The Children's Clinic New Patient & Yearly Update Data Form

New ☐ Update ☐

(Office Use Only)	Greenway #	Dentrix #

I. Parent/Guardian Information (Información de padre/guardián legal)

Please select one for each section (Por favor de seleccionar uno para cada sección)

Relationship (Relación)
- ☐ Parent (Padre/Madre)
- ☐ Legal Guardian (Guardián Legal)
- ☐ Foster (Padre Adoptivo)
- ☐ Other (Otro) _____

Status (Statu)
- ☐ Married (Casada/o)
- ☐ Single (Soltera/o)
- ☐ Divorced (Divorciada/o)
- ☐ Separated (Separada/o)
- ☐ Other (Otro) _____

Race (Raza)
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown
- ☐ Decline

Ethnicity (Etnicidad):
- ☐ Asian
- ☐ Black/Af.Am.
- ☐ Pacific Islander
- ☐ Native Hawaiian
- ☐ Unknown
- ☐ Am. Ind./ Alask.
- ☐ White
- ☐ Other Multi Racial
- ☐ Other_____
- ☐ Decline

Father (Last, First Name)/ Padre (Apellido, Primer Nombre)	DOB (Fecha de Nacimiento):
Mother (Last, First Name) / Madre (Apellido, Primer Nombre)	DOB (Fecha de Nacimiento):
Legal Guardian (Last, First Name)/Guardián Legal (Apellido, Primer Nombre)	DOB (Fecha de Nacimiento):

Address (Dirección), Apartment # (Apartamento #), City (Ciudad), State (Estado), Zip Code (Código Postal)

Home Phone # (# de Casa), Cell Phone # (# de Celular), Work Phone # (# de Trabajo), Email Address (Correo Electrónico)

Language Preference (Preferencia de Lenguaje) Do you speak English (Usted habla Inglés)? Yes (Si) or No

II. Patient Information (Información de Paciente)

Patient Name (Last, First and Middle Name) | Gender (Genero): ☐ Female (Femenino) ☐ Male (Masculino)

D.O.B (Fecha Nacimiento) | Patient Email Address, if over 13yrs (Correo electrónico de Paciente, si arriba de 13 años)

Race (Raza)
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown
- ☐ Decline

Ethnicity (Etnicidad)
- ☐ Asian
- ☐ Black/Af.Am.
- ☐ Pacific
- ☐ Unknown
- ☐ Amer. Indian /Alaskan
- ☐ White
- ☐ Native Hawaiian
- ☐ Other Multi Racial
- ☐ Other: _____
- ☐ Decline

III. Pharmacy Information (Información de Farmacia)

Pharmacy Name (Farmacia), Cross Streets/City (Calles Cruzadas/Ciudad), Phone # (Teléfono), Fax

IV. Insurance Information (Información de Seguro)

Is your child on Public Aid/Medicaid/Allkids (Su niño tiene asistencia pública/Medicaid/Allkids)? YES (Si) or NO

If yes, Please provide the Medicaid/All kids # (Si la respuesta es si, por favor de proveer el numero to Medicaid/Allkids):	**If no, ask for All kids information** (Si la respuesta es no, pregunte por información de Allkids).

Do you have private medical/dental insurance? (Tiene seguro privado medico/dental)? YES (Si) or NO

If yes, please provide insurance name and number (Si la respuesta es sí, por favor de proveer el nombre y número de seguranza):

Yearly Income of everyone in household before deductions, which includes TANF cash, child support, etc: (Cuál es la cantidad de ingreso anual de todos en la familia, cual incluye a suporte de niño, TANF efectivo, etc): _____	Number of family members (Número de miembros en la familia): _____

Do you have other children that attend our office if so include (Tiene otros niños que son pacientes de la clínica):

Last Name (Apellido)	First Name (Primer Nombre)	Birthdate (Fecha de Nacimiento)	Medical (Medico)	Dental (Dental)

-Please turn form over (Por favor de voltear forma)-

V. Consent (Consentimiento)

Consent: I consent to medical treatment by The Children's Clinic including but not limited to Dental Care: use of local anesthetics, analgesics, x-rays, dental material & treatment as is indicated, to physical assessments, immunizations and diagnostic test, I-CARE/TOTS Registry.

