

American Academy of Pediatrics



BRIGHT FUTURES PREVISIT QUESTIONNAIRE

9 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? No Yes, describe:

Blank space for describing concerns, questions, or problems.

TELL US ABOUT YOUR CHILD AND FAMILY.

What excites or delights you most about your child?

Blank space for describing what excites or delights the parent most about their child.

Does your child have special health care needs? No Yes, describe:

Blank space for describing special health care needs.

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

Blank space for describing major changes in the child's or family's life.

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

Blank space for describing new medical problems in relatives.

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

YOUR GROWING AND DEVELOPING CHILD

Do you have specific concerns about your child's development, learning, or behavior? No Yes, describe:

Blank space for describing concerns about the child's development, learning, or behavior.

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

Please print.

9 YEAR VISIT

RISK ASSESSMENT

Anemia	Does your child's diet include iron-rich foods, such as meat, iron-fortified cereals, or beans?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
	Does your child eat a vegetarian diet (does not eat red meat, chicken, fish, or seafood)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	If your child is a vegetarian (does not eat red meat, chicken, fish, or seafood), does your child take an iron supplement?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
	Do you ever struggle to put food on the table?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Hearing	Do you have concerns about how your child hears?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Do you have concerns about how your child speaks?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Oral health	Does your child's primary water source contain fluoride?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
Tuberculosis	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)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Has your child had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test result?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Is your child infected with HIV?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Vision	Do you have concerns about how your child sees?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Has your child ever failed a school vision screening test?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Does your child tend to squint?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> 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?	<input type="radio"/> No	<input type="radio"/> Yes
Has your child ever been bullied or hurt physically by someone?	<input type="radio"/> No	<input type="radio"/> Yes
Has your child felt excluded or not a part of any group of friends?	<input type="radio"/> No	<input type="radio"/> Yes
Has your child ever told you she was touched in a way that made her uncomfortable or on her private parts?	<input type="radio"/> No	<input type="radio"/> 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?	<input type="radio"/> No	<input type="radio"/> Yes
Within the past 12 months, did the food you bought not last, and you did not have money to get more?	<input type="radio"/> No	<input type="radio"/> Yes
Tobacco, E-cigarettes, Alcohol, and Drugs		
Is there anyone in your child's life whose alcohol or drug use concerns you?	<input type="radio"/> No	<input type="radio"/> Yes
Do any of your child's friends smoke, use or vape e-cigarettes, drink alcohol or beer, or use drugs?	<input type="radio"/> No	<input type="radio"/> Yes
Harm From the Internet		
Do you know about your child's Internet use?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have rules for the Internet?	<input type="radio"/> Yes	<input type="radio"/> No
Have you installed an Internet safety filter on your computers, tablets, and smartphones?	<input type="radio"/> Yes	<input type="radio"/> No
Emotional Security and Self-esteem		
Does your child usually seem happy?	<input type="radio"/> Yes	<input type="radio"/> No
Are there things your child is really good at doing or is proud of?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child have the chance to help others at home, at school, or in your community?	<input type="radio"/> Yes	<input type="radio"/> No

Please print.

9 YEAR VISIT

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

Connectedness With Family and Peers		
Do your family members get along well with each other?	<input type="radio"/> Yes	<input type="radio"/> No
Does your family do things together?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child have chores or responsibilities at home?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child have friends at school or in your neighborhood?	<input type="radio"/> Yes	<input type="radio"/> No

YOUR GROWING CHILD

Temper Problems, Setting Reasonable Limits, and Friends		
Has your child experienced any recent stresses at home or in school?	<input type="radio"/> No	<input type="radio"/> Yes
Do you have clear rules and expectations for your child?	<input type="radio"/> Yes	<input type="radio"/> No
When your child breaks the rules, are you consistent with consequences and discipline?	<input type="radio"/> Yes	<input type="radio"/> No
Do you help your child control his anger, deal with worries, and solve problems?	<input type="radio"/> Yes	<input type="radio"/> No
Have you and your child talked about how to say no to smoking, alcohol, and drug use?	<input type="radio"/> Yes	<input type="radio"/> No
Onset of Puberty and Sexual Safety		
Have you talked with your child about the body changes that occur during puberty?	<input type="radio"/> Yes	<input type="radio"/> No
Have you discussed privacy and body safety with your child?	<input type="radio"/> Yes	<input type="radio"/> No
Have you and your child talked about sex?	<input type="radio"/> Yes	<input type="radio"/> 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?	<input type="radio"/> Yes	<input type="radio"/> No

