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			
T. AN	T'	. 31	N/I
Last Name	Fir	st 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 (PeachCare will be listed as Managed Care Provider).	\bigcirc	OR
(F) has health insurance that pays for vaccines.	\bigcirc	

PATIENT NAME:		DATE:	
	Please print.		

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE **10 YEAR VISIT**



To provide you and your child 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? O No O Yes, describe:
TELL US ABOUT YOUR CHILD AND FAMILY.
What excites or delights you most about your child?
Does your child have special health care needs? O No O Yes, describe:
Have there been major changes lately in your child's or family's life? ○ No ○ Yes , describe:
Have any of your child's relatives developed new medical problems since your last visit? O No O Yes O Unsure If yes or unsure, please describe:
Does your child live with anyone who smokes or spend time in places where people smoke or use e-cigarettes? O No O Yes O Unsure
YOUR GROWING AND DEVELOPING CHILD
Do you have specific concerns about your child's development, learning, or behavior? O No O Yes, describe:
Check off each of the items that are true for your child.
 ☐ Shows the ability to get along with others and control his emotions ☐ Chooses to eat healthy foods and participate in physical activity every day ☐ Forms caring, supportive relationships with family members, other adults, and peers

PATIENT NAME:		DATE:	
	Please print.		

10 YEAR VISIT

RISK ASSESSMENT

	Does your child's diet include iron-rich foods, such as meat, iron-fortified cereals, or beans?	O Yes	O No	O Unsure
	Does your child eat a vegetarian diet (does not eat red meat, chicken, fish, or seafood)?	O No	O Yes	O Unsure
Anemia	If your child is a vegetarian (does not eat red meat, chicken, fish, or seafood), does your child take an iron supplement?	O Yes	O No	O Unsure
	Do you ever struggle to put food on the table?	O No	O Yes	O Unsure
Oral health	Does your child's primary water source contain fluoride?	O Yes	O No	O Unsure
	Was your child 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
Tuberculosis	Has your child 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
	Is your child infected with HIV?	O No	O Yes	O Unsure

ANTICIPATORY GUIDANCE

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

YOUR FAMILY'S HEALTH AND WELL-BEING

Neighborhood and Family Violence		
Are there frequent reports of violence in your community or school?	O No	O Yes
Has your child ever been bullied or hurt physically by someone?	O No	O Yes
Has your child felt excluded or not a part of any group of friends?	O No	O Yes
Has your child ever told you she was touched in a way that made her uncomfortable or on her private parts?	O No	O Yes
Food Security		
Within the past 12 months, were you ever worried whether your food would run out before you got money to buy more?	O No	O Yes
Within the past 12 months, did the food you bought not last, and you did not have money to get more?	O No	O Yes
Tobacco, E-cigarettes, Alcohol, and Drugs		
Is there anyone in your child's life whose alcohol or drug use concerns you?	O No	O Yes
Do any of your child's friends smoke, use or vape e-cigarettes, drink alcohol or beer, or use drugs?	O No	O Yes
Harm From the Internet		
Do you know about your child's Internet use?	O Yes	O No
Do you have rules for the Internet?	O Yes	O No
Have you installed an Internet safety filter on computers, tablets, and smartphones?	O Yes	O No
Emotional Security and Self-esteem		
Does your child usually seem happy?	O Yes	O No
Are there things your child is really good at doing or is proud of?	O Yes	O No
Does your child have the chance to help others at home, at school, or in your community?	O Yes	O No
Connectedness With Family and Peers		
Do your family members get along well with each other?	O Yes	O No
Does your family do things together?	O Yes	O No
Does your child have chores or responsibilities at home?	O Yes	O No
Does your child have friends at school or in your neighborhood?	O Yes	O No

PATIENT NAME:		DATE:	
	Please print.		