X_____ **Date (Fecha)**_____ **Relationship to minor** _____
Parent or Legal Guardian of Child (Firma del padre o tutor legal) (Relación al paciente)

Consent for Purposed of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my child's protected health information by The Children's Clinic for the purpose of diagnosing or providing treatment to my child, obtaining payment for my child's health care bills or to conduct health care operations of The Children's Clinic. I understand that diagnosis or treatment of my child by Dr. Karen Walker M.D., Dr. Hathiwala M.D., Dr. Stephanie Weller M.D., Dr. Jill Baskin, DDS, Dr.Briney DDS, Dr. Samore DDS, Dr. Wanda Laszcz, Dr. Margaret Vizgirda DDS, Dr. Daniela Brzozowski DDS, Dr. Rosa Ortega DDS, Darla DeWolff NP, Jazmine Dillard DDS, may be conditioned upon my consent as evidenced by my signature on this document. I understand that Pillars Mental Health Agency is affiliated with the IWS Children's Clinic as a provider of on-site behavioral health services. As a care provider, Pillars has access to medical and/or dental records in order to provide better coordinated care services. I also understand that the Oak Park Mental Health Board might review the same charts as part of audit purposes contracted by grants to the clinic.

I understand I have the right to request a restriction as to how my child's protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Children's Clinic is not required to agree to the restrictions that I may request. However, If The Children's Clinic agrees to a restriction that I may request, the restriction is binding on The Children's Clinic and Dr. Karen Walker M.D., Dr. Hathiwala M.D., Dr. Stephanie Weller M.D., Dr. Jill Baskin, DDS, Dr. Briney DDS, Dr. Samore DDS, Dr. Wanda Laszcz , Dr.Margaret Vizgirda DDS, Dr. Daniela Brzozowski DDS, Dr. Rosa Ortega DDS, Darla DeWolff NP, Jazmine Dillard DDS.

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Karen Walker M.D., Dr. Hathiwala M.D., Dr. Stephanie Weller M.D., Dr. Jill Baskin, DDS, Dr. Briney DDS, Dr. Samore DDS, Dr. Wanda Laszcz, Dr. Margaret Vizgirda DDS, Dr. Daniela Brzozowski DDS, Dr. Rosa Ortega DDS, Darla DeWolff NP, Jazmine Dillard DDS, or The Children's Clinic has taken action in reliance on this consent.

My Childs "protected health information" means health information, including my demographic information, collected from me and created or received by my child's physician and dentist, another healthcare provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or conditions and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review The Children's Clinic's Notice of Privacy Practices prior to signing this document. The Children's Clinic's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my child's protected health information that will occur in my child's treatment, payment of my bills or in the performance of health care operations of The Children's Clinic. The Notice of Privacy Practices for The Children's Clinic is also provided at the front desk and on The Children's Clinic website at www.childrenscliniciws.org The Notice of Privacy Practices also describes my rights and The Children's Clinic's duties with respect to my child's protected health information.

The Children's Clinic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing The Children's Clinic's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my child's next appointment.

_____	_____	_____
Signature of Parent or Legal Guardian of Patient	Print Name of Parent or Legal Guardian of Patient	Date/Fecha

_____	_____	_____
Emergency Contact Information Name **Información de contacto de emergencia Nombre**	**Relationship to patient** **La relación al paciente**	**Phone #** **Teléfono**

Comments/Comentarios:_____

The Community Mental Health Board of Oak Park Township pays in part for The Children's Clinic behavioral health services.

Referral Information

Whom may we thank for referring you to our practice? ☐ Family Member ☐ Friend ☐ Other patient ☐Auto-Assigned
☐ Medical/Dental Office Name/Address: _____ ☐ Web Page ☐ Facebook ☐ School
☐ Self ☐ Medical Card/Allkids ☐ Other _____
Name of person or office & address referring you to our practice: _____

Información de Referencia

¿Quién podemos dar las gracias por referirlo a nuestra práctica? ☐Miembro de la familia ☐ Amigo ☐Otro paciente ☐Asignado Automático ☐Oficina de médico/dental Nombre/dirección: _____ ☐La Página del Internet ☐ Facebook
☐La Escuela ☐ Tarjeta Medica / Allkids ☐Yo Mismo ☐Otro _____
E**l nombre de persona o oficina y dirección** que refieren usted a nuestra práctica: _____