RIVER PEDIATRIC CLINIC INTAKE FORM

<table>
<tr><th colspan="5">PATIENT & CONTACT INFORMATION</th></tr>
<tr><td>Name (First and Last):</td><td>Birth Date
(MM/DD/YY):</td><td></td><td>Age:</td><td>Pronouns:
❒ She/her
❒ He/him
❒ They/them</td></tr>
<tr><td>Gender:
❒ Girl
❒ Boy
❒ Transgender
❒ Nonbinary
❒ Prefer not to answer</td><td>Sex assigned at Birth:
❒ Male
❒ Female
❒ Intersex</td><td></td><td>Race
❒ White
❒ Black / African American
❒ American Indian / Alaska Native
❒ Asian
❒ Native Hawaiian / Other Pacific Islander
❒ Prefer not to answer</td><td>Ethnicity:
❒Hispanic or Latino
❒ Not Hispanic or Latino
❒ Prefer not to answer</td></tr>
<tr><td colspan="2">Email Address & Phone Number:</td><td></td><td colspan="2">Home Address:</td></tr>
<tr><td colspan="2">Parent/Guardian 1 Information

Name: _____

DOB: _____

Phone: _____

Email: _____

Address: _____
❒Address same as patient

Occupation:_____

Emergency Contact? ❒ Yes ❒ No

Relationship to Patient: ❒Mother ❒Father ❒Other</td><td></td><td colspan="2">Parent/Guardian 2 Information

Name:
_____

DOB: _____

Phone:
_____

Email:
_____

Address:
_____
❒Address same as patient

Occupation:_____
_

Emergency Contact? ❒ Yes ❒ No

Relationship to Patient: ❒Mother ❒Father ❒Other</td></tr>
</table>

Primary Insurance Provider:
❒ Kaiser ❒ Blue Shield ❒ Aetna ❒ Anthem Blue Cross ❒ MediCare ❒ MediCal
❒ Other: _____ ❒ No Insurance

All services provided at RIVER Pediatric Clinic are free of charge, however we may use this information to help patients access services unavailable at our clinic.

Does the patient have a pediatrician or primary care provider? ❒ Yes ❒ No

Name of Pediatrician: _____

Address: _____

Phone Number: _____

Last Appt: _____ Frequency of Visits: ❒ weekly/monthly ❒ annually ❒ less than annual

Preferred Pharmacy: _____
(Name & Address)

MEDICAL HISTORY

Reason for Visit:

Has the patient EVER had any of the following?

Anemia/Bleeding tendency ..... □ Y □ N
Asthma/Breathing problems ..... □ Y □ N
Behavioral problems .....□ Y □ N
Blood Transfusion..... □ Y □ N
Bowel/Stomach problems ..... □ Y □ N
Cancer/Leukemia ..... □ Y □ N
Chicken Pox/Shingles .....□ Y □ N
Developmental disorder ..... □ Y □ N
Diabetes ..... □ Y □ N
Ear/Nose/Throat Disorder ..... □ Y □ N
Eczema/Skin disorder ..... □ Y □ N
Eye Disorder ..... □ Y □ N
Growth disorder.....□ Y □ N
Heart disorder/defect ..... □ Y □ N
Kidney/Bladder problems ..... □ Y □ N
Liver disease ..... □ Y □ N
Seizure or Epilepsy ..... □ Y □ N
Thyroid disorder ..... □ Y □ N
Other (please list): _____

Medication(s)/Supplements(s):

_____

_____

Allergies: _____ ❒ No known allergies

Is patient adopted? □ Y □ N *If 'Y', please answer the following to the best of your knowledge.*
Birth weight: ____(lbs)/____(oz) Born by: □ C-Section □ Vaginal Delivery Gestational Age: ____

Please describe any health problems the mother or patient experienced during pregnancy or after birth, if any:

Immunization History:
Hep B ❒ #1 ❒ #2 ❒ #3
Rotavirus. ❒#1 ❒ #2 ❒#3
DTaP ❒#1 ❒ #2 ❒#3 ❒ #4
HIB. ❒#1 ❒ #2 ❒ #3
PCV 13 or 15 ❒#1 ❒ #2 ❒ #3 ❒ #4
IPV (Inactivated Polio Vaccine) ❒#1 ❒ #2 ❒ #3
COVID-19 ❒#1 Boosters?
❒ Influenza Year of last flu vaccine?
❒ MMR (Measles/Mumps/Rubella)
❒ Varicella (Chicken Pox)

The following sections are optional. If possible, please allow your adolescent to answer the questions for themselves.