10 YEAR VISIT

YOUR GROWING CHILD

YOUR GROWING CHILD		
Temper Problems, Setting Reasonable Limits, and Friends		
Has your child experienced any recent stresses at home or in school?	O No	O Yes
Do you have clear rules and expectations for your child?	O Yes	O No
When your child breaks the rules, are you consistent with consequences and discipline?	O Yes	O No
Do you help your child control his anger, deal with worries, and solve problems?	O Yes	O No
Have you and your child talked about how to say no to smoking, alcohol, and drug use?	O Yes	O No
Onset of Puberty and Sexual Safety		
Have you talked with your child about the body changes that occur during puberty?	O Yes	O No
Have you discussed privacy and body safety with your child?	O Yes	O No
Have you and your child talked about sex?	O Yes	O No
Does your child know to tell a trusted adult if someone touches her private parts or if someone encourages her to do other things that make her uncomfortable or she knows are wrong?	O Yes	O No
SCHOOL		
Do you have concerns about your child's school experience?	O No	O Yes
Has your child missed more than 2 days of school in any month?	O No	O Yes
Does your child have any difficulties at school or get extra help in any subjects?	O No	O Yes
Does your child participate in activities outside of school?	O Yes	O No
STAYING HEALTHY	-	
Healthy Teeth		
Does your child have a dentist?	O Yes	O No

Healthy Teeth		
Does your child have a dentist?	O Yes	O No
Does your child brush and floss his teeth every day?	O Yes	O No
Does your child use a mouth guard when playing contact sports?	O Yes	O No
Does your child regularly drink soda, juice, or other sugar-sweetened drinks?	O No	O Yes
Nutrition		
Do you have any concerns about your child's weight?	O No	O Yes
Do you have any concerns about her eating? This includes drinking enough milk and eating vegetables and fruits.	O No	O Yes
Do you eat family meals together?	O Yes	O No
Do you hear your child talking about how he looks or dieting?	O No	O Yes
Physical Activity		
Is your child physically active at least 1 hour a day? This includes running, playing sports, or active play with friends.	O Yes	O No
Do you have any concerns about your child's physical activity level, such as it being either too much or too little?	O No	O Yes
Does your child have trouble going to sleep or does she wake up during the night?	O No	O Yes
How much time every day does your child spend watching TV, playing video games, or using computers, tablets, or smartphones (not counting schoolwork)?		hours
Does your child have a TV or an Internet-connected device in his bedroom?	O No	O Yes
Has your family made a family media use plan to help everyone balance time spent on media with other family and personal activities?	O Yes	O No

SAFETY

Car Safety			
Does your child always sit in a belt-positioning booster seat or lap and shoulder seat belt in the back seat every time she rides in a vehicle?	O Yes	O No	
Does everyone in the vehicle always use a lap and shoulder seat belt?	O Yes	O No	
Safety During Physical Activity			
Does your child always wear a helmet to protect his head when biking, skating, or doing other outdoor activities?	O Yes	O No	

PATIENT NAME:		DATE:
	Please print.	

10 YEAR VISIT

SAFETY (CONTINUED)

Outdoor Safety				
Does your child know how to swim?	O Yes	O No		
Does your child know to always have an adult watching her in the water and never to swim alone?	O Yes	O No		
Does your child always use sunscreen when playing outside?	O Yes	O No		
Knowing Your Child's Friends and Their Families				
Do you know your child's friends and their families?	O Yes	O No		
Does your child know how to get help in an emergency if you are not there?	O Yes	O No		
Gun Safety				
Does anyone in your home or the homes where your child spends time have a gun?	O No	O Yes		
If yes, is the gun unloaded and locked up?	O Yes	O No		
If yes, is the ammunition stored and locked up separately from the gun?	O Yes	O No		
Have you talked with your child about gun safety?	O Yes	O No		

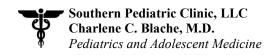
Consistent with Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 4th Edition

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



The information contained in this questionnaire should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances. Original questionnaire included as part of the *Bright Futures Tool and Resource Kit*, 2nd Edition.

The American Academy of Pediatrics (AAP) does not review or endorse any modifications made to this questionnaire and in no event shall the AAP be liable for any such changes.



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?		

