PHSC
Primary Health Services Center
"Champions in Health Care"

PATIENT'S CONSENT FORM

Name:	Date of Birth: (MM/DD/YY)	Age:	Chart Number:
Address:	City:	State:	Zip:
Email Address:	SS#:	Sex: ☐ Male ☐ Female	
Home Phone:	Mobile Phone No.:	Veteran Status: ☐ Veteran ☐ Not a Veteran	

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widower

Insurance Type:
☐ Medicaid
☐ Medicare
☐ Medicaid/Medicare
☐ Private

Race: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Also check below
☐ Black ☐ White ☐ Asian ☐ American Indian/Alaskan Native
☐ Native Hawaiian ☐ Pacific Islander ☐ More than one race
☐ Race Unreported

	Number in Household	Monthly Income: $
Emergency Contact Person:	Relationship:	Phone Number:

CONSENT TO TREAT/PROCESS CLAIMS: I do hereby authorize PHSC or any member of their staff, under the direct supervision of appropriate licensed personnel, to provide such medical services to patients as he or she may deem reasonable and necessary to treat me, or my minor child, for any illness, condition, or disease which I am or may be afflicted.

RELEASE OF MEDICAL RECORDS: I authorize the release of my medical records to my family physician and/or to my insurance carrier to process any and all claims. And I authorize the release of medical records from other physicians to assist in my treatment.

LABORATORY SERVICES: Please be advised that if Laboratory tests are ordered or collected that our outside laboratory will bill you for all laboratory work. If any charge went towards your insurance, it will be billed to the party (Secondary insurance/patient/patient guarantor).

ADVANCE DIRECTIVES: It is the policy of PHSC as a primary care site NOT to honor any Advance Directives a patient may possess. A minimal of basic life support efforts will be initiated by staff and EMS will be activated. The patient may invoke his/her Advance Directives after being transferred from PHSC to the nearest tertiary care site.

PATIENT RIGHTS: I have received a copy of PHSC's Notice of Privacy Practices, which makes me aware of my privacy rights and HIPAA.

Housing Status:
☐ Public Housing ☐ Own a Home ☐ Family Justice/Well Springs ☐ Rent ☐ Other

☐ Homeless (If yes, please put check mark on current situation:
☐ Transitional shelter ☐ Streets ☐ Doubled-up (Living with someone else)

Signature of Patient/Responsible Person *X*	Date:
PHSC Witness *X*	Date:

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Date:_____

PEDIATRIC RECORD

Patient's Name _____ ☐ Male ☐ Female Age _____

Parent or Guardian's Name _____

Date of Birth _____ Daytime Phone No. _____

HISTORY OF PRESENT ILLNESS

_____

_____

_____

ENVIRONMENTAL HISTORY

☐ Apartment
☐ Private home
☐ Bedrooms
☐ Smokers
☐ Pets
☐ Smoke Detectors____

☐ Own Room
☐ Share room with
☐ Persons living in house
_____
_____

Water Sewage
☐ City Utilities
☐ Septic tank
☐ Farm water

PAST MEDICAL HISTORY:

☐ No previous hospitalization ☐ No major illness
☐ Other: _____

BIRTH DATA

Age of Mom_____ Gravida/Para_____
Prenatal Care: ☐ Yes (>8 visits) ☐ No
Complications during pregnancy___
_____
☐ Full term ☐ Premature _____wks
Type of delivery
☐ Normal Delivery
☐ C-Section due to _____
Birth weight _____
Birth hospital _____
Complications after delivery _____
_____

FEEDING DATA

☐ Breast feeding _____ mins.
Every _____ hrs.
☐ Formula: Type _____
Amount per feeding _____
Every _____ hrs.
☐ Regular Diet
☐ Special Diet _____
☐ Feeding problems _____
☐ Good Appetite

DEVELOPMENTAL FACTS

Held up head _____
Rolled over_____
Sat alone_____
Stood alone_____
Walked_____
Said words_____
Toilet trained_____
Grade level_____

FAMILY HISTORY

Mother_____
Father_____
Brothers/Sisters:
1._____Age___Sex___Height___
2._____Age___Sex___Height___
3._____Age___Sex___Height___
4._____Age___Sex___Height___
5._____Age___Sex___Height___

Family Medical History:
☐ Cancer_____
☐ Heart disease_____
☐ Diabetes_____
☐ Anemia_____
☐ Sickle Cell_____
☐ Mental illness_____
☐ High blood pressure_____
☐ Asthma_____
☐ Seizures_____
☐ Bad nerves_____
☐ Tuberculosis_____
☐ Stroke_____
☐ Others_____
_____

ABBREVIATIONS:
MGM – Maternal Grandmother
MGF – Maternal Grandfather
MA – Maternal Aunt
MU – Maternal Uncle
MGA – Maternal Great Aunt
MGU – Maternal Great Uncle
PGM – Paternal Grandmother
PGF – Paternal Grandfather
PA – Paternal Aunt
PU – Paternal Uncle
PGA – Paternal Great Aunt

RECORD OF ILLNESS

Allergies_____
Chicken pox_____
Pneumonia_____
T&A_____
Tonsillitis_____
Ear tube placement_____
Major operations and/or injuries
_____
_____

Home Meds:_____
_____

ROS:
☐ Regular bowel movement
☐ Good hearing
☐ Good vision
☐ Rashes _____
☐ Other _____

ACCOUNT OF IMMUNIZATIONS

DTap	1._____		Rota	1._____	
	2._____			2._____	
	3._____			3._____	
	4._____			4._____	
	5._____		HIB	1._____	
Tdap/Td	1._____			2._____	
	2._____			3._____	
IPV	1._____			4._____	
	2._____		Va	1._____	
	3._____			2._____	
	4._____		HBV	1._____	
PCVT	1._____			2._____	
	2._____			3._____	
	3._____		HAV	1._____	
	4._____			2._____	
MMR	1._____		MCV4	1._____	
	2._____		Other	_____	

Reviewed by_____ ☐ Advance Directives Policy discussed