SCHOOL

Do you have concerns about your child's school experience?	<input type="radio"/> No	<input type="radio"/> Yes
Has your child missed more than 2 days of school in any month?	<input type="radio"/> No	<input type="radio"/> Yes
Does your child have any difficulties at school or get extra help in any subjects?	<input type="radio"/> No	<input type="radio"/> Yes
Does your child participate in activities outside of school?	<input type="radio"/> Yes	<input type="radio"/> No

STAYING HEALTHY

Healthy Teeth		
Does your child have a dentist?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child brush and floss his teeth every day?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child use a mouth guard when playing contact sports?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child regularly drink soda, juice, or other sugar-sweetened drinks?	<input type="radio"/> No	<input type="radio"/> Yes
Nutrition		
Do you have any concerns about your child's weight?	<input type="radio"/> No	<input type="radio"/> Yes
Do you have any concerns about her eating? This includes drinking enough milk and eating vegetables and fruits.	<input type="radio"/> No	<input type="radio"/> Yes
Do you eat family meals together?	<input type="radio"/> Yes	<input type="radio"/> No
Do you hear your child talking about how he looks or dieting?	<input type="radio"/> No	<input type="radio"/> Yes
Physical Activity		
Is your child physically active at least 1 hour a day? This includes running, playing sports, or active play with friends.	<input type="radio"/> Yes	<input type="radio"/> No
Do you have any concerns about your child's physical activity level, such as it being either too much or too little?	<input type="radio"/> No	<input type="radio"/> Yes
Does your child have trouble going to sleep or does she wake up during the night?	<input type="radio"/> No	<input type="radio"/> 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 her bedroom?	<input type="radio"/> No	<input type="radio"/> Yes
Has your family made a family media use plan to help everyone balance time spent on media with other family and personal activities?	<input type="radio"/> Yes	<input type="radio"/> No

Please print.

9 YEAR VISIT

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 he rides in a vehicle?	<input type="radio"/> Yes	<input type="radio"/> No
Does everyone in the vehicle always use a lap and shoulder seat belt?	<input type="radio"/> Yes	<input type="radio"/> No
Outdoor Safety		
Does your child always wear a helmet to protect her head when biking, skating, or doing other outdoor activities?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child know how to swim?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child know to always have an adult watching him in the water and never to swim alone?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child always use sunscreen when playing outside?	<input type="radio"/> Yes	<input type="radio"/> No
Knowing Your Child's Friends and Their Families		
Do you know your child's friends and their families?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child know how to get help in an emergency if you are not there?	<input type="radio"/> Yes	<input type="radio"/> No
Gun Safety		
Does anyone in your home or the homes where your child spends time have a gun?	<input type="radio"/> No	<input type="radio"/> Yes
If yes, is the gun unloaded and locked up?	<input type="radio"/> Yes	<input type="radio"/> No
If yes, is the ammunition stored and locked up separately from the gun?	<input type="radio"/> Yes	<input type="radio"/> No
Have you talked with your child about gun safety?	<input type="radio"/> Yes	<input type="radio"/> 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>.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®



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.

© 2019 American Academy of Pediatrics. All rights reserved.



