HVCH Rural Health Clinic
Child/Minor Registration Form

Date_____

Please Print Clearly Patient Social Security # _____-_____-_____

Name (as listed with insurance): _____

Nickname: _____DOB:_____ Sex: Male Female

Mailing Address: _____

Physical Address:_____

City:_____ State:_____ Zip:_____

Race:_____ Ethnicity: **Hispanic/Latino** or **Not Hispanic/Latino** Language:_____

Responsible Party: Name:_____DOB_____Phone_____

Responsible Party SSN: _____-_____-_____ Relationship to Patient:_____

Address (if different from above): _____

Parent/Guardian: Name:_____DOB_____Phone_____

Parent/Guardian: Name:_____DOB_____Phone_____

Parent/Guardian Email:_____

Pharmacy Name & Location_____

Please list the names of any siblings/children in the home who see our providers:_____
_____

Insurance Information

Primary Insurance:_____ID#_____

Subscriber's Name: _____Relationship:_____

Subscriber's DOB:_____ Subscriber's Social Security Number: _____

Secondary Insurance: _____ID#_____

Subscriber's Name: _____ Relationship:_____

Subscriber's DOB:_____ Subscriber's Social Security Number:_____

Medication List

Patient Name:_____

Date of Birth: _____ **Today's Date**:_____

List all medications, including prescription medication from all physicians, over the counter medications, herbal supplements, and vitamins. If you don't know please call your pharmacist to confirm. This list will need to be approved and every patient will have an OARRS report completed.

Medication name	Dose (mg)	Instructions	Prescribing Doctor

Allergies

Please list all allergies to medications, foods, and/or the environment (bees, pollen, mold, etc)

Allergen/Medication	Reaction	Severity of Reaction

HVCH Rural Health Clinic, Pediatrics
1383 West Hunter St. Logan, Ohio 43138
Phone (740)385-3069 Fax (740)0865
Dr. Mark Scarmack, M.D.
Fallon Magdich-Ritchey, NP-C
Adrienne Nihiser, NP-C

Parent/Guardian Consent for Treatment

Consent to be treated by HVCH Rural Health Clinic:

I, _____, parent/guardian of _____(child's name), give my consent for HVCH Rural Health Clinic to treat my child and perform any services that are indicated by my child's age or symptoms.

Consent to child to be brought to the office for treatment by another adult:

I give my consent to HVCH Rural Health Clinic for treatment and immunization for my child when he/she is accompanied to the clinic by the following person(s):

Name_____ *relationship to child*_____

Name_____ *relationship to child*_____

Name_____ *relationship to child*_____

Release of medical information:

Pertinent medical information regarding my child's treatment may only be released to the following person(s):

Name_____ *relationship to child*_____

Name_____ *relationship to child*_____

Name_____ *relationship to child*_____

I also consent to let HVCH Rural Health Clinic share/release medical information to/with my doctors, or referring/referral health care provider; and/or to any insurance company or organization that helps pay my bill.

I agree to be financially responsible for all care rendered. I consent to let HVCH Rural Health Clinic bill my insurance companies, Medicaid or third party payers for health care services provided.

I certify that the information I have given to HVCH Rural Health Clinic is correct and accurate to the best of my knowledge.

If I decide to stop my child's medical care against the advice of doctors, I am responsible for any adverse consequences.

These authorizations will remain in effect until I revoke them in writing.

Parent/Guardian Signature Date

HEALTH HISTORY & PHYSICAL FORM FOR MINORS

NAME: _____ Date of Birth: _____TODAY'S DATE: _____

DATE OF LAST PHYSICAL EXAM: _____ PRIMARY CARE PROVIDER: _____

PERSONAL MEDICAL HISTORY: (Please circle/fill in all that apply)

ADHD	Congenital Heart Disease	HIV (or AIDS)
Allergies, Seasonal	Crohn's Disease	Hepatitis
Anemia	Cystic Fibrosis	Irritable Bowel Syndrome
Anxiety	Depression	Kidney Disease
Arrythmia (Irregular Heartbeat)	Diabetes: 1 or 2	Learning/Cognitive Disorder
Autism	Eczema	Liver Disease
Bipolar	Epilepsy	Lupus
Bladder problems/Incontinence	Gallstones	Lyme Disease
Bleeding Problems	GERD/Acid Reflux	Migraines
Cancer:_____	Headaches	Nosebleeds
Celiac Disease	Hemophilia	Neuromuscular Disorder
Cerebral Palsy	Hiatal Hernia	Neurologic Disorder/Seizures
Chemical Dependency	High Blood Pressure	Psoriasis
Clotting Disorder	High Cholesterol	Sickle Cell Anemia

OTHER MEDICAL PROBLEMS NOT LISTED ABOVE:

_____

_____

Eyes: _____ Wears glasses _____ Wears contacts _____ Vision Changes (date of changes: _____)

