3721 Lynn Road, Suite 104 Raleigh, NC 27613 Office: 919 825-3600 Fax: 984 200-6001

Authorization to Use/Release/Disclose Health Information

Please complete one form per child

Please Note: We can serve your child better if we receive their's records prior to their 1st appointment.

I hereby authorize the use, release and/or disclosure of my health information as described below.
Patient Name:_____ Date of Birth:____/____/_____

Organization(s) Providing the Information:	Organization Receiving the Information:
Name:_____	Mack Pediatrics
Street:_____	3721 Lynn Road, Suite 104
City/State/Zipcode:_____	Raleigh, NC 27613
Phone_____ Fax_____	Phone 919-825-3600 Fax 984-200-6001

I authorize this information to be sent to Mack Pediatrics at the above address:
X Copy of specified medical records: first and last wellness check, last sick/problem visit, immunization record, medication list, allergies, problem list, and diagnosis list.

- I have the right to revoke this Authorization, in writing, at any time by notifying Mack Pediatrics. Such revocation will not apply to information that has already been disclosed in reliance of this Authorization.
- I have the right not to sign this Authorization. Mack Pediatrics will not condition treatments, payment for services or enrollment or eligibility for benefit on whether I sign this Authorization.
- The Organization Providing the Information may deny in writing your request to inspect and/or copy your records in limited circumstances. You may request a review of the denial in writing.
- I have read and understand this Authorization, have had the opportunity to have my questions answered, have signed this Authorization freely and, if requested have received a copy of it.
- This Authorization expires one year after the date below unless otherwise specified:_____

Signature: _____Name:_____ Date ____/____/_____
Relationship to Child:_____

3721 Lynn Road, Suite 104 Raleigh, NC 27613 Office: 919 825-3600 Fax: 984 200-6001

Please complete one form per child

Patient: _____ Date of Birth:____/____/_____

Acknowledgment of Receipt - Notice of Privacy Practices

I have received a copy of the HIPAA roles and regulations to review for my knowledge and use. I have the right to request a copy for my own use.

Person signing for patient: _____
Signature: _____
Relationship to patient: _____

Consent for treatment

I consent to allow the clinical staff at Mack Pediatrics, including Dr. Mack and her nurse-associates, to treat my child as medically necessary or medically indicated on my child's office visit.

Person signing for patient: _____
Signature: _____
Relationship to patient: _____

If Patient or Patient's personal representative does not sign, indicate below the reasons why signature could not be obtained:

Name of practice staff member:_____Date:____/____/_____

3721 Lynn Road, Suite 104 Raleigh, NC 27613 Office: 919 825-3600 Fax: 984 200-6001

New Patient Questionnaire

Please complete one form per child

Patient Name:_____ Date of Birth:____/____/_____

1. How did you hear of Mack Pediatrics?

_____

If referred to us, by whom?_____

2. Tell us why you need a new Pediatric Practice(circle one): New baby / New to area / Second opinion
If "Second opinion", please explain:

_____

Other reason:_____

3. Is your child up to date on vaccinations/immunizations? No__ Yes___If no, please indicate why and review our vaccination policy. Mack Pediatrics does not accept families who choose not to vaccinate for personal or religious reasons. Reason child is not fully vaccinated:_____

_____

4. Who has custody of child? _____ If any special arrangements are in place due to separation/ divorce or parents, any foster care, adoption, etc., please complete our "Separated-Divorced Custody Summary" form and provide necessary documentation indicating who has the right to bring the child to appointments.

3721 Lynn Road, Suite 104 Raleigh, NC 27613 Office: 919 825-3600 Fax: 984 200-6001

Patient Medical/Social History (please complete one per child)

Name of patient (child): _____
Date of Birth:____/____/_____ Today's Date:____/____/_____
If applicable, patient's cell phone number: _____

Is your child allergic to any medication? No__ Yes___ If yes, please indicate the name of medication(s) and type of reaction:_____
Has your child had a serious reaction to an immunization? No__ Yes___ If yes, which immunization and type of reaction? _____
Does your child have any food allergies? No__ Yes___ If yes, please list food/reaction:_____
_____
Has your child been prescribed an epinephrine injector (Epi-Pen or Auvi-Q) for a severe allergic reaction? No__ Yes___

Medications your child is taking (include herbals and vitamins):

MEDICATION	DOSAGE	TIMES A DAY

Check yes if your child currently has or has had any of the following medical conditions:

	yes		yes
Attention Deficit Disorder		Hearing problems	
Asthma		Vision problems	
Frequent wheezing or coughing		Teeth problems	
Urinary tract infections		Constipation	
Recurrent or frequent ear infections		Anemia	
Recurrent or frequent strep throat		Eczema, hives or skin conditions	
Heart murmur		Convulsions/ central nervous system problems	

Other medical conditions not listed above?_____
Any hospitalizations? Please describe (date/ location/ reason):_____
Any surgeries? No__ Yes___ If yes, please complete indented list below:
Ear tube placement? No__ Yes___ If yes, at what age?_____
Tonsillectomy? No__ Yes___ If yes, at what age?_____
Adenoidectomy? No__ Yes___ If yes, at what age?_____
Other surgeries, including circumcision?_____
Any serious injuries? No__ Yes___ If yes, what and at what age?_____
Prematurity or complications at birth? No__ Yes___ Please describe_____

Has anyone in your child's immediate family had any of the following conditions?