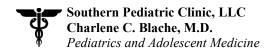
SUICIDE RISK SCREENING	YES	NO
In the past few weeks, have you wished you were dead?		
In the past few weeks, have you felt that you or your family would be better off if you were dead?		
In the past week, have you been having thoughts about killing yourself?		
Have you ever tried to kill yourself?		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



v 1 eatairies and Adoiescent Med	ши	Fax 229 • 241 • 2088			
Patient Demographics Form					
Address Race \square Black or African Amer	Zip Code		F		
Ethnicity Hispanic or Latino Preferred language Englis	□ Not Hispanic or Latino □ Other: □	her:			
MOTHER/LEGAL GUARDIA	N'S NAME:	Birthdate			
Social Security #					
Address		e Phone	-		
Employer		Work			
EATHED/LECAL CHADDIAN'S NA	AME.	Dieth data			
FATHER/LEGAL GUARDIAN'S NA					
Social Security #					
Address Employer		Work			
EN	MERGENCY CONTACT OTH	HER THAN PARENT			
Name:	Relationship	Mobile Phone Number:			
Physical Address:					
MEDICAL INSURA	ANCE INFORMATION: PROVIDE	A COPY OF EACH INSURANCE CARD			
Primary Insurance	Policy Number	Policy Holder's Name / Date of Birth /	Sex (M/I		
Secondary Insurance	Policy Number	Policy Holder's Name / Date of Birth / S	Sex (M/F		
WE STRONGLY BE	LIEVE IN VACCINATING O	OUR PATIENTS ACCORDING TO THE			
RECOMMENDED AM		DIATRICS AND CENTER FOR DISEASI	E		
	GUIDELINE	.	_		

BY SIGNING BELOW, YOU ARE AGREEING TO ALLOW US TO VACCINATE YOUR CHILD.

Parent/Guardian Printed Name	Signature	Date

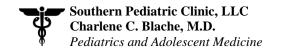


406-M Northside Drive Valdosta, GA 31602 Ph. 229 • 241 • 0059 Fax 229 • 241 • 2088

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 N	ame:		Date of Birth:		
MOTHE	R'S NAME WHO IS LEGAL (GUARDIAN		Birthdate	
FATHER'S NAME WHO IS LEGAL GUARDIAN				Birthdate	
	ediatric Clinic, LLC and employees TPO). Please review the Notice of	•	-	carry out treatment, payment and healthcare nt.	
2. 3. 4. 5. 6.	right to revise its Notice of Priva I have read and understand the N questions. Southern Pediatric Clinic, and a in person in reference that assist Southern Pediatric Clinic may to Southern Pediatric Clinic may do to above, to anyone specified be Southern Pediatric Clinic will not court-ordered documents for your peak and person in the Notice of Pediatric Clinic will not court-ordered documents for your pediatric Clinic will not court to the pediatric Clinic will not court-ordered documents for your pediatric Clinic will not court to the pediatric Clinic	ney Practices at any time and Notices of Privacy Practices to a lithose associated, may call to the practice in carrying out a lithose in carrying out a lithose in carrying out a lithose in a lithose in carrying out a lithose in a lithose	that I will have access to revision that are in place and that I may comy home or other designated located from the such as appointment reminostic tests and labs for diagnosistic tests and labs for diagnosis tests and labs f	ontact the Privacy Officer listed for further cation and leave a message on voice mail or orders and patient statements.	
COMPLIA		Name	Relationship to I		
agree to my my PHI to ca	requested restrictions, but if it doesn	't, it is bound by this agreement in tin writing, except to the exte	at. By signing this form, I am consent that which the practice has alre	O. However, the practices are not required to senting to the practice's use and disclosure of eady made disclosures upon my prior consent d(ren).	
	Or. Blache to release any medical info ent to Dr. Blache. I also authorize So			ughter and request the insurance company to ontact information listed above.	
Parent/Gua	ardian Printed Name	Sign	ature	Date	



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

Financial Consent

ASSIGNMENT OF	RENEFITS/RII	I ING AUTHORIZ	ATION 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 INFORMA	ATION: 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
		1 (4)110-01
		Office Staff Initials