KELLY FAMILY CLINIC
Family Medicine & Obstetrics

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Address: _____City:_____State:_____Zip:_____

Primary Phone: (_____) _____ Secondary Phone: (_____) _____ Other Phone: (____) _____

SS#: _____-____-_____ Race: _____ Ethnicity: _____ Preferred language: _____

Emergency contact: _____ Phone: (_____) _____ Relationship: _____

Preferred pharmacy: _____ Location: _____

INSURANCE INFORMATION

Policy holder: _____ DOB: _____

Holder's SSN#: _____-____-_____ Relationship to Patient: _____

Financial Responsibility/Assignment of Benefits

As a courtesy to you, our office will file insurance for all reimbursable services to both your primary and secondary insurance carriers. While we do our best to accurately predict your insurance coverage, sometimes our estimates are inaccurate due to circumstances beyond our control. Should your insurance not pay as we expect, or does not pay in a timely manner, you will be responsible for the unpaid portion of your charges.

I assign to C. Kelly Family Clinic, PA, any insurance, or other third party benefits available for health care services provided to me. I understand that C. Kelly Family Clinic, PA has the right to refuse or accept assignment of such benefits.

I have been given the opportunity to read the clinic's patient policies and procedures. The policies are available upon request.

Signature of Patient or Responsible Party: _____ Date: _____

HIPAA INFORMATION

Protected health information (PHI) will only be released from our practice with a properly executed authorization from the patient or his/her personal representative, except for treatment, payment, or health care operations and as otherwise required by law. Examples of some instances in which we are required to disclose your PHI include: Public health activities; information regarding victims of abuse, neglect, or domestic violence; health oversight activities; judicial and administrative proceedings; law enforcement purposes; organ donations purposes; research purposes under certain circumstances; national security and intelligence; and correctional institutions**. C. Kelly Family Clinic, PA** will only use or disclose PHI, except as noted above, consistent with the terms of the authorization.

I understand that I have the right to review the notice of Privacy Practices that provides a more complete description of information uses and disclosures.

Kelly Family Clinic may share my PHI with the following additional person(s): _____

Signature_____ Date _____

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MOTHER'S INFORMATION

Name: _____ Date of Birth: _____

Address: _____City:_____State:_____Zip:_____

Primary Phone: (_____) _____ Secondary Phone: (_____) _____ Other Phone: (_____) _____

SS#: _____ - _____ - _____ Email Address: _____

FATHER'S INFORMATION

Name: _____ Date of Birth: _____

☐ SAME AS ABOVE
Address: _____City:_____State:_____Zip:_____

Primary Phone: (_____) _____ Secondary Phone: (_____) _____ Other Phone: (_____) _____

SS#: _____ - _____ - _____ Email Address: _____

GUARANTOR INFORMATION – PERSON RESPONSIBLE FOR BILLING ACCOUNT

Name: _____ Date of Birth: _____

☐ SAME AS ABOVE
Address: _____City:_____State:_____Zip:_____

Primary Phone: (_____) _____ Secondary Phone: (_____) _____ Other Phone: (_____) _____

SS#: _____ - _____ - _____ Email Address: _____

SOCIAL HISTORY

Parent's Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Lives with: ☐ Both parents ☐ Mother ☐ Father ☐ Grandparents ☐ Other: _____

Siblings (name and age):_____

Mother's Occupation: _____ Father's Occupation: _____

Guardian's Occupation: _____

Day Care: ☐ Full time ☐ Part time ☐ None If none, who cares for your child during the day? _____

School: _____

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Medical History:

Has your child ever been admitted to the hospital? ☐ Yes ☐ No **If so, when/ reason?** _____

Surgical history/ Year/ Age: _____

List any known medical conditions: _____

Medication allergies, Adverse reactions, Other allergies

☐ **No Known Drug Allergies**

Name	Reaction

Current Medications: (include over the counter medications and food supplements)

☐ **No Current Medications**

Drug Name	Dose	How Often

Family History: Have any of your child's family members (mother, father, siblings, grandparents) had any of the following problems?

	Condition	Family Member
	Heart Condition	
	Diabetes	
	High Blood Pressure	
	High Cholesterol	
	Thyroid Disease	
	Migraines	

	Condition	Family Member
	Asthma	
	Seizure Disorder	
	Depression	
	Other Mental Illness	
	ADD/ADHD	
	Cancer:_____	

Any other illness in the family not listed? _____

Reason for Visit: _____

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Physician Assistant Consent for Treatment

This facility has on staff a physician assistant to assist in the delivery of medical care.

A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by the Texas Medical Board. Under the supervision of a physician, a physician assistant can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care.

"Supervision" does not require the constant physical presence of a supervising physician, but rather overseeing the activities of, and accepting responsibility for the medical services provided.

A physician assistant may provide such medical services that are within his/her education, training and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulate a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Assisting at surgery
- Offering counseling and education
- Supplying sample medications and writing prescriptions (where allowed by law)
- Making appropriate referrals

I have read the above, and hereby consent to the services of a physician assistant for my health care needs.

I understand that at any time I can refuse to see the physician assistant and request to see a physician.

_____ _____

Signature Date

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Immunization Intent

Please initial the following statements:

___ I understand that Dr. Kelly will be my baby's pediatrician both in the hospital after delivery and for follow-up well child visits in the clinic.

___ I understand that Dr. Kelly requires all patients to be fully immunized.

___ I agree that my child will be immunized according to the schedule recommended by the CDC.

___ I understand that if I choose to follow a different schedule or to not immunize my child, Dr. Kelly will be unable to treat my child for any healthcare.

_____ _____

Signature Date