	Yes	Relationship to child		Yes	Relationship to child
High blood pressure			Sickle cell anemia		
Heart attack age <55			Cystic fibrosis		
Stroke at age <55			Hemophilia		
Diabetes Type 1			Tuberculosis		
Diabetes Type 2			Hepatitis		
High cholesterol			AIDS		
Thyroid problems			Mental illness		
Obesity			SIDS		
Asthma			Cancer		
Allergic disorders			Genetic syndromes		
Seizures/epilepsy			Deafness		
Migraine headaches			Drug or alcohol abuse		

Social History/Safety/Environment:

What type of home do you live in?	House	Apartment	Other:_____
What is the source of your child's drinking water?	City	Public well	Private well | Bottled
Is there a working smoke detector on every floor at home?	No	Yes	
Does anyone smoke in the home?	No	Yes	
Is there any violence in the home?	No	Yes	
Is your child in daycare or preschool?	No	Yes	Where?
Is your child enrolled in school?	No	Yes	Where?
If your child is less than 6 years old, do they use a carseat?	No	Yes	
If your child is 4-12 years old, do they use a booster seat in the car?	No	Yes	
If your child is less than 13 years old, do they ride in the back-seat of the car?	No	Yes	
Does your child wear a seat belt when in a car?	No	Yes	
Does your child wear a helmet when riding a bicycle or using a scooter?	No	Yes	
Do you have pets?	No	Yes	If yes, what kind? _____
Are there guns or firearms in your home?	No	Yes	If yes, how are they secured?_____

If transferring here from elsewhere, does your child have a record of vaccinations? No__ Yes___
Is your child adopted? No__ Yes___ If yes, from what country or geographic area? _____
At what age was your child when adopted?:_____
Signature: _____Name:_____ Date ____/____/_____
Relationship to child:_____

_____

3721 Lynn Road, Suite 104 Raleigh, NC 27613 Office: 919 825-3600 Fax: 984 200-6001

Vaccination Policy (please complete one per child)

The physicians and staff of Mack Pediatrics fully support the efficacy and safety of vaccines (aka shots, immunizations, vaccinations). We follow the standard vaccination schedule as recommended by the ACIP (Advisory Committee on Immunization Practice, part of the CDC Centers for Disease Control and Prevention) and the North Carolina State Law as the minimum requirement for vaccination for all of our patients. Mack Pediatrics expects our patients to be vaccinated on time per the ACIP schedule, starting with the Hepatitis B vaccine in the first 24 hours of life in the hospital or birthing center (if vaccine is available).

If you are transferring your child into our practice from another medical provider, we will review the child's immunization records. If we determine that your child is significantly delayed or behind on shots, you will be asked to schedule a vaccine consultation before we will see your child as a patient. We will work with new families to comply with vaccine recommendations and get back on track for your child's current age. However, if a requested vaccine consultation does not occur, or if you are not willing to comply with NC vaccination laws, Mack Pediatrics is not the right practice for your family and we will not accept the child as a new patient. If you decide during the course of being a patient family here at Mack Pediatrics that you do not wish to continue to comply with the NC vaccination laws, then you acknowledge here that your children will be dismissed from Mack Pediatrics and will need another pediatric practice.

We are happy to discuss your questions about vaccines during wellness appointments. If there are extensive concerns or questions, parents will need to set up a separate vaccine consultation appointment. It is important to understand that this visit may not be covered by insurance and parents will be responsible for paying for this consultation at the time of service. Such consultations usually range in cost from $150-$300, depending on the amount of time spent with the physician.

Vaccine Consent Form:

By signing this consent, I am giving Mack Pediatrics permission to vaccinate my child at this and future appointments. I will be offered a Vaccine Information Statement explaining each vaccine before it is administered. I may also refer to https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html for the Immunization Schedules of the Centers for Disease Control and Prevention.

I, parent/guardian of _____ (child's name) have read the vaccination policy and give permission for age-appropriate immunizations to be administered.

Signature: _____Name:_____ Date ____/____/_____

Relationship to child:_____