Mental Health Screening:
Is the patient experiencing issues with any of the following (check all that apply)?
❒ Sleeping problems ❒ Eating problems ❒ Fatigue ❒ Depressed mood
❒ Excessive worry ❒ Anxiety attacks ❒ Racing thoughts ❒ Avoidance
❒ Crying spells ❒ Concentration/forgetfulness ❒ Loss of interest
❒ Increased irritability ❒ Excessive energy ❒ Unable to enjoy activities
❒ Thoughts of dying ❒ Impulsivity ❒ School performance
❒ Aggression to self/others/property ❒ Nightmares ❒ Self-harm
❒ Other: _____

Has the patient been treated for any psychological or psychiatric problems at any other time? If yes, please describe the mental health problems and interventions that were made.

_____

_____

Reproductive and Sexual Health Screening: (skip if not applicable)
Age of first menstrual period: _____
Is menstruation regular? □ Y □ N
Is the patient experiencing any difficulties related to menstrual periods? Please explain.
_____

Is the patient sexually active? □ Y □ N
If yes, please answer the following:
In recent months, how many sex partners has the patient had? _____
Does the patient engage in the following (select all that apply)?
❒ Genital sex ❒ Anal sex ❒ Oral sex
Has the patient previously gotten tested for STIs/STDs? □ Y □ N

Is the patient currently using birth control? ❒Yes ❒No ❒Not applicable

SOCIAL HISTORY
Primary Language(s) Spoken at Home: ❒ English ❒ Spanish ❒ Other: _____ Language Preference: _____
Parent/ Guardian Signature: _____ Date: _____

GENERAL CONSENT FOR MEDICAL TREATMENT OF MINOR

Name of Patient: _____ Birth Date: _____

I hereby authorize RIVER Pediatric Clinic to provide my child with simple, common, and routine medical services such as those listed below, to the extent my consent is required by law. I understand that under federal and state laws there are certain services that my child may receive that do not need my consent.

Consent must be given for the following services:

1. Diagnosis and treatment of minor and acute illnesses	8. Vision and hearing screening
2. Diagnosis and treatment of mental health issues	9. Laboratory Services
3. First aid for minor injuries	10. Limited x-ray services
4. Physical examinations	11. Over-the-counter items/Prescriptions
5. Assistance with chronic ongoing illnesses, such as: asthma, diabetes, and epilepsy	12. Diet and weight control programs
6. Treatment of acne and other skin problems	13. Referral for health care services that cannot be provided at the Health Center
7. Immunizations	14. Emergency treatment

1. I understand that this consent only applies to services provided at RIVER Pediatric Clinic (RPC) or another Student Run Clinic which is a result of a referral made by the RIVER Pediatric Clinic and does not allow any other private or public facility to provide services to my child.
2. I hereby authorize RPC to give my insurance carrier(s) medical or dental record information needed to complete my child's insurance claims.
3. I understand that my child's medical and/or dental records, including immunization records, will be kept confidential but that this information may be shared with other health care providers for purposes of my child's care and treatment. No other release of my child's health information is allowed without written permission by me, except as permitted or required by law. I understand that RPC's privacy policy is published in the RPC Notice of Privacy Practices.
4. I understand that this consent may be revoked, restricted or revised at any time in writing by me, however, this will not affect services and/or treatment previously provided by RPC and other prior reliance by RPC on this consent. This Consent Form remains in effect until my child turns 18, or until revoked in writing.

Signature of Parent/Legal Guardian/: _____ Date: _____
Printed Name: _____

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGMENT

Name of Patient: _____ Birth Date: _____

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive. By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?

❒ YES ❒ NO

May we leave a message on your answering machine at home or on your cell phone?

❒ YES ❒ NO

May we discuss your medical condition with any member of your family?

❒ YES ❒ NO

If YES, please name the member(s) allowed:

_____

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Parent/Guardian Signature: _____

Date:_____