SOCIAL HISTORY: (Please circle/fill in all that apply)

Caffeine: Currently / Past / Never Drinks/day:_____

Smoking/ Vaping: Currently / Past / Never Packs/day:_____

Alcohol: Currently / Past / Never Drinks/day:_____

Recreational Drug Use: Currently / Past / Never

SURGICAL HISTORY: (Please list all prior surgeries and approximate dates performed)

_____ _____

_____ _____

HEALTH MAINTENANCE/ VACCINATION HISTORY:

Required Vaccines (*per state of Ohio for school attendance)*	Date:	**Recommended Vaccines**	Date:
DTap/Tdap/Td		Influenza (flu)	
Meningococcal/Men B		Human Papilloma Virus (HPV)	
Measles Mumps Rubella (MMR)		Hepatitis A	
Varicella		Pneumoccal	
Polio		Hib (Hemophilus influenza type B)	
Hepatitis B		Covid	

FAMILY HISTORY:

FATHER: Living: Age_____ Deceased: Age_____

Alcoholism	Bipolar	COPD	Heart Disease	Kidney Disease
Anemia	Blood Clot	Dementia	High Blood Pressure	Osteoporosis
Arthritis	Cancer: _____	Depression	High Cholesterol	Stroke
Asthma	Chemical Dependency	Diabetes 1 or 2	Kidney Disease	Thyroid Problems

Other: _____

MOTHER: Living: Age_____ Deceased: Age_____

Alcoholism	Bipolar	COPD	Heart Disease	Kidney Disease
Anemia	Blood Clot	Dementia	High Blood Pressure	Osteoporosis
Arthritis	Cancer: _____	Depression	High Cholesterol	Stroke
Asthma	Chemical Dependency	Diabetes 1 or 2	Kidney Disease	Thyroid Problems

Other: _____

SIBLINGS: Living: Age(s) ___ ___ ___ Deceased: Age(s)___ ___ ___

Alcoholism	Bipolar	COPD	Heart Disease	Kidney Disease
Anemia	Blood Clot	Dementia	High Blood Pressure	Osteoporosis
Arthritis	Cancer: _____	Depression	High Cholesterol	Stroke
Asthma	Chemical Dependency	Diabetes 1 or 2	Kidney Disease	Thyroid Problems

<u>List other medical providers you see on a regular basis</u> (i.e. Mental Health Provider, Neurologist, Kidney specialist, etc.)

_____
_____
_____
_____

<u>FOR OFFICE USE ONLY!!!!</u>

- ☐ Registration
- ☐ Insurance
- ☐ HIPAA
- ☐ H&P
- ☐ Medication List
- ☐ Preloaded by: _____

Patient Signature: _____ Date: _____

Provider Reviewed: _____ Date: _____

HOCKING VALLEY
Community Hospital

HVCH Rural Health Clinic, Family Practice & Pediatrics
1383 West Hunter St. Logan, Ohio 43138
Phone (740)385-3069/(740)385-0202
Dr. Brian Still, D.O. • Amanda Downs-Davis, NP-C
Fallon Magdich-Ritchey, NP-C • Adrienne Nihiser, NP-C
• Dr. Conner Hosner, MD

Consent to Treat an Unaccompanied Minor

The providers and staff of HVCH Rural Health Clinic, Family Practice & Pediatrics place a great emphasis on the health and well-being of our patients. With so many parents working outside the home or with other commitments, we realize that you may not be able to accompany your child to every visit at our clinic**. If your child presents to the clinic unaccompanied, documentation providing consent to treat from the parent/guardian is *required***. If they do not have expressed written consent from their parent/guardian the appointment will be rescheduled.

In an effort to provide the care needed, we have developed a Consent to Treat an Unaccompanied Minor form that will be placed in your child's medical record, should it be necessary. This form allows our providers to provide both routine and emergency medical care for your minor child in your absence. This consent will remain in effect until revoked in writing or otherwise stated on this form.

Patient Name:_____ **Date of Birth:**_____

I, the parent or legal guardian of the above named minor patient, do herby authorize the providers at Hocking Valley Community Hospital Rural Health Clinic, Family Practice & Pediatrics to perform medical treatment including physical examination, medical diagnosis and treatment or other medical care which is deemed advisable by the treating provider who is licensed in the state of Ohio. I further acknowledge that I am responsible for any portion of charges that are not covered by the minor's insurance. This authorization is valid for the following services (please check all that apply):

◯ **For any and all medical treatment (Preventative care, immunization, and care for illness)**

◯ **For specific problem/concern(s) and/or a specific date range as listed below:**

_____

◯ **Today's Visit ONLY :**_____/_____/_____

This consent will remain valid until revoked in writing unless otherwise stated on this form.

Parent or legal guardian (please print name): _____

Parent or legal guardian signature:_____

Date Effective:_____ /_____/_____

Witness/Staff signature:_____