Patient Information Form

	Today's Date _____
Child's Name _____	Birthdate _____ Sex <u> </u> M / F
Address _____ Zip Code _____ Social Security # _____	
Name & birthdates of child's brothers and/or sisters (include last name if different) _____ _____	
Has your child ever been seen at our practice? <input type="checkbox"/> NO <input type="checkbox"/> YES When? _____	
Have any of your child's brothers and/or sisters ever been seen at our practice? <input type="checkbox"/> YES <input type="checkbox"/> NO	
If yes, which brothers or sisters? _____	
If your child (or children) has not been seen before, who may we thank for referring you to our office? _____	
Name of child's previous doctor _____	
Name of parents' family doctor _____	
Name of mother's obstetrician/gynecologist _____	
How did you hear about SPC? <input type="checkbox"/> Physician / Hospital <input type="checkbox"/> Marketing Ads <input type="checkbox"/> Social Media (Facebook / Instagram) <input type="checkbox"/> Google <input type="checkbox"/> SPC's Website <input type="checkbox"/> Patient <input type="checkbox"/> Signage (building) <input type="checkbox"/> Related Profession (Physical Therapy etc.): _____ <input type="checkbox"/> Other: _____	

MOTHER'S NAME WHO IS LEGAL GUARDIAN _____	Birthdate _____
Social Security # _____	Marital Status _____ Email _____
Address _____ Home Phone _____	
Employer _____	Occupation _____ Work Phone _____

FATHER'S NAME WHO IS LEGAL GUARDIAN _____	Birthdate _____
Social Security # _____	Marital Status _____ Email _____
Address _____ Home Phone _____	
Employer _____	Occupation _____ Work Phone _____

MEDICAL INSURANCE INFORMATION: PROVIDE A COPY OF EACH INSURANCE CARD		
Primary Policy Holder Name	Primary Insurance	Secondary Ins./Medicaid

EMERGENCY CONTACT OTHER THAN PARENT Name _____
Relationship _____ Address _____ Home Phone _____

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



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).
- ___ 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						
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; border: 1px solid black; text-align: center;">M</td> <td style="width: 10%; border: 1px solid black; text-align: center;">F</td> <td style="border: 1px solid black;"></td> </tr> </table>	M	F					Secondary Ins./Medicaid	Secondary Ins./Medicaid Policy Number
M	F							

Office Staff Initials



**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	Disclose PHI		Accompany to Appointment	
		<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	_____	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	_____	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	_____	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	_____	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	_____	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	_____	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	_____	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no

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 may 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).

 Signature of Parent/Guardian

 Date

 Printed Name of Parent/Guardian



Child's Name _____

DOB _____

CELL PHONE USE POLICY

The purpose of this policy is to outline the acceptable use of cellular phone (“cellphones”) and other communication devices, including but not limited to, mobiles phones, iPhones, iPads, iPods, tablets, or any other wireless device (collectively referred to as “communication devices”) at *Southern Pediatric Clinic, LLC*. These rules are in place to protect the workers and *Southern Pediatric Clinic, LLC*, along with the privacy of each of our patients. Inappropriate use of communication devices may harm others within the office by violating HIPAA laws and regulations.

1. **Who this Policy Applies To:**

This Policy applies to patients that are being seen within the office and their family members.

2. **What devices this Policy Applies To: (Video recording or pictures during vaccinations is PROHIBITED)**

- a. All devices that can be used for recording.
- b. All devices that can be used for communicating with others.
- c. All devices that may hinder the quality of care the patient may receive.

3. **Permitted Use:**

The devices mentioned can be used in the lobby if needed. However, it is recommended that the patient or family members be conscious of others that may be in the lobby.

4. **Violations of This Policy:**

Patients or family members that violate this policy may be asked to leave and are subject to dismissal depending on circumstances.

I have read and will abide by the terms of this policy regarding the use of communication devices in this office.

Signature of Parent/Guardian or Patient _____

Date _____



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 may 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 as 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 (PeachState, WellCare, AmeriGroup, CareSource or SSI Medicaid).	<input type="radio"/>	OR
(B) is American Indian or Alaskan Native.	<input type="radio"/>	OR
(C) does not have health insurance.	<input type="radio"/>	OR
(D) has health insurance that does not pay for vaccines.	<input type="radio"/>	OR
(E) is enrolled in PeachCare (PeachCare will be listed as Managed Care Provider).	<input type="radio"/>	OR
(F) has health insurance that pays for vaccines.	<input type="radio"/>	

Parent/Guardian Name (print)

Signature

Date