress, and physician order(s).

____ For those families where parents are separated or divorced, the parent who brings the child or children to the office visit and authorizes treatment is responsible for payment(s). Payments are due when services are rendered. If the divorced/custodial decree makes the non-custodial parent/guardian responsible for partial or all medical costs, it will be the responsibility of the authorizing parent to collect payment from the other parent.

2. NOTICE OF PATIENT RESPONSIBILITY FOR CO-PAYS, PERCENTAGES & DEDUCTIBLES:

Southern Pediatric Clinic will attempt to verify your insurance benefits and eligibility. The information we receive is based on the information you and your insurance company provide to us. As a courtesy, we will bill your insurance company for their portion of your bill. Ultimately it is your responsibility to see that we are paid appropriately by your insurance company. If the information given to us by you or your insurance company proves to be inaccurate and a balance remains, you will be billed for that balance and are responsible for payment within thirty (30) days unless you set up a payment plan with our billing specialists.

BY SIGNING BELOW, YOU INDICATE THAT:

1. You agree with the provisions of the payment source as described above. You understand that if you accept the services we have provided, you are ultimately responsible for payment. Should it be necessary to use collection services, any additional fees will also be your responsibility.
2. You authorize payment of any insurance benefits directly to Southern Pediatric Clinic.
3. You authorize the release of medical information to and from Southern Pediatric Clinic.
4. You agree to pay all co-pays, percentages, and deductibles at the time of service.

Patient Name _____ Date of Birth _____

Responsible Party Name and Signature _____ Today's Date _____

MEDICAL INSURANCE INFORMATION: PROVIDE A COPY OF INSURANCE CARD(S)

Primary Policy Holder Name	Primary Insurance	Primary Insurance Policy Number
M F		
Primary Policy Sex / Date of Birth	Secondary Ins./Medicaid	Secondary Ins./Medicaid Policy Number

Office Staff